



# **Appendix F: Intensive Clinic Based Support**

**Last Updated: 08/15/2022**

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# Appendix F: Intensive Clinic Based Support

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## Definitions

“Care Coordination” means locating and coordinating services across multiple providers to include sharing of information among health care providers and others who are involved with an individual's health care, to improve the restorative care and align service plans.

“Crisis Intervention” means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.

“Health Literacy Counseling” means patient counseling on mental health, and, as appropriate, addiction, treatment, and recovery, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.

“Peer Recovery Support Services” means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual.

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

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

“Week” is defined as Sunday through Saturday

The following definitions found in Chapter 2 of this manual, apply to this Appendix:

- Licensed Behavior Analyst (LBA)
- Licensed Mental Health Professional (LMHP)
- LMHP-resident (LMHP-R)
- LMHP-resident in psychology (LMHP-RP)
- LMHP-supervisee in social work (LMHP-S)
- Registered Peer Recovery Specialist
- Qualified mental health professional-adult (QMHP-A)
- QMHP-child (QMHP-C)
- QMHP-eligible (QMHP-E)

The following definitions found in Chapter 4 of this manual, apply to this Appendix:

- Assessment
- Comprehensive Needs Assessment
- Counseling
- Individual Service Plan (ISP)
- Psychoeducation
- Treatment Planning

## **Mental Health Intensive Outpatient Services (MH-IOP)**

<p>Service Definition</p>	<p>Mental Health Intensive Outpatient Services (MH-IOP) are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time-limited treatment programs that integrate evidence-based practices for youth (ages 6-17 years) and adults (18 years +). Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, children younger than age 6 may receive services based on medical necessity. MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. MH-IOP services are appropriate when an individual requires at least six hours of clinical services a week (for youth ages 6-17), or nine hours of clinical services as week (for adults 18 years and older) over several days a week and totaling a maximum of 19 hours per week. A MH-IOP requires psychiatric oversight with medication management included in the coordinated structure of the treatment program schedule. MH-IOP tapers in intensity as an individual's symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care.</p>
<p>Critical Features &amp; Service Components</p>	<p>MH-IOP is an active treatment program of services that includes an individualized treatment plan describing the coordination of those services and how they will address the individual's goals. MH-IOP services include structured schedules for participants. Treatment goals should be measurable, person-centered, recovery oriented, trauma-informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission.</p> <p>Critical features of MH-IOP include:</p> <ul style="list-style-type: none"> <li>• The integration and documentation of evidence based practices to address family, social and community risk factors and provide coping skills to improve symptoms and functioning; and</li> <li>• The promotion of behavior change in the individual's natural environment, with the overriding goal of empowering the individuals, their identified family natural supports to promote improved functioning; and</li> <li>• The inclusion of rigorous quality assurance mechanisms that focus on achieving individual outcomes through monitoring treatment fidelity and progress and adjusting treatment goals and plans to address individual needs and barriers as they arise.</li> </ul> <p>This service is appropriate for individuals who do not require the intensive level of care of inpatient, residential or partial hospitalization services, but do require more intensive services than traditional outpatient psychiatric services, and would benefit from a structured setting.</p> <p>MH-IOP services include both the comprehensive, structured delivery of evidence-based therapy services in combination with care coordination activities that seek to support recovery and movement into a lower level of care, such as traditional outpatient psychiatric services. Care coordination services should focus on identification of additional needs to support recovery (e.g. housing, employment, food stability, mentoring, and parenting supports) and connecting the individual and natural supports to appropriate referrals to meet these needs.</p> <p>Covered service components include assessment, treatment planning, individual, family and group therapy, skills restoration/development, health literacy counseling/psychoeducational activities, crisis intervention, peer recovery support services and care coordination.</p>

<p>Required Activities</p>	<p>In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-IOP:</p> <ul style="list-style-type: none"> <li>• At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter 4 for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-IOP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter 4 for details).</li> <li>• An evaluation for medication management by a physician, nurse practitioner or physician assistant must be conducted within 72 hours of admission into the service. The provider must coordinate medication management with existing medical and psychiatric providers.</li> <li>• Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.</li> <li>• ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.</li> <li>• MH-IOP must be available to allow for 9-19 hours of intervention a week (for adults) or 6-19 hours of intervention a week (youth ages 6-17) with programming to occur across 3-4 days of services weekly.</li> <li>• Components of the treatment program must include all of the following:       <ol style="list-style-type: none"> <li>1. Individualized treatment planning;</li> <li>2. Individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others) in the assessment, treatment, and continuing care of the individual;</li> <li>3. Skill restoration / development;</li> <li>4. Health literacy counseling / psychoeducational activities;</li> <li>5. Care coordination &amp; referral for consultation, supplemental, or step-down service providers;</li> <li>6. Crisis intervention</li> <li>7. Peer Recovery Support Services;</li> <li>8. Medication management</li> <li>9. Occupational therapy, as an optional supplement, when it is directly related to the behavioral health goals; and</li> <li>10. Psychological assessment/testing as an optional supplement.</li> <li>11. Care coordination through referrals to higher and lower levels of care, as well as community and social supports, should include the following:           <ol style="list-style-type: none"> <li>1. The provider should collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;</li> <li>2. The provider should establish and maintain referral relationships with step-down programs appropriate to the population served;</li> <li>3. The provider should, with individual's consent, collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.</li> </ol> </li> </ol> </li> <li>• A minimum of 2 distinct service components must be provided daily. If the minimum service components are not met, providers must document the reason in the individual's medical record. If the session involves a Comprehensive Needs Assessment no other component shall be required in order to bill the per diem.</li> <li>• A minimum of 2 hours of therapy (individual, group or family) by a LMHP, LMHP-R, LMHP-RP or LMHP-S shall be provided per individual per week. Individuals may be pulled out of scheduled skill-based groups to participate in therapy. If the individual continues to meet with an existing outpatient therapy provider, the MH-IOP provider must coordinate the treatment plan with the provider.</li> <li>• Group therapy shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the licensed mental health professional.</li> <li>• A minimum of 3 sessions of group-based delivery of skills-restoration/development shall be provided per week.</li> <li>• 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. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.</li> <li>• Whenever possible, crisis intervention should be delivered by the MH-IOP staff, including after program hours.</li> <li>• In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record and notify the MCO or the FFS contractor Utilization Management (UM) staff when the minimum sessions have not been provided (see service authorization section for additional information).</li> <li>• If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the FFS contractor care coordination to reassess for another level of care or model to better meet the individual's needs.</li> <li>• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).</li> </ul>
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Service Limitations	<p>In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV, the following service limitations apply:</p> <ul style="list-style-type: none"> <li>• MH-IOP may not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0 (with the exception of ASAM level 3.1), Mental Health Partial Hospitalization Programs, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or inpatient admission. A seven day overlap with any outpatient or community based behavioral health service may be allowed for care coordination and continuity of care.</li> <li>• If an individual has an authorization for a behavioral health service prior to admission to MH-IOP that is not allowed to be authorized concurrently with MH-IOP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-IOP within 31 days. Contact the individual’s MCO or FFS contractor for authorization requirements.</li> <li>• MH-IOP may be billed only within 7 days prior to discharge from Residential Levels of Care, as the individual is transitioning to a lower level of care.</li> <li>• Activities that are not reimbursed or authorized:             <ol style="list-style-type: none"> <li>1. Time spent in any activity that is not a covered service component;</li> <li>2. Transportation;</li> <li>3. Staff travel time;</li> <li>4. Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions;</li> <li>5. Time spent in snacks or meals;</li> <li>6. Time when the individual is not present at the program;</li> <li>7. Time spent in educational instruction; nor</li> <li>8. Supervision hours of the staff.</li> </ol> </li> </ul> <p>Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.</p>
<b>MH-IOP Provider Participation Requirements</b>	
Provider Qualifications	<p>MH-IOP service providers shall be accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), DNV Healthcare or Joint Commission, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of Mental Health Intensive Outpatient Services, and credentialed with the individual’s Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. For newly DBHDS licensed providers, documentation from the accrediting body that accreditation has been initiated must be submitted to the MCO or FFS Contractor. Full accreditation must be completed within two years of the date on the documentation submitted. MH-IOP service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.</p> <p>MH-IOP services should occur in a clinic type setting. Schools may serve as settings for co-location of MH-IOP programs for youth, and their design should take place in coordination with the school to assure that an appropriate school-based clinic setting is available. Regardless of setting, these programs should not be disruptive of the school day or provided as part of the school day structure for youth participants.</p>
Staff Requirements	<p>MH-IOP service providers shall meet the staff requirements as follows: A multidisciplinary treatment team is comprised, at a minimum, of the following:</p> <ul style="list-style-type: none"> <li>• Clinical Director - Licensed Clinical Psychologist (LCP), Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT);</li> <li>• Physician/Nurse Practitioner/Physician Assistant (to provide assessments and weekly medication management)</li> <li>• LMHP, LMHP-R, LMHP-RP, or LMHP-S;</li> <li>• QMHP-A, QMHP-C or QMHP-E;</li> <li>• Registered Peer Recovery Specialist;</li> <li>• Occupational Therapists (Required only for specialty programs, provided at least 2 days per month)</li> </ul> <p>Staff shall be cross-trained to understand behavioral health disorders, signs and symptoms of substance use disorders, be able to understand and explain the uses of psychotropic medications, and understand interactions with substance use and other addictive disorders.</p> <p>Staffing ratios should not exceed one staff member per five individuals in the program. Clinical supervision of staff should not exceed one supervisor for six direct care workers.</p> <p>Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S.</p> <p>Skills Restoration/Development, Crisis Intervention and Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E.</p> <p>Health literacy counseling / psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist or a Registered Nurse (RN) or Licensed Practical Nurse (LPN) with at least one year of clinical experience.</p> <p>Peer recovery support services must be provided by a Registered Peer Recovery Specialist.</p> <p>RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians, Physician Assistants and Occupational Therapists shall hold an active license issued by the Virginia Board of Medicine.</p>
<b>MH-IOP Medical Necessity Criteria</b>	

<p>Admission Criteria          Diagnosis, Symptoms, and Functional Impairment</p>	<p>Must meet all of the following criteria:</p> <ol style="list-style-type: none"> <li>1.             <ol style="list-style-type: none"> <li>1.                 <ol style="list-style-type: none"> <li>1. The individual must exhibit symptoms consistent with a DSM diagnosis (using the most current version of the DSM) that is documented in the initial assessment that requires and can reasonably be expected to respond to treatment interventions</li> </ol> </li> <li>1.                 <ol style="list-style-type: none"> <li>1. Within the past 30 days, the individual has experienced persistent or increasing symptoms associated with their primary DSM disorder which has contributed to decreased functioning in their home, school, occupational or community settings that has led to negative consequences and difficulties maintaining supportive, sustaining relationships with identified family and peers due to a psychiatric disorder. Interventions at lower levels of care or in alternative, community-based rehabilitation services have been attempted but have been unsuccessful in adequately addressing the symptoms and supporting recovery for the individual to baseline levels of functional capacity;</li> <li>3. The individual is at risk for admission to inpatient hospitalization, residential treatment services, residential crisis stabilization or partial hospitalization as evidenced by acute intensification of symptoms, but has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; or the individual is stepping down from inpatient hospitalization, residential crisis stabilization, or a partial hospitalization program and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision;</li> <li>4. The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours and a safety plan has been established;</li> <li>5. The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team;</li> <li>6. The individual can reliably attend, and actively participate in, all phases of the treatment program;</li> <li>7. The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and</li> <li>8. For youth, there is a family/caregiver resource that is available to engage with treatment providers and support and reinforce the tenets of the MH-IOP services.</li> </ol> </li> </ol> </li> </ol>
<p>Exclusion Criteria</p>	<p>Individuals meeting any of the following are ineligible for MH-IOP:</p> <ul style="list-style-type: none"> <li>• Functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100;</li> <li>• The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;</li> <li>• The individual's psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;</li> <li>• The individual, their authorized representative, or their guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment;</li> <li>• The individual requires a level of structure and supervision beyond the scope of the program;</li> <li>• The individual has medical conditions or impairments that needs immediate attention;</li> <li>• The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration; and/or</li> <li>• Presenting issues are primarily due to Substance Use Disorder; in this case, the individual should be evaluated for Addiction and Recovery Treatment Services.</li> </ul>



<p>Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment</p>	<p>Individuals must meet all of the following:</p> <ol style="list-style-type: none"> <li>1. The individual continues to meet admission criteria;</li> <li>2. Another less intensive level of care would not be adequate to administer care;</li> <li>3. Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care;</li> <li>4. The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan (ISP) has been revised to incorporate new goals;</li> <li>5. The individualized treatment plan (ISP), updated every 30 calendar days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan (ISP);</li> <li>6. Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan (ISP) is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;</li> <li>7. A psychiatric medical evaluation documents that medication options have been considered or initiated;</li> <li>8. The individual's natural supports (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway; and</li> <li>9. Documentation demonstrates that coordination of care and vigorous, active discharge planning has been ongoing from the day of admission with the goal of transitioning individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.</li> </ol> <p>If the above criteria are not met, there are some circumstances under which authorization may be extended for up to 10 calendar days. These circumstances include any of the following:</p> <ol style="list-style-type: none"> <li>1. The individual has clearly defined treatment objectives that can reasonably be achieved through continued MH-IOP treatment, such treatment is necessary in order for the discharge plan to be successful, and there is no less intensive level of care available in which the objectives can be safely accomplished;</li> <li>2. Individuals can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the individual to be discharged directly to a less intensive community rather than to a more restrictive setting; and/or</li> <li>3. The individual is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued by the provider delivering the service but are not available (including but not limited to such resources as placement options, substance use treatment or mental health appointments, therapeutic mentoring, etc.).</li> </ol> <p>Individuals may be authorized to participate in less than nine hours a week for adults and six hours a week for youth as a transitional step down to lower level services for one to two weeks prior to transitioning to promote recovery. Providers should seek approval for such a transition from the MCO or the FFS contractor and the provider shall document the rationale in the individual's ISP.</p>
<p>Discharge Criteria</p>	<p>The individual meets discharge criteria if any of the following are met:</p> <ul style="list-style-type: none"> <li>• The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available;       <ul style="list-style-type: none"> <li>■ Required consent for treatment is withdrawn or not obtained;</li> <li>■ The individual does not appear to be participating in the treatment plan (ISP) and has not benefited from MH-IOP despite documented efforts to engage the individual. For youth, there is lack of treatment progress attributable to lack of involvement and engagement by the identified family/caregivers;</li> <li>■ The individual's ISP goals have been met, and an appropriate aftercare treatment plan has been established;</li> <li>■ If there is any lapse in service indicative of a need for another level of care;           <ul style="list-style-type: none"> <li>■ If there is a lapse in service greater than 7 consecutive calendar days;</li> <li>■ The individual's level of functioning has improved with respect to the goals outlined in the ISP, and there is reasonable expectations that the individual can to maintain this recovery process at a lower level of treatment; or</li> <li>■ The individual is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, residential crisis stabilization unit or other residential treatment setting for more than 7 days and is not ready for discharge to home.</li> </ul> </li> </ul> </li> </ul>
<p><b>MH-IOP Service Authorization and Utilization Review</b></p>	
<p>Service Authorization</p>	<p>Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Additional service authorization information is located in Appendix C to this manual.</p> <ul style="list-style-type: none"> <li>• One unit of service is one day.</li> <li>• A minimum of 3 sessions is required to achieve 9 to 19 hours of services per week for adults; a minimum of 2 sessions is required to achieve 6 to 19 hours of services per week for youth. The provider shall document any deviation from the ISP in the individual's medical record and reason for the deviation.</li> <li>• A maximum of 5 units may be billed per week.</li> <li>• In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must notify the MCO or the FFS contractor Utilization Management (UM) staff when the minimum sessions have not been provided. Documentation of any ISP deviation as well as reason for the deviation should be submitted at the time of the next authorization review.</li> <li>• If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the FFS contractor UM staff to reassess for another Level of Care or model to better meet the individual's needs.</li> </ul> <p>Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at <a href="http://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/">www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/</a>.</p>

Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.
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## MH-IOP Billing Guidance

An example of staffing requirements for a program with 10 individuals participating includes:

- 1 full time QMHP (QMHP-A, QMHP-C or QMHP-E)
- 1 full time LMHP (including LMHP-R, LMHP-RP or LMHP-S)
- 1 full time Registered Peer Recovery Specialist; and
- 1 full time clinical director - LPC, LCSW, LMFT or Psychologist

An example of staffing requirements for a program with 30 individuals participating includes:

- 2 full time QMHPs (QMHP-A, QMHP-C or QMHP-E)
- 3 full time LMHPs (including LMHP-R, LMHP-RP or LMHP-S)
- 1 full time Registered Peer Recovery Specialist; and
- 1 full time clinical director - LPC, LCSW, LMFT or Psychologist

Programs that bill the specialty rate for individuals receiving occupational therapy must provide these services at least 2 days a month.

One unit of service is a one day session with a minimum of 2 service components per session to achieve 9 to 19 hours of intervention per week for adults and 6 to 19 hours of intervention per week for youth. A maximum of 5 units shall be billed per week.

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.

Billing Code	Unit	Description	Notes	Provider Qualifications
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S9480	Per Diem	Mental Health Intensive Outpatient Program	Only one unit can be billed per day	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
S9480	n/a	Comprehensive Needs Assessment	S9480 is used to bill the comprehensive needs assessment when the provider determines that MNC are met and the individual will enter the MH-IOP program.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant
90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S
90792	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a psychiatrist, physician assistant or nurse practitioner completes the comprehensive needs assessment, determines that the individual does not meet MNC and will not enter the service.	Psychiatrists, Physician Assistants, and Nurse Practitioners
90839		Psychotherapy for Crisis	This code should be used outside of scheduled program hours (does not count towards minimum service components for per diem if provided outside of scheduled program hours).	LMHP, LMHP-R, LMHP-RP, LMHP-S
90840	+ 30 min			

H0024 (MH) T1012 (ARTS)	1 unit =15 minutes	Peer Recovery Support Services	<p>This code should be used when provided outside of scheduled program hours (does not count towards minimum service components for per diem if provided outside of scheduled program hours).</p> <p>See Peer Recovery Support Services Supplement for program requirements.</p>	Registered Peer Recovery Specialist
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## Mental Health Partial Hospitalization Program (MH-PHP)

MH-PHP Level of Care Guidelines	
Service Definition	<p>Mental Health Partial Hospitalization (MH-PHP) services are short-term, non-residential interventions that are more intensive than outpatient services and that are required to stabilize an individual's psychiatric condition. The service is delivered under physician direction to individuals at risk of psychiatric hospitalization or transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a medical necessity for the service arising from behavioral health disorders that result in significant functional impairments in major life activities.</p> <p>Mental Health Partial Hospitalization Programs (MH-PHPs) are highly structured clinical programs designed to provide an intensive combination of interventions and services similar to an inpatient program, but available on a less than 24-hour basis. MH-PHPs are active, focused and time-limited treatment programs intended to stabilize acute symptoms in youth (6-17 years old) and adults (18 years +). Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, children younger than age 6 may receive services based on medical necessity. The average length of stay may be four to six weeks, though length of stay should reflect individual symptom severity, needs, goals and medical necessity criteria. MH-PHP can serve as a transition program, such as a step-down option following an inpatient hospitalization. MH-PHP can serve as a diversion for an individual from inpatient care, by providing an alternative that allows for intensive clinical services without hospital admission. The target population consists of individuals that would likely require inpatient hospitalization in the absence of receiving this service. MH-PHPs may occur in either a hospital- or community-based location.</p> <p>MH-PHP services are appropriate when an individual requires at least four hours of clinical services a day, over several days a week and totaling a minimum of 20 hours per week. A MH-PHP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-PHP tapers in intensity and frequency as an individual's symptoms improve, they are able to establish/reestablish community supports, and they are able to resume daily activities or are able to participate in a lower level of care.</p>

<p>Critical Features &amp; Service Components</p>	<p>MH-PHP involves a multidisciplinary team approach under the direction of a physician. MH-PHP programs include structured schedules for participants. MH-PHP must be available at a minimum of 20 hours per week, a minimum of five days per week, four hours per day. Treatment goals should be measurable, person-centered, recovery oriented, trauma-informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission. Emergency services must be available through the MH-PHP 24-hours a day and seven days a week</p> <p>Programs for youth should accommodate for or integrate required academic instruction in coordination with the appropriate funding source, but the academic instruction itself is not a critical feature or eligible for Medicaid reimbursement.</p> <p>Covered service components include</p> <ul style="list-style-type: none"> <li>• assessment,</li> <li>• treatment planning,</li> <li>• individual, family and group therapy,</li> <li>• skills restoration/development,</li> <li>• health literacy counseling/psychoeducational activities,</li> <li>• crisis intervention,</li> <li>• peer recovery support services and</li> <li>• care coordination.</li> </ul>
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<p>Required Activities</p>	<p>In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-PHP:</p> <ul style="list-style-type: none"> <li>• At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-PHP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details).</li> <li>• Initial medication evaluation must be conducted by the Psychiatrist, Nurse Practitioner, or Physician Assistant with the individual via in-person or telemedicine evaluation within 48 hours of admission.</li> <li>• Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.</li> <li>• ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements</li> <li>• Components of the treatment program must include all of the following:       <ol style="list-style-type: none"> <li>1. Individualized treatment planning;</li> <li>2. Daily individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others);</li> <li>3. Skill restoration/development and health literacy counseling/psychoeducational interventions;</li> <li>4. Medication management as well as additional clinically indicated psychiatric and medical consultation services must be available. Referrals for consultation to external prescribing providers are allowable and must be made via formal agreement. The provider must coordinate medication management with existing medical and psychiatric providers;</li> <li>5. Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral;</li> <li>6. Crisis intervention and safety planning support available 24/7;</li> <li>7. Peer recovery support services, offered as an optional supplement for individuals;</li> <li>8. Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:           <ol style="list-style-type: none"> <li>1. The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;</li> <li>2. The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;</li> <li>3. The provider shall, with individual's consent, collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.</li> </ol> </li> </ol> </li> <li>• At least three of the following service components shall be provided per day based on the treatment needs identified in the initial comprehensive assessment:       <ul style="list-style-type: none"> <li>• Daily therapeutic interventions with a planned format including individual, group or family therapy;</li> <li>• medication management (as clinically indicated; minimum of weekly);</li> <li>• Skill restoration/development</li> <li>• Health literacy counseling/psychoeducation interventions; and</li> <li>• Occupational and/or other therapies performed by a professional acting within the scope of their practice.</li> </ul> </li> <li>• If the session involves a Comprehensive Needs Assessment as a service component, only one of the above listed components shall be required in order to bill the per diem that day.</li> <li>• The minimum number of service hours per week is 20 hours with at least four service hours per session, a minimum of 5 days per week.</li> <li>• In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record and notify the MCO or the FFS contractor Utilization Management (UM) staff at the next service authorization request (see service authorization section for additional information).</li> <li>• If the individual consistently deviates from the required services in the ISP, the provider would work with the MCO or the FFS Contractor care coordinator to reassess for another level of care or model to better meet the individual's needs.</li> <li>• Group mental health therapy by LMHPs, LMHP-Rs, LMHP-RPs and LMHP-Ss shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the LMHP, LMHP-R, LMHP-RP, and LMHP-S.</li> <li>• If the individual continues to meet with an existing outpatient therapy provider, the MH-PHP provider must coordinate the treatment plan with the provider.</li> <li>• Whenever possible, crisis intervention should be delivered by the MH-PHP staff, including after program hours.</li> <li>• An updated assessment conducted by a LMHP LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant is required at every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued services. DMAS or its contractor(s) may request the results of this assessment to evaluate approval of reimbursement for continued services. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.</li> <li>• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).</li> </ul>
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Service Limitations	<p>In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:</p> <ul style="list-style-type: none"> <li>• MH-PHP shall not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Applied Behavior Analysis, Mental Health Intensive Outpatient Services, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or Inpatient Hospitalization. A seven day overlap with any outpatient or community based behavioral health service may be allowed for care coordination and continuity of care.</li> <li>• If an individual has an authorization for a behavioral health service prior to admission to MH-PHP that is not allowed to be authorized concurrently with MH-PHP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-PHP within 31 days. Contact the individual's MCO or FFS Contractor for authorization requirements.</li> <li>• If an individual is participating in Assertive Community Treatment and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services.</li> <li>• Activities that are not reimbursed or authorized include:             <ul style="list-style-type: none"> <li>• Time spent in any activity that is not a covered service component;</li> <li>• Transportation;</li> <li>• Staff travel time;</li> <li>• Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions;</li> <li>• Time spent in snacks or meals;</li> <li>• Time when the individual is not present at the program;</li> <li>• Time spent in educational instruction; nor</li> <li>• Supervision hours of the staff.</li> </ul> </li> <li>• Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.</li> </ul>
<b>MH-PHP Provider Participation Requirements</b>	
Provider Qualifications	<p>MH-PHP service providers shall be licensed by DBHDS as a provider of a Mental Health Partial Hospitalization Program, be Medicare certified as a partial hospitalization program and credentialed with the individual's Medicaid Managed Care Organization for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. MH-PHP service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. Providers have a year from the date they become contracted in the MCO network or FFS Contractor as a MH-PHP provider to become Medicare certified.</p>
Staff Requirements	<p>MH-PHP service providers shall meet the staff requirements as follows:</p> <p>A multidisciplinary treatment team is comprised, at a minimum, of the following:</p> <ul style="list-style-type: none"> <li>• Board certified/board eligible psychiatrist. For children under age 14, the psychiatrist must be a board certified/board eligible child and adolescent psychiatrist; and/or</li> <li>• Licensed Nurse Practitioner; and</li> <li>• Licensed Mental Health Professional (LMHP)</li> <li>• Registered Peer Recovery Specialist</li> </ul> <p>Staff shall be cross-trained to understand behavioral health disorders, signs and symptoms of substance use disorders, and be able to understand and explain the uses of psychotropic medications and interactions with substance use and other addiction disorders.</p> <p>Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.</p> <p>Health literacy counseling/psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist or a RN or LPN with at least one year of clinical experience.</p> <p>Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E.</p> <p>Skills restoration/development and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E.</p> <p>Peer recovery support services must be provided by a Registered Peer Recovery Specialist.</p> <p>Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners (NP) shall hold an active license issued by the Virginia Board of Nursing. Physicians, Physician Assistants and Occupational Therapists shall hold an active license issued by the Virginia Board of Medicine.</p>
<b>MH-PHP Medical Necessity Criteria</b>	

<p>Admission Criteria - Diagnosis, Symptoms, and Functional Impairment</p>	<p>Must meet all of the following criteria:</p> <ol style="list-style-type: none"> <li>1.       <ol style="list-style-type: none"> <li>1. The individual must exhibit symptoms consistent with a DSM diagnosis (using the most current version of the DSM) that is documented in the initial assessment that requires and can reasonably be expected to respond to treatment interventions ;</li> <li>2. There is a clinical determination that in the last 14 days, the individual has manifested an acute and significant or profound impairment in daily functioning in the home, school, community or occupational setting that has led to negative consequences and difficulties maintaining supportive, sustained relationships with identified family and peers due to a psychiatric disorder;</li> <li>3. The individual is at risk for admission to inpatient hospitalization, residential treatment services or residential crisis stabilization as evidenced by acute intensification of symptoms, but has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; or the individual is stepping down from inpatient hospitalization or residential crisis stabilization and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision;</li> <li>4. The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours and a safety plan has been established;</li> <li>5. The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team, including psychiatric interventions for medication management;</li> <li>6. The individual can reliably attend, and actively participate in, all phases of the treatment program necessary to stabilize his/her condition;</li> <li>7. The severity of the presenting symptoms cannot be safely or adequately addressed in a less intensive level of care;</li> <li>8. The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and</li> <li>9. If an individual is being admitted to MH-PHP primarily for an eating disorder, the following must also be met:           <ol style="list-style-type: none"> <li>1. The individual exhibits symptoms consistent with an eating disorder diagnosis and requires at least two of the following:               <ol style="list-style-type: none"> <li>1. As a result of eating disorder behaviors, weight stabilization above 80% IBW (or BMI 15-17); or</li> <li>2. Daily, or near daily supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight management behavior, such as caloric restriction, intake refusal, vomiting/purging, excessive exercise, compulsive eating/binging; or</li> <li>3. Individual misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) and cannot be treated at a lower level of care.</li> </ol> </li> <li>2. Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require 24-hour medical monitoring or procedures provided in a hospital level of care.</li> <li>3. If the above criteria are not met, service authorization requests and medical necessity will be assessed on an individualized basis to determine if the individual's treatment needs can be best met in this setting and can be delivered in a safe and effective manner.</li> </ol> </li> </ol> </li> </ol>
<p>Exclusion Criteria</p>	<p>Individuals meeting any of the following are ineligible for MH-PHP:</p> <ul style="list-style-type: none"> <li>•       <ul style="list-style-type: none"> <li>■ The individual's functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100;</li> <li>■ The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;</li> <li>■ The individual's psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;</li> <li>■ The individual, their authorized representative, or their guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment;</li> <li>■ The individual requires a level of structure and supervision beyond the scope of the program;</li> <li>■ The individual has medical conditions or impairments that needs immediate attention; and/or</li> <li>■ The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration.</li> <li>■ Presenting issues are primarily due to Substance Use Disorder; in this case the individual should be evaluated for Addiction and Recovery Treatment Services.</li> </ul> </li> </ul>



<p>Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment</p>	<p>Individuals must meet all of the following:</p> <ol style="list-style-type: none"> <li>1.             <ol style="list-style-type: none"> <li>1. The individual continues to meet admission criteria;</li> <li>2. Another less intensive level of care would not be adequate to administer care;</li> <li>3. Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care;</li> <li>4. The individualized treatment plan (ISP), updated every 30 calendar days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan (ISP);</li> <li>5. Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan (ISP) is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;</li> <li>6. A psychiatric medical evaluation documents that medication options have been considered or initiated;</li> <li>7. The individual's natural supports (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway;</li> <li>8. Documentation demonstrates that coordination of care and vigorous, active discharge planning has been ongoing from the day of admission with the goal of transitioning individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning; and</li> <li>9. If an individual is being admitted to MH-PHP for an eating disorder, then one of the following must also be met:                     <ol style="list-style-type: none"> <li>1. Individual has had no stabilization of weight since admission or there is continued instability in food intake; or</li> <li>2. The eating disorder behaviors persist and continue to put the individual's medical status in jeopardy.</li> </ol> </li> </ol> </li> </ol> <p>If the above criteria are not met, there are some circumstances under which authorization may be extended for up to 10 calendar days. These circumstances include any of the following:</p> <ol style="list-style-type: none"> <li>1. The individual has clearly defined treatment objectives that can reasonably be achieved through continued MH-PHP treatment, such treatment is necessary in order for the discharge plan to be successful, and there is no less intensive level of care available in which the objectives can be safely accomplished;</li> <li>2. Individuals can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the individual to be discharged directly to a less intensive community rather than to a more restrictive setting; and/or</li> <li>3. The individual is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued by the provider delivering the service but are not available (including but not limited to such resources as placement options, substance use treatment or mental health appointments, therapeutic mentoring, etc.).</li> </ol> <p>Individuals may be authorized to participate in less than 20 hours a week as a transitional step down to lower level services for one to two weeks prior to transitioning to promote recovery. Providers should seek approval for such a transition from the MCO or the FFS contractor and the provider shall document the rationale in the individual's ISP.</p>
<p>Discharge Criteria</p>	<p>The individual meets discharge criteria if any of the following are met:</p> <ul style="list-style-type: none"> <li>• The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available;</li> <li>• Required consent for treatment is withdrawn or not obtained;</li> <li>• The individual does not appear to be participating in the treatment plan (ISP) despite documented efforts to engage the individual;</li> <li>• The individual's level of functioning has improved with respect to the goals outlined in the ISP, and there is reasonable expectations that the individual can to maintain this recovery process at a lower level of treatment;</li> <li>• For eating disorders, individual has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care; and/or</li> <li>• If there is a lapse in service greater than seven consecutive calendar days, including circumstances where this lapse is due to admission for a medical or psychiatric inpatient hospitalization.</li> </ul>
<p><b>MH-PHP Service Authorization and Utilization Review</b>                  Service Authorization</p>	<p>MH-PHP requires service authorization and shall be delivered by a service provider who meets the provider qualifications listed above.</p> <p>Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Additional service authorization information is located in Appendix C to this manual.</p> <p>An individual may participate in MH-PHP services concurrent with Opioid Treatment Services/Medication Assisted Treatment. The MH-PHP provider and the buprenorphine-waivered practitioner shall collaborate and corroborate these efforts in documentation.</p> <ul style="list-style-type: none"> <li>• One unit of service is one day.</li> <li>• The minimum number of service hours per week is 20 hours with at least four service hours per service day, a minimum of 5 days per week.</li> <li>• In cases that an individual does not complete the minimum of four clinical service hours per service day or attend treatment a minimum of five days per week, the provider shall:             <ul style="list-style-type: none"> <li>• Document any ISP deviation as well as the reason for the deviation in the individual's medical record; and</li> <li>• Notify the MCO or the Fee for Service contractor Utilization Management (UM) staff when they have not been able to provide the minimum required sessions. The provider shall submit documentation at the time of the next authorization review.</li> <li>• If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the Fee for Service contractor UM staff to reassess for another Level of Care or model to better meet the individual's needs.</li> </ul> </li> </ul>
<p>Documentation and Utilization Review</p>	<p>Refer to Chapter VI of this manual for documentation and utilization review requirements.</p>

## MH-PHP Billing Guidance

Rates and Billing Mechanisms for MH-PHP are determined by the setting of service delivery:

- Community Based Clinic Programs bill on 1500 claim form
- Hospital Based Programs bill on UB-04 claim form using revenue codes 0912 or 0913

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

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

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

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

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

*The CPT codes listed in the table below are a subset of the possible codes/services that these professionals may bill outside the per diem. These particular codes are specified below because their billing explicitly differs from how a similar service would be billed by other LMHPs and is based on Medicare standard practice.*

Billing Code	Unit	Description	Notes	Provider Qualifications
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H0035	Per Diem	Mental Health Partial Hospitalization Program	Only one unit can be billed per day	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H0035	n/a	Comprehensive Needs Assessment	If a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Behavior Analyst (LBA), Certified Psychiatric Clinical Nurse Specialist (CNS), LMHP-R or LMHP-S conducts the comprehensive needs assessment and determines that MNC is met and the individual participates in one other MH-PHP service component that day, the comprehensive needs assessment is included in the per diem.	LCSW, LPC, LMFT, LBA, Certified Psychiatric CNS, LMHP-R, LMHP-S

90791	n/a	Psychiatric Diagnostic Evaluation	90791 is used to bill for the comprehensive needs assessment when: <ul style="list-style-type: none"> <li>• Staff conducting the assessment is a Licensed Clinical Psychologist (LCP) or LMHP-RP; OR</li> <li>• Any qualified staff conducts the comprehensive needs assessment and determines that the individual does not meet MNC and will not enter the service; OR</li> <li>• The comprehensive needs assessment is the only MH-PHP service provided on the day of the assessment</li> </ul>	LCP, LMHP-RP  If the individual does not enter the service or does not participate in another MH-PHP service component the day of the assessment, can be billed by additional qualified providers.
90792	n/a	Psychiatric Diagnostic Evaluation	90792 is used when staff conducting the assessment is a psychiatrist, physician assistant or nurse practitioner.	Psychiatrist, Nurse Practitioner, Physician Assistant
90839	First 60 minutes	Psychotherapy for Crisis	These codes should be used when: <ul style="list-style-type: none"> <li>• Staff conducting the intervention is a psychiatrist, physician assistant, nurse practitioner, LCP, or LMHP-RP. or</li> <li>• Any qualified staff delivers the service component outside of program hours.</li> </ul>	Within program hours: Psychiatrist, Physician Assistant, Nurse Practitioner, LCP, or LMHP-RP  Outside of program hours: LMHP, LMHP-R, LMHP-RP, LMHP-S
90840	+ 30 minutes			

<p>H0024 <i>Individual</i></p> <p>H0025 <i>Group</i></p>	<p>15 min</p>	<p>Peer Recovery Support Services</p>	<p>Peer Support and Family Support Partner Services</p> <p>Offered as an option to individuals and billed outside the per diem if the individual participates in the service; any registration and authorization requirements must be followed.</p>	<p>Registered Peer Recovery Specialists</p>
<p>CPT and Evaluation and Management Codes</p>	<p>Varying</p>	<p>Psychiatric Services</p>	<p>Codes available for billing activities related to the psychiatric services of the individual by psychiatrists, physician assistants, nurse practitioners, LCPs and LMHP-RPs are allowable outside of the per diem</p>	<p>Psychiatrist, Physician Assistant, Nurse Practitioner, LCP and LMHP-RP.</p>