



Virginia Medicaid General Community Mental Health Rehabilitation Services (CMHRS) UM Guideline

Subject: Virginia Medicaid General CMHRS

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| Description |
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Community Mental Health and Rehabilitation Services (CMHRS) are available for adults and children.
Consist of the following services and requirements:

1) Day treatment/partial hospitalization;

- a. These services may only be rendered by an Licensed Mental Health Professional (LMHP), LMHP-supervisee (LMHP-S), LMHP-resident (LMHP-R), Licensed Mental Health Professional Resident in Psychology (LMHP-RP), Qualified Mental Health Professional – Adult (QMHP-A), Qualified Mental Health Professional – Child (QMHP-C), Qualified Mental Health Professional – Eligible (QMHP-E), or a Qualified Mental Health Paraprofessional in Mental Health (QPPMH);
- b. The program shall operate a minimum of two continuous hours in a 24-hour period;
- c. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a non-residential setting;
- d. Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition.

2) Psychosocial rehabilitation;

- a. The enrolled provider of psychosocial rehabilitation services shall be licensed by Department of Behavioral Health and Developmental Services (DBHDS) as a provider of psychosocial rehabilitation services;
- b. Psychosocial rehabilitation services may be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-R, LMHP-RP, or LMHP-S;
- c. The program shall operate a minimum of two continuous hours in a 24-hour period.

3) Crisis services;

a. Crisis Intervention

- i. Provide immediate mental health care, available 24 hours a day, seven days per week;
- ii. An LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified pre-screener shall conduct a face to-face service-specific provider intake. The intake shall document the need for and the anticipated duration of the crisis service;
- iii. Crisis intervention shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified pre-screener;
- iv. In order to receive reimbursement, providers shall submit a registration for initial services and request preauthorization for any continuation of services
- v. Services shall be documented through daily notes and a daily log of time spent in the

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- delivery of services;
- vi. The crisis intervention services provider shall be licensed as a provider of emergency services by DBHDS.

b. Crisis Stabilization

- i. In order to receive reimbursement, providers shall submit a registration for initial services and request preauthorization for any continuation of services
- ii. The provision of this service to an individual shall be registered within 48 hours of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination;
- iii. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or a certified pre-screener;
- iv. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.

4) Intensive community treatment (ICT);

- a. These services may only be rendered by a team that meets the requirements of [12VAC35-105-1370](#);
- b. The enrolled ICT provider shall be licensed by the DBHDS as a provider of intensive community services or as a program of assertive community treatment, and must provide and make available emergency services 24-hours per day, seven days per week, 365 days per year, either directly or on call;
- c. Shall include medical, psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community;
- d. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided.

5) Mental health skill building (MHSS);

- a. Mental health skill-building services (MHSS) shall be defined as:
 - i. Goal-directed training;
 - ii. To enable individuals to achieve and maintain community stability and independence;
 - iii. In the most appropriate, least restrictive environment;
- b. These services shall provide goal-directed training in the following areas in order to be reimbursed:
 - 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 of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. 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 this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service;
- c. Individuals qualifying for this service shall demonstrate a clinical necessity for the service:
 - i. Arising from a condition due to mental, behavioral, or emotional illness;
 - ii. That results in significant functional impairments in major life activities.

- d. Services are provided to individuals who require individualized goal-directed training in order to achieve or maintain stability and independence in the community;
- e. Provider qualifications. The enrolled provider of mental health skill-building services must be licensed by DBHDS as a provider of mental health community support (defined in 12VAC35-105-20). Individuals employed or contracted by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. Mental health skill-building services 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 mental health skill-building services record;
- f. Mental health skill-building services shall 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. These services, in order to be covered, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and are reflected in provider records and on providers' claims for services by recognized diagnosis codes, that support and are consistent with the requested professional services. The individual shall have one of the following as a primary current DSM or ICD-10 diagnosis:
 - i. Schizophrenia or other psychotic disorder as set out in the DSM, Major Depressive Disorder – Recurrent;
 - ii. Bipolar I; or
 - iii. Bipolar II;
 - iv. Any other mental health disorder that a physician has documented specific to the identified individual within the past year to include all of the following:
 - (1) That is a serious mental illness;
 - (2) That results in severe and recurrent disability;
 - (3) That produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND;
 - (4) That the individual requires individualized training in order to achieve or maintain independent living in the community).
- g. 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. All services which do not require service authorization require registration. This registration shall transmit service-specific information to Department of Medical Assistance Services (DMAS) or its contractor in accordance with service authorization requirements.

6) Mental Health Peer Support

- a. Peer Support Services for adults is a person centered, strength-based, and recovery oriented rehabilitative service for individual's 21 years or older provided by a Peer Recovery Specialist (PRS) successful in the recovery process with lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in the recovery to reduce the disabling effects of a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support;

- b. Services assist the individual develop and maintain a path to recovery, resiliency, and wellness;
- c. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness;
- d. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist individuals in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder. The PRS shall perform the service within the scope of their knowledge, lived-experience, and education;
- e. A PRS shall perform MH Peer Support Services or Family Support Partners under the oversight of a LMHP, LMHP-R, LMHP-RP, or LMHP-S making the recommendation for services and providing the clinical oversight of the individual's Recovery, Resiliency, and Wellness Plan;
- f. The PRS rendering MH Family Support Partners shall be employed by or have a contractual relationship with an enrolled/credentialed provider licensed for one of the following:
 - i. Acute Care General and Emergency Department Hospital Services licensed by Virginia Department of Health;
 - ii. Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by Department of Behavioral Health and Developmental Services;
 - iii. Psychiatric Residential Treatment Facility licensed by Department of Behavioral Health and Developmental Services;
 - iv. Therapeutic Group Home licensed by Department of Behavioral Health and Developmental Services;
 - v. Outpatient mental health clinic services licensed by Department of Behavioral Health and Developmental Services;
 - vi. Outpatient psychiatric services provider;
 - vii. A Community Mental Health and Rehabilitative Services provider licensed by the Department of Behavioral Health and Developmental Services as a provider of one of the following Community Mental Health and Rehabilitative Services as defined in [12VAC30-50-130](#), [12VAC30-50-226](#), [12VAC30-50-420](#), or [12VAC30-50-430](#) for which the youth under 21 meets eligibility criteria:
 - (1) Intensive In-Home;
 - (2) Therapeutic Day Treatment;
 - (3) Day Treatment/Partial Hospitalization;
 - (4) Crisis Intervention;
 - (5) Crisis Stabilization;
 - (6) Mental Health Skill-building Services; or
 - (7) Mental Health Case Management.
 - viii. Only the licensed and enrolled/credentialed provider referenced above under MH Peer Support Services and MH Family Support Partners shall be eligible to bill and receive reimbursement;
 - ix. Payments shall not be permitted to providers that fail to enter into an enrollment agreement with HealthKeepers, Inc.;
 - x. Reimbursement shall be subject to retraction for any billed service that is determined to not be in compliance with DMAS requirements;
 - xi. The caseload assignment of a full time PRS shall not exceed 12-15 individuals at any one time and 30-40 individuals annually allowing for new case assignments as those on the existing caseload begin to self-manage with less support. The caseload assignment of a part-

time PRS shall not exceed 6-9 individuals at any one time and 15 annually.

7) **Supervision Requirements: MH Peers - Family Support Partners**

- a. Clinical oversight of the services and of the individual's Recovery, Resiliency, and Wellness Plan shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S, making the recommendation for Family Support Partners;
- b. Direct supervision of the PRS shall be provided as needed based on the level of urgency and intensity of service being provided. Supervisors shall maintain documentation of all supervisory sessions;
- c. If the PRS has less than 12 months experience delivering Peer Support Services or Family Support Partners, they shall receive face-to-face, one-to-one supervisory meetings of sufficient length to address identified challenges for a minimum of 30 minutes, two times a month. The direct supervisor must be available at least by telephone while the PRS is on duty;
- d. If the PRS has been delivering Support Services or Family Support Partners over 12 months and fewer than 24 months they must receive monthly face-to-face, one-to-one supervision of sufficient length to address identified challenges for a minimum of 30 minutes. The direct supervisor must be available by phone for consult within 24 hours of service delivery if needed for challenging situations;
- e. "Direct Supervisor" in a mental health setting is the person who provides direct supervision to the Peer Recovery Specialist. The direct supervisor shall:
 - i. Have two consecutive years of practical experience rendering peer support services or family support services, have certification training as a PRS under a certifying body approved by Department of Behavioral Health and Developmental Services (DBHDS) , and have completed the DBHDS PRS supervisor training; or
 - ii. Be a qualified mental health professional (QMHP) as defined in 12VAC30-105-20 with at least two consecutive years of experience as a QMPH, and who has completed the DBHDS PRS supervisor training; or
 - iii. Be an LMHP, LMHP-R, LMHP-RP, or LMHP-S who has documented completion of the DBHDS PRS supervisor training who is acting within their scope of practice under state law. An LMHP, LMHP-R, LMHP-RP, or LMHP-S providing services before April 1, 2018 shall have until April 1, 2018 to complete the DBHDS PRS supervisor training.
- f. The Direct Supervisor shall have an employment (or contract) relationship with the same provider entity that employs/contracts with the PRS;
- g. Documentation of all supervision sessions shall be maintained by the enrolled/credentialed provider in a supervisor's log or the PRS' personnel file.

8) **Service Delivery**

- a. Service delivery shall be based on the individual's identified needs, established medical necessity criteria, consistent with the recommendation of the referring practitioner who recommended services and goals identified in the individual Recovery Resiliency and Wellness Plan;
- b. The level of services provided and total time billed by the enrolled/credentialed provider for the week shall not exceed the frequency established in the Recovery, Resiliency, and Wellness Plan;
- c. As determined by the goal(s) identified in the Recovery, Resiliency and Wellness Plan services may be rendered in the provider's office or in the community, or both;
- d. Peer Support Services and Family Support Partners shall be rendered on an individual basis or in a group;

- e. Services shall be delivered in compliance with the following minimum contact requirements:
 - i. Billing shall occur only for services provided with the individual present;
 - ii. Telephone time is supplemental rather than replacement of face to face contact and is limited to 25% or less of total time per recipient per calendar year;
 - iii. Justification for services rendered with the individual via telephone shall be documented;
 - iv. Any telephone time rendered over the 25% limit will be subject to retraction;
 - v. Contact shall be made with the individual receiving Peer Support Services or Family Support Partners a minimum of twice each month;
 - vi. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact, subject to the 25% limitation described above, depending on the individual's support needs and documented preferences;
 - vii. In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented the provider may bill for a maximum of two telephone contacts in that specified month, not to exceed 2 units;
 - viii. After two consecutive months of unsuccessful attempts to make face-to-face contact, discharge shall occur;
 - ix. Peer Support Services or Family Support Partners may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space;
 - x. Peer Support Services shall be an ancillary service and shall not impede, interrupt, or interfere with the provision of the primary service setting;

9) Service-Specific Provider Intakes for all Mental Health Services shall be conducted by:

- a. A licensed mental health professional (LMHP); or
- b. LMHP-supervisee in social work or LMHP-S;
- c. LMHP-resident or LMHP-R; or
- d. LMHP-resident in psychology or LMHP-RP

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Clinical Indications

Day treatment/partial hospitalization Medically

Necessary:

Services shall be provided (must have 1-5):

- 1) Day treatment/partial hospitalization services shall be provided:
 - a. Following a service specific provider intake; **AND**
 - b. The service specific provider intake is authorized by the appropriate professional listed above:
 - i. Shall be fully completed;
 - ii. Signed; **AND**
 - iii. Dated by the appropriate professional listed above within 30 days of service initiation.
- 2) The service-specific provider intake, as defined at [12VAC30-50-130](#), and outlined below, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.
 - a. Documented history of the severity, intensity, and duration of mental health care problems and issues and **shall contain all** of the following elements:
 - i. 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. Dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- 3) An Individual Service Plan (ISP), as defined in [12VAC30-50-226](#), shall be fully completed, signed, and dated by the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, the QMHP-A, QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-R, LMHP-RP, or LMHP-S within 30 days of service initiation. The ISP contains, but is not limited to:
 - a. The individual's treatment or training needs;
 - b. The individual's goals and measurable objectives to meet the identified needs;
 - c. Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
 - d. The estimated timetable for achieving the goals and objectives; AND**
 - e. An individualized discharge plan that describes transition to other appropriate services;
 - f. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual;
 - g. If the individual is a minor child, the ISP shall also be signed by the individual's parent/legal

- guardian;
- h. 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.
- 4) At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP-A or LMHP or LMHP Resident/Supervisee, by a QMHP-A, QMHP-E, LMHP, or LMHP Supervisee or Resident.
 - 5) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet **at least two of the following** (please provide details):
 - a. Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of:
 - i. Hospitalization; **OR**
 - ii. Homelessness; **OR**
 - iii. isolation from social supports (link to symptoms);
 - b. Experience difficulty in activities of daily living such as (please provide detail):
 - i. Maintaining personal hygiene;
 - ii. Preparing food and maintaining adequate nutrition; or
 - iii. Managing finances to such a degree that health or safety is jeopardized;
 - c. Exhibit such inappropriate behavior that the individual requires repeated interventions or monitoring by (specify at least one):
 - i. Behavioral health,
 - ii. Social services, **OR**
 - iii. Judicial system; **OR**
 - d. Exhibit difficulty in cognitive ability such that they are unable to (please provide detail):
 - i. Recognize personal danger; **OR**
 - ii. Recognize significantly inappropriate social behavior.

Continued Stay Criteria

- 1) Continues to meet admission criteria

Not Medically Necessary:

- 1) Individuals shall be discharged from this service when:
 - a. They are no longer in an acute psychiatric state; **AND**
 - b. Other less intensive services may achieve or maintain psychiatric stabilization;

Psychosocial Rehabilitation

Medical Necessary:

Services shall be provided to those individuals who:

- 1) Have experienced long-term or repeated psychiatric hospitalization, or
- 2) Who experience difficulty in activities of daily living and interpersonal skills, or
- 3) Whose support system is limited or non-existent, or
- 4) Who are unable to function in the community without intensive intervention or
- 5) When long-term services are needed to maintain the individual in the community.

Services shall be provided following a service-specific provider intake that clearly documents the need

for services.

- 1) This intake shall be completed by an appropriate professional listed above.
- 2) The service-specific provider intake, as defined at [12VAC30-50-130](#), shall document the individual's behavior and describe how the individual meets criteria for this service including:
 - a. Documented history of the severity, intensity, and duration of mental health care problems and issues and **shall contain all** of the following elements:
 - i. 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. Dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- 3) The ISP contains, but is not limited to:
 - a. The individual's treatment or training needs;
 - b. The individual's goals and measurable objectives to meet the identified needs;
 - c. Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
 - d. The estimated timetable for achieving the goals and objectives; AND**
 - e. An individualized discharge plan that describes transition to other appropriate services;
 - f. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual;
 - g. 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.
- 4) An ISP shall be completed by either the appropriate professional listed above or the QMHP-A, QMHP-E, or QMHP-C and be reviewed/approved by the appropriate professional listed above within:
 - a. Thirty (30) calendar days of service initiation;
 - b. At least every three months;
 - c. The ISP shall be rewritten at least annually;
 - i. Need for higher level of care;
 - ii. As needed per events in the individual's life;
 - d. Reviewed by the appropriate professional listed above, modify as appropriate, and update the ISP.
- 5) Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by the appropriate professional listed above who shall document the continued need for the service.
- 6) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from:

- a. Mental;
 - b. Behavioral; or
 - c. Emotional illness that results in significant functional impairments in major life activities.
- 7) Services are provided to individuals:
- a. Who without these services would be unable to remain in the community (please provide detail); **OR**
 - b. Who meet **at least two** of the following criteria on a continuing or intermittent basis:
 - i. 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;
 - ii. 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;
 - iii. Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or
 - iv. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

Continued Stay Criteria

- 1) Continues to meet medically necessary criteria listed above;
- 2) Requires assistance to remain in the community;
- 3) Continues to meet at least two of the requirements in 6.b above.

Not Medically Necessary:

- 1) Does not meet the medically necessary criteria listed above;
- 2) Can remain in the community without assistance;
- 3) Meets less than two items listed in 6.b above;

Crisis (Intervention and Stabilization) Crisis Intervention

Medically Necessary:

Initiation of crisis intervention services shall be indicated following a service-specific provider intake that documents a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress.

- 1) The service-specific provider intake, as defined at [12VAC30-50-130](#), shall document the individual's behavior and describe how the individual meets criteria for this service.
 - a. Documented history of the severity, intensity, and duration of mental health care problems and issues and **shall contain all** of the following elements:
 - i. 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. Dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- 2) An individual service plan (ISP) **shall not be required** for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.
- 3) For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP **shall be developed** or revised to reflect the short-term counseling goals by the fourth face-to-face contact.
- 4) Crisis intervention services may be provided to eligible individuals outside of the clinic, provided the provision of out-of-clinic services is clinically/programmatically appropriate.
- a. Crisis intervention may involve contacts with the family or significant others.
- 5) For an admission to a freestanding inpatient psychiatric facility for individuals younger than age 21, federal regulations ([42 CFR 441.152](#)) require certification of the admission (certification of need for services) by an independent team. The independent team must include mental health professionals, including a physician. Certification of need includes:
- a. A team specified in [§ 441.154](#) must certify that:
 - i. Ambulatory care resources available in the community do not meet the treatment needs of the [beneficiary](#);
 - ii. Proper treatment of the [beneficiary](#)'s psychiatric condition requires services on an [inpatient basis](#) under the direction of a [physician](#); **AND**
 - iii. The services can reasonably be expected to improve the [beneficiary](#)'s condition or prevent further regression so that the services will no longer be needed.
 - b. The certification specified in this section and in [§ 441.153](#) satisfies the utilization [control](#) requirement for [physician](#) certification in §§ [456.60](#), [456.160](#), and [456.360](#) of this subchapter.

Crisis intervention shall:

- 1) To assist individuals who are experiencing acute psychiatric dysfunction;
- 2) Requiring immediate clinical attention;
- 3) This service's objectives shall be to:
 - a. Prevent exacerbation of a condition;
 - b.** To prevent injury to the client or others; **AND**
 - c. To provide treatment in the context of the least restrictive setting.
- 4) Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises.
- 5) Crisis intervention services may include:
 - a. Office visits;
 - b. Home visits;
 - c. Preadmission screenings;
 - d.** Telephone contacts; **AND**

- e. Other client-related activities for the prevention of institutionalization.
- 6) The provision of this service to an individual shall be registered with Anthem within one business day or the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.
- 7) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service (please provide detail):
 - a. 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;
 - b. 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;
 - c. Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or
 - d. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

Continued Stay Criteria

- 1) Continue to meet medically necessary criteria with supported detail of need

Not Medically Necessary:

- 1) Medically necessary criteria are not met;
- 2) More intensive or lesser level of care is appropriate;
- 3) The service meets the definition of a "failed Service". (see definitions)

Crisis stabilization services Medically

Necessary:

- 1) Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.
- 2) This service shall be initiated following a face-to-face service-specific provider intake by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, or a certified pre-screener, as defined in [12VAC30-50-226](#).
 - a. Documented history of the severity, intensity, and duration of mental health care problems and issues and **shall contain all** of the following elements:
 - i. 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. Dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- 3) The Individual Service Plan (ISP) must be developed or revised within three calendar days of admission to this service. The LMHP, LMHP-R, LMHP-RP, LMHP-S, certified pre-screener, QMHP-A, QMHP-C, or QMHP-E shall develop the ISP.
- 4) The ISP contains, but is not limited to:
- a. The individual's treatment or training needs;
 - b. The individual's goals and measurable objectives to meet the identified needs;
 - c. Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
 - d. The estimated timetable for achieving the goals and objectives; AND**
 - e. An individualized discharge plan that describes transition to other appropriate services;
 - f. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual;
 - g. 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.
- 5) Providers of residential crisis stabilization shall be licensed by DBHDS as providers of residential or non-residential crisis stabilization services. Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of mental health non-residential crisis stabilization.
- 6) Crisis stabilization services for non-hospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation.
- 7) The goals of crisis stabilization programs shall be:
- a. To avert hospitalization or re-hospitalization,
 - b. Provide normative environments with a high assurance of safety and security for crisis intervention,
 - c. Stabilize individuals in psychiatric crisis, AND**
 - d. Mobilize the resources of the community support system and family members and others for ongoing maintenance and rehabilitation.
- 8) The crisis stabilization program shall provide to individuals, as appropriate:
- a. Psychiatric assessment including medication evaluation,
 - b. Treatment planning,
 - c. Symptom and behavior management, AND**
 - d. Individual and group counseling.
- 9) This service may be provided in any of the following settings, but shall not be limited to:
- a. The home of an individual who lives with family or other primary caregiver;
 - b. The home of an individual who lives independently; or
 - c. Community-based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).
- 10) Services must be documented through daily progress notes and a daily log of times spent in the delivery of services. The service-specific provider intake, as defined at [12VAC30-50-130](#), shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the

service:

- a. Arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.
- b. Individuals must meet **at least two** of the following criteria at the time of admission to the service:
 - i. Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;
 - ii. 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;
 - iii. Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; **OR**
 - iv. Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

Continued Stay Criteria

- 1) When medically necessary criteria continue to be met.

Not Medically Necessary:

- 1) Individuals with medical conditions that require hospital care;
- 2) Individuals with primary diagnosis of substance abuse;
- 3) Individuals with psychiatric conditions that cannot be managed in the community (i.e., individuals who are of imminent danger to themselves or others);
- 4) Room and board, custodial care, and general supervision are not components of this service
- 5) Individuals may not receive IIH or ICT while receiving Crisis Stabilization services since both of those services include crisis response.

Case management Medically Necessary:

Services pursuant to [12VAC30-50-420](#) (seriously mentally ill adults and emotionally disturbed children) or [12VAC30-50-430](#) (youth at risk of serious emotional disturbance). A comprehensive service specific provider assessment must be completed by a qualified mental health case manager to determine the need for services. The CM service specific provider assessment is part of the first month of CM service and requires no service authorization

- 1) The ISP shall document the need for case management and be fully completed within 30 calendar days of initiation of the service.
- 2) The ISP contains, but is not limited to:
 - a. The individual's treatment or training needs;
 - b. The individual's goals and measurable objectives to meet the identified needs;
 - c. Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
 - d. The estimated timetable for achieving the goals and objectives; **AND**
 - e. An individualized discharge plan that describes transition to other appropriate services;
 - f. The individual shall be included in the development of the ISP and the ISP shall be signed by

- the individual;
- g. If the individual is a minor child, the ISP shall also be signed by the individual's parent/legal guardian;
 - h. 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.
- 3) The case manager shall review the ISP at least every three months. The review will be due by:
- a. The last day of the third month following the month in which the last review was completed;
 - b. A grace period will be granted up to the last day of the fourth month following the month of the last review;
 - c. 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.
- 4) The ISP shall also be updated at least annually.
- 5) The provider of case management services shall be licensed by DBHDS as a provider of case management services.

Continued Stay Criteria

- 1) Medically necessary criteria continue to be met.

Not Medically Necessary:

- 1) The service meets the definition of a "failed Service". (see definitions)

Intensive community treatment (ICT) Medically Necessary:

- 1) To qualify for ICT, the individual must meet **at least one** of the following criteria (please provide detail):
- a. The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or require intervention by the mental health or criminal justice system due to inappropriate social behavior.
 - b. The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance use disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.
2. A written, service-specific provider intake, as defined at [12VAC30-50-130](#), that documents the individual's eligibility and the need for this service must be completed prior to the initiation of services.
- a. Documented history of the severity, intensity, and duration of mental health care problems and issues and **shall contain all** of the following elements:
 - i. 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. Dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- 2) This intake documentation shall be maintained in the individual's records.
- 3) An ISP, based on the needs as determined by the service-specific provider intake, must be initiated at the time of admission and must be fully developed by the appropriate professional listed above within 30 days of the initiation of services.
- 4) The ISP contains, but is not limited to:
- a. The individual's treatment or training needs;
 - b. The individual's goals and measurable objectives to meet the identified needs;
 - c. Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
 - d. The estimated timetable for achieving the goals and objectives; AND**
 - e. An individualized discharge plan that describes transition to other appropriate services;
 - f. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual;
 - g. 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.
- 5) There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

Continued Stay Criteria

- 1) Member continues to meet Medical Necessity Criteria.

Not Medically Necessary:

- 1) The service meets the definition of a "failed Service". (see definitions)

Mental Health Skill- building Services Medically Necessary:

- 1) Individuals ages **21 and older shall meet all** of the following criteria in order to be eligible to receive mental health skill-building services:

OR

Individuals aged **18 to 21 years shall meet all** of the following criteria in order to be eligible to receive mental health skill-building services **in addition** shall not be living 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, MHSS shall only be authorized for up to six months prior to the date of transition.

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

- i. Schizophrenia or other psychotic disorder as set out in the DSM-5;
- ii. Major depressive disorder;
- iii. Recurrent Bipolar I or Bipolar II; **OR**
- iv. Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following:
 1. Is a serious mental illness;
 2. Results in severe and recurrent disability;
 3. Produces functional limitations in the individual's major life activities that are documented in the individual's medical record; **AND**
 4. Requires individualized training for the individual in order to achieve or maintain independent living in the community.
- b. The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills, such as (please provide detail):
 - i. Symptom management;
 - ii. Adherence to psychiatric and physical health medication treatment plans;
 - iii. Appropriate use of social skills and personal support systems;
 - iv. Skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition;
 - v. Money management; **AND**
 - vi. Use of community resources.
- c. The individual shall have a prior history of any of the following (please provide detail):
 - i. Psychiatric hospitalization;
 - ii. Either residential or non-residential crisis stabilization;
 - iii. Intensive community treatment (ICT) or program of assertive community treatment (PACT) services;
 - iv. Placement in a psychiatric residential treatment facility (RTC Level C) as a result of decompensation related to the individual's serious mental illness; or
 - v. A temporary detention order (TDO) evaluation, pursuant to § 37.2-809 B of the Code of Virginia.
 - vi. This criterion shall be met in order to be initially admitted to services and not for subsequent authorizations of service.
 - vii. Discharge summaries from prior providers that clearly indicate*:
 1. The type of treatment provided;
 2. The dates of the treatment previously provided; **AND**
 3. The name of the treatment provider shall be sufficient to meet this requirement.
*Family member statements shall not suffice to meet this requirement.
- d. The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the service-specific provider intake date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services and shall not be required 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 the treatment provider shall be sufficient to meet this requirement.
*Family member statements shall not suffice to meet this requirement.
- 2) At admission, an appropriate face-to-face service-specific provider intake must be conducted, documented, signed, and dated by the appropriate professional listed above.
- 3) The service-specific provider intake shall be required at the onset of services, as defined at [12VAC30-50-130](#), shall document the individual's behavior and describe how the individual meets criteria for this service. Service-specific provider intake includes:
 - a. Documented history of the severity, intensity, and duration of mental health care problems and issues and **shall contain all** of the following elements:
 - i. 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. Dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- 4) The primary psychiatric diagnosis shall be documented as part of the intake. The appropriate professional listed above performing the intake shall document the primary mental health diagnosis on the intake form.
- 5) An individual service plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. Requirements for service-specific provider intakes and ISPs are set out in [12VAC30-50-130](#). The ISP contains, but is not limited to:
 - a. The individual's treatment or training needs;
 - b. The individual's goals and measurable objectives to meet the identified needs:
 - i. If the provider knows or has reason to know of the individual's non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP, if:
 1. The care is delivered by the qualified paraprofessional, the supervising appropriate professional listed above shall be informed of any non-adherence to the prescribed medication regimen;
 2. The appropriate professional listed above shall coordinate care with the prescribing physician regarding any concerns about medication non-adherence (provided that the individual has consented to such sharing of information);
 3. The provider shall document **all** of the following minimum elements of the contact between the appropriate professional listed above and the prescribing physician:
 - a) Name and title of caller;

- b) Name and title of professional who was called;
 - c) Name of organization that the prescribing professional works for;
 - d) Date and time of call;
 - e) Reason for the care coordination call;
 - f) Description of medication regimen issue or issues to be discussed; and
 - g) Whether or not there was a resolution of medication regimen issue or issues.
- c. Services to be provided with the recommended frequency to accomplish the measurable goals and objectives;
- d. The estimated timetable for achieving the goals and objectives; **AND**
- e. An individualized discharge plan that describes transition to other appropriate services (please provide detail);
- f. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual;
- g. 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.
- 6) The appropriate professional listed above shall complete, sign, and date the ISP within 30 days of the admission to this service.
- a. The ISP shall include documentation of how many days per week and how many hours per week are required to carry out the goals in the ISP;
 - b. The total time billed for the week shall not exceed the frequency established in the individual's ISP.;
 - c. The ISP shall indicate the dated signature of the appropriate professional listed above and the individual;
 - d. The ISP shall indicate:
 - i. The specific training and services to be provided;
 - ii. The goals and objectives to be accomplished; and
 - iii. Criteria for discharge as part of a discharge plan that includes the projected length of service;
 - iv. If the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.
- 7) Every three months, the appropriate professional listed above shall:
- a. Review with the individual in a manner in which he may participate with the process;
 - b. Modify as appropriate; **AND**
 - c. Update the ISP when changes with the individual warrant;
 - d. Be rewritten at least annually to reflect the new goals for the next year:
 - i. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and needs as well as any newly identified problem. Documentation of this review shall be treatment 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 appropriate professional listed above and the individual.
 - ii. 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.
- 8) Discharge summaries shall be prepared by providers for all of the individuals in their care. Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record.

- 9) Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record. The provider shall document evidence of the individual's prior psychiatric services history, as required by [12VAC30-50-226](#) B 6 b (3) and [12VAC30-50-226](#) B 6 c (4), by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Documentation of telephone contacts with the prior provider shall include the following minimum elements:
- a. Name and title of caller;
 - b. Name and title of professional who was called;
 - c. Name of organization that the professional works for;
 - d. Date and time of call;
 - e. Specific placement provided;
 - f. Type of treatment previously provided;
 - g. Name of treatment provider; and
 - h. Dates of previous treatment.
 - i. 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 the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.
 - j. The provider shall document evidence of the psychiatric medication history, as required by [12VAC30-50-226](#) B 6 b (4) and [12VAC30-50-226](#) B 6 c (5), by:
 - i. Maintaining a photocopy of prescription information from a prescription bottle; **OR**
 - ii. Contacting the current or previous prescribing provider of health care services;
 - iii. Contacting current or previous pharmacy after obtaining written consent from the individual;
 - k. Prescription lists or medical records, including discharge summaries, obtained from the pharmacy or current or previous prescribing provider of health care services that contain*:
 - i. The name of the prescribing physician;
 - ii. The name of the medication with dosage and frequency; **AND**
 - iii. The date of the prescription shall be sufficient to meet these criteria.
- * Family member statements shall not suffice to meet this requirement.
- 10) In the absence of such documentation, the current provider shall document all contacts (i.e., telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements:
- a. Name and title of caller,
 - b. Name and title of prior professional who was called,
 - c. Name of organization that the professional works for,
 - d. Date and time of call,
 - e. Specific prescription confirmed,
 - f. Name of prescribing physician,
 - g. Name of medication, and
 - h. Date of prescription.
- 11) An independent clinical assessment, established in [12VAC30-130-3020](#), shall be completed for the individual.
- a. Effective July 18, 2011, an ICA shall be required as a part of the service authorization process for Medicaid and Family Access to Medical Insurance Security (FAMIS) intensive in-home (IIH) services, therapeutic day treatment (TDT), or mental health support services (MHSS) for

individuals up to the age of 21. This ICA shall be performed prior to the request for service authorization and initiation of treatment for individuals who are not currently receiving or authorized for services. The ICA shall be completed prior to the service provider conducting an intake or providing treatment.

- i. Each individual shall have at least one ICA prior to the initiation of either IIH or TDT, or MHSS for individuals up to the age of 21.
 - ii. For individuals who are already receiving IIH services or TDT, or MHSS, as of July 18, 2011, the requirement for a completed ICA shall be effective for service reauthorizations for dates of services on and after September 1, 2011.
 - iii. Individuals who are being discharged from residential treatment (DMAS service Levels A, B, or C) or inpatient psychiatric hospitalization do not need an ICA prior to receiving community IIH services or TDT, or MHSS. They shall be required, however, to have an ICA as part of the first subsequent service reauthorization for IIH services, TDT, MHSS, or any combination thereof.
- b. The ICA shall be completed and submitted to DMAS or its service authorization contractor by the independent assessor prior to the service provider submitting the service authorization or reauthorization request to the DMAS service authorization contractor. Failure to meet these requirements shall result in the provider's service authorization or reauthorization request being returned to the provider.
- c. A copy of the ICA shall be retained in the service provider's individual's file.
- d. If a service provider receives a request from parents or legal guardians to provide IIH services, TDT, or MHSS for individuals who are younger than 21 years of age, the service provider shall refer the parent or legal guardian to the BHSA or the local CSB/BHA to obtain the ICA prior to providing services.
- i. In order to provide services, the service provider shall be required to conduct a service-specific provider intake as defined in 12VAC30-50-130.
 - ii. If the selected service provider concurs that the child meets criteria for the service recommended by the independent assessor, the selected service provider shall submit a service authorization request to DMAS service authorization contractor. The service-specific provider's intake for IIH services, TDT, or MHSS shall not occur prior to the completion of the ICA by the BHSA or CSB/BHA, or its subcontractor.
 - iii. If within 30 days after the ICA a service provider identifies the need for services that were not recommended by the ICA, the service provider shall contact the independent assessor and request a modification. The request for a modification shall be based on a significant change in the individual's life that occurred after the ICA was conducted. Examples of a significant change may include, but shall not be limited to, hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent or legal guardian.
 - iv. If the independent assessment is greater than 30 days old, a new ICA must be obtained prior to the initiation of IIH services, TDT, or MHSS for individuals younger than 21 years of age.
 - v. If the parent or legal guardian disagrees with the ICA recommendation, the parent or legal guardian may appeal the recommendation in accordance with Part I (12VAC30-110-10 et seq.) In the alternative, the parent or legal guardian may request that a service provider perform his own evaluation. If after conducting a service-specific provider intake the service provider identifies additional documentation previously not submitted for the ICA that demonstrates the service is medically necessary and clinically

indicated, the service provider may submit the supplemental information with a service authorization request to the DMAS service authorization contractor. The DMAS service authorization contractor will review the service authorization submission and the ICA and make a determination. If the determination results in a service denial, the individual, parent or legal guardian, and service provider will be notified of the decision and their appeal rights pursuant to Part I (12VAC30-110-10 et seq.).

- e. If the individual is in immediate need of treatment, the independent clinical assessor shall refer the individual to the appropriate enrolled Medicaid emergency services providers in accordance with [12VAC30-50-226](#) and shall also alert the individual's managed care organization.

Continued Stay Criteria

- 1) Medically Necessary criteria continue to be met.

Not Medically Necessary:

- 1) Activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record;
- 2) Mental health skill-building services shall not be available to individuals who are receiving treatment foster care ([12VAC30-130-900](#) et seq.);

Mental Health Peer Support Services

Medically Necessary: Individuals 21 years or older qualifying for Mental Health Peer Support Services shall meet the following requirements:

- 1) Have a documented mental health disorder diagnosis;
- 2) Require recovery oriented services for the acquisition of skills needed to engage in and maintain recovery; the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and increasing responsibilities, wellness potential, and shared accountability for the individual's own recovery;
- 3) Demonstrate moderate to severe functional impairment because of the diagnosis that interferes with or limits performance (relative to the person's ethnic or cultural environment) in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his or her illness, living more independently);

Continued Stay Criteria

- 1) To qualify for continued peer support services and family support partners, MNC criteria shall continue to be met;
- 2) Progress notes shall document the status of progress relative to the goals identified in the Recovery Resiliency and Wellness Plan; **AND**
- 3) The individual continues to require the monthly minimum contact requirements.

Not Medically Necessary:

- 1) Goals of the Recovery Resiliency and Wellness Plan have been substantially met; **OR**
- 2) The Individual or as applicable for youth under 21, the caregiver, request discharge; **OR**

- 3) The individual or as applicable for youth under 21, the caregiver, fail to make the monthly minimum contact requirements or the individual or caregiver, as applicable, discontinues participation in services.

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| Coding |
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*Coding source from Virginia Administrative Code. Staff travel time shall not be included in billable time for reimbursement.

| Procedure / HCPC Code | Modifier | Service Definition |
|-----------------------|----------|--|
| H0035 | HB | Day Treatment/Partial Hospitalization for Adults |
| H2017 | - | Psychosocial Rehabilitation |
| H0036 | - | Crisis Intervention |
| H2019 | - | Crisis Stabilization |
| H0023 | - | Mental Health Case Management |
| H0039 | - | Intensive Community Treatment |
| H0046 | - | Mental Health Skill-building Services (MHSS) |
| H0024 | - | Mental Health Peer support Individual |
| H0025 | - | Mental Health Peer support Group |

- 1) Day Treatment/Partial Hospitalization
 - a. These services include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.
 - b. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.
 - c. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist.

- 2) Psychosocial Rehabilitation
 - a. 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.
 - b. Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a non-residential setting.
 - c. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

- d. One unit of service is defined as a minimum of two but less than four hours on a given day.
 - e. Two units are defined as at least four but less than seven hours in a given day.
 - f. Three units of service shall be defined as seven or more hours in a given day.
 - g. Authorization is required for Medicaid reimbursement.
- 3) Crisis Intervention
- a. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact.
 - b. A unit shall equal 15 minutes.
 - c. Client-related activities provided in association with a face-to-face contact are reimbursable
 - d. Travel by staff to provide out-of-clinic services shall not be reimbursable.
 - e. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.
 - f. Preadmission screenings for individuals younger than age 21 cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met.
- 4) Crisis Stabilization
- a. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.
 - b. Only one unit of service shall be reimbursed for this intake.
 - c. Crisis Stabilization services are not reimbursable for members residing in Residential Treatment Settings.
- 5) Case Management
- a. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean:
 - i. An individual for whom there is an ISP in effect;
 - ii. That requires regular direct or client-related contacts or activity; or
 - iii. Communication with the individuals or families, significant others, service providers, and others including;
 - iv. A minimum of one face-to-face individual contact within a 90-day period.
 - b. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur
 - c. 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.
 - d. There shall be no maximum service limits for case management services. Case management shall not be billed for persons in institutions for mental disease.
- 6) Intensive community treatment (ICT)
- a. A unit equals one hour.
 - b. ICT may be billed if the individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

- 7) Mental Health Skill building Services limits and exclusions
- a. Providers shall be reimbursed one unit for each intake utilizing the appropriate billing code. Service specific provider intakes shall be repeated upon any lapse in services of more than 60 calendar days.
 - b. Reauthorizations for service shall only be granted if the provider demonstrates 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.
 - c. Only direct face-to-face contacts and services to an individual shall be reimbursable.
 - d. Any services provided to the individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction or tutoring in reading, science, mathematics, or GED.
 - e. Any services provided to individuals that are strictly vocational in nature shall not be billable. However, support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.
 - f. Room and board, custodial care, and general supervision are not components of this service.
 - g. These services may be authorized up to six consecutive months as long as the individual meets the coverage criteria for this service.
 - h. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed.
 - i. Only direct face-to-face contacts and services to the individual shall be reimbursable. One unit is 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day.
 - j. Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the provider's 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.
 - k. Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.
 - l. Mental health skill-building services shall not be reimbursed for individuals who are also receiving independent living skills services, the Department of Social Services independent living program ([22VAC40-151](#)), independent living services ([22VAC40-131](#) and [22VAC40-151](#)), or independent living arrangement ([22VAC40-131](#)) or any Comprehensive Services Act-funded independent living skills programs.
 - m. Mental health skill-building services shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities or hospitals.
 - n. Mental health skill-building services shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of mental health skill-building services.
 - o. Mental health skill-building services shall not be available for residents of residential treatment centers (Level C facilities) except for the intake code H0032 (modifier U8) in the

- seven days immediately prior to discharge.
- p. Mental health skill-building services shall not be reimbursed if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability Waiver ([12VAC30-120-1000](#) et seq.), Individual and Family Developmental Disabilities Support Waiver ([12VAC30-120-700](#) et seq.), the Elderly or Disabled with Consumer Direction Waiver ([12VAC30-120-900](#) et seq.), and EPSDT services ([12VAC30-50-130](#)).
 - q. Mental health skill-building services shall not be duplicative of other services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services

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- that there will be coordination of services by either the appropriate professional to avoid duplication of services.
- r. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving mental health skill building services unless their physicians issue a signed and dated statement indicating that the individuals can benefit from this service.
 - s. Individuals who are not diagnosed with a serious mental health 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 mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in [12VAC30-50-226B 6 b \(1\)](#) or [12VAC30-50-226B 6 c \(2\)](#) and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health support services.

Mental Health Peer Support services

- 1) Peer Support Services and Family Support Partners shall be registered and providers can access registration forms here: http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx
- 2) Peer Support Services are billed separately from the per diem or Diagnostic Related Group (DRG) for the following MH Settings.
 - a. Hospital Emergency Department Services licensed by Virginia Department of Health.
 - b. Acute Care General Hospital licensed by Virginia Department of Health.
 - c. Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit licensed by the Department of Behavioral Health and Developmental Services.
 - d. Psychiatric Residential Treatment Facility licensed by Department of Behavioral Health and Developmental Services.
 - e. Therapeutic Group Home licensed by Department of Behavioral Health and Developmental Services.
- 3) Hospital Emergency Department Services licensed by Virginia Department of Health.
- 4) Peer Services claims should be submitted on a CMS-1500

Discussion/General Information

Utilization reviews shall include determinations that providers meet the following requirements:

- 1) The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain, prior to the delivery of services, and shall maintain and update periodically as the Department of Medical Assistance Services (DMAS) or its contractor requires, a current provider enrollment agreement for each Medicaid service that the provider offers. DMAS shall not reimburse providers who do not enter into a provider enrollment agreement for a service prior to offering that service.
- 2) The provider shall document and maintain individual case records in accordance with state and federal requirements.

- 3) The provider shall ensure eligible individuals have free choice of providers of mental health services and other medical care under the Individual Service Plan.
- 4) Providers shall comply with DMAS marketing requirements as set out in [12VAC30-130-2000](#). Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to [12VAC30-130-2000](#) E. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).
- 5) If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to [12VAC30-50-420](#) or [12VAC30-50-430](#), the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.
- 6) The provider shall determine who the primary care provider is and inform him of the individual's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.
- 7) The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. The ISP shall be updated annually or as the needs and progress of the individual changes. An ISP that is not updated either annually or as the treatment interventions based on the needs and progress of the individual change shall be considered outdated. An ISP that does not include all required elements specified in [12VAC30-50-226](#) shall be considered incomplete. All ISPs shall be completed, signed, and contemporaneously dated by the appropriate professional listed above preparing the ISP within a maximum of 30 days of the date of the completed intake unless otherwise specified. The child's or adolescent's ISP shall also be signed by the parent/legal guardian and the adult individual shall sign his own. If the individual, whether a child, adolescent, or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP. Signatures shall be obtained unless there is a clinical reason that renders the individual unable to sign the ISP.
 - a. Every three months, the appropriate professional shall review the ISP, modify the ISP as appropriate, and update the ISP, and all of these activities shall occur with the individual in a manner in which the individual may participate in the process. The ISP shall be rewritten at least annually;
 - b. 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 problems.
 - c. Documentation of ISP review shall be added to the individual's medical record no later than 15 days from the calendar 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.

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Definitions

Child or adolescent: means the same as "adolescent or child" defined in [12VAC30-50-130](#).

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

Licensed mental health professional or LMHP: means the same as defined in [12VAC30-50-130](#).

LMHP-resident or LMHP-R: means the same as defined in [12VAC30-50-130](#).

LMHP-resident in psychology" or "LMHP-RP: means the same as defined in [12VAC30-50-130](#).

LMHP-supervisee in social work, LMHP-supervisee, or LMHP-S: means the same as defined in [12VAC30-50-130](#).

"Peer recovery specialist" or "PRS": a person who has the qualifications, education, and experience established by the Department of Behavioral Health and Developmental Services (DBHDS) as set forth in 12VAC35-250-10 through 12VAC35-250-50 and who has received certification in good standing by a certifying body recognized by DBHDS as set forth in 12VAC35-250-40. A PRS is professionally qualified and trained (i) to provide collaborative services to assist individuals in achieving sustained recovery from the effects of mental health, substance abuse disorders, or both (ii) to provide peer support as a self-identified individual successful in the recovery process with lived experience with mental health or substance use disorders, or co-occurring mental health and substance use disorders, and (iii) to offer support and assistance in helping others in the recovery and community-integration process. A PRS may be a parent of a minor or adult child with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder, or an adult with personal experience with a family member with a similar mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. Manual Title Peer Services Supplement Chapter Page 8 Chapter Subject Peer Support Services and Family Support Partners Page Revision Date June 30, 2017

Qualified mental health professional-adult or QMHP-A: means the same as defined in [12VAC30-50-130](#).

Qualified mental health professional-child or QMHP-C: means the same as defined in [12VAC30-50-130](#).

Qualified mental health professional-eligible or QMHP-E: means the same as defined in [12VAC35-105-20](#).

References

Government Agency, Medical Society, and Other Authoritative Publications:

1. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Arlington, VA. 2013. Available at: <http://dsm.psychiatryonline.org/book.aspx?bookid=556>. Accessed on 03/20/2020.
2. [Virginia Administrative Code, Title 12 Health, Agency 30 Department of Medical Assistance Services, Chapter 60. Standards Established and Methods Used to Assure High Quality Care Preface:](#) Access on 03/20/2020.

Websites for Additional Information

1. [Code of Virginia](#)

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