

MENTAL HEALTH INTENSIVE OUTPATIENT SERVICES & PARTIAL HOSPITALIZATION PROGRAM PROVIDER MANUAL TRAINING

May 2021



**PROJECT
BRAVO**



Closed Captioning Available

The link to view live captions for this webinar is:

<https://www.streamtext.net/text.aspx?event=HamiltonRelayRCC-0526-VA2674>

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- Streaming text will run simultaneously with the presentation.
- We recommend opening a second window with the link provided and resizing it in such a fashion that it appears below/next to the webinar screen. This allows the viewer to see both the webinar and its associated text/graphics while also being able to comfortably view the real-time captions.
- If you have any questions please send an email to CivilRightsCoordinator@dmas.virginia.gov

About Today's Webinar

- The presentation portion of this webinar will be recorded and posted to the DMAS website along with the powerpoint presentation.
- The CHAT function has been disabled
- All participants are muted
- DMAS will not be answering questions during the presentation.
 - If time permits, DMAS will answer questions at the end of the presentation
 - Please use the Q&A function to type in your questions
 - If your question(s) is not answered you may email the DMAS Behavioral Health Division at enhancedbh@dmass.virginia.gov

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Friendly Reminder:

- This is a training about the Mental Health Intensive Outpatient Services and Partial Hospitalization Programs Manuals.



- ***This is NOT a training about Addiction and Recovery Treatment Services IOP-PHP training.***



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Agenda Today



- Background and Context
 - Project BRAVO: Enhancement of BH Services
 - Purpose and Function of PHP-IOP in the Medicaid System
 - Provider Manual Overviews
 - Question and Answer Session (recording will be off)

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Agenda Today



Provider Manual Overviews

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| <ul style="list-style-type: none"> • Intensive Outpatient Services <ul style="list-style-type: none"> ▪ Service Definition ▪ Critical Features and Service Components ▪ Provider Qualifications and Staff Requirements ▪ Service Authorization ▪ Medical Necessity Criteria <ul style="list-style-type: none"> • Admission Criteria: Diagnosis, Symptoms and Functional Impairment • Exclusion Criteria • Continued Stay Criteria • Discharge Criteria • Service Limitations ▪ Billing Guidance | <ul style="list-style-type: none"> • Partial Hospitalization Programs <ul style="list-style-type: none"> ▪ Service Definition ▪ Critical Features and Service Components ▪ Provider Qualifications and Staff Requirements ▪ Service Authorization ▪ Medical Necessity Criteria <ul style="list-style-type: none"> • Admission Criteria: Diagnosis, Symptoms and Functional Impairment • Exclusion Criteria • Continued Stay Criteria • Discharge Criteria • Service Limitations ▪ Billing Guidance |
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Enhanced Behavioral Health Services for Virginia Project BRAVO



Behavioral Health Redesign for Access, Value and Outcomes

Vision

Implement fully-integrated behavioral health services that provide a full continuum of care to Medicaid members. This comprehensive system will focus on access to services that are:



High Quality

Quality care from quality providers in community settings such as home, schools and primary care



Evidence-Based

Proven practices that are preventive and offered in the least restrictive environment



Trauma-Informed

Better outcomes from best-practice services that acknowledge and address the impact of trauma for individuals



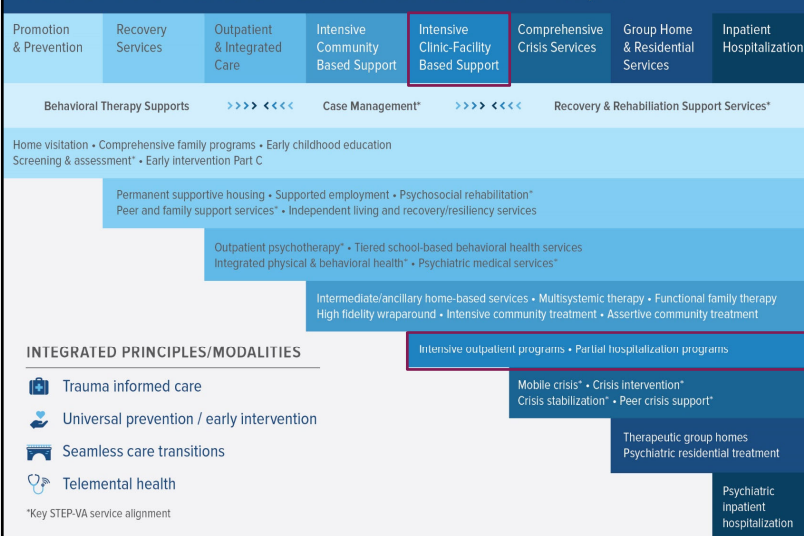
Cost-Effective

Encourages use of services and delivery mechanism that have been shown to reduce cost of care for system

The North Star Behavioral Health Services Enhancement



Continuum of Behavioral Health Services Across the Life Span



Intensive Outpatient Services and Partial Hospitalization Programs fall into the "Intensive Clinic-Facility Based Support" level of care

INTEGRATED PRINCIPLES/MODALITIES

- Trauma informed care
- Universal prevention / early intervention
- Seamless care transitions
- Telemental health

*Key STEP-VA service alignment

Rationale for PHP-IOP Priority



Alleviation of the Psychiatric Bed Crisis



- These services provide two, new services allowing for diversion or discharge options for the highest levels of care: inpatient psychiatric hospitalization and residential treatment.
- Aligned with values of supporting members in the least restrictive environment (trauma informed) and research supports system utility (evidence-based)
- Approximately 1/5 individuals served in inpatient settings for mental health problems could be served in partial hospitalization programs (PHP).
 - Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser K. *Day hospital versus admission for acute psychiatric disorders*. Cochrane Database of Systematic Reviews 2011, Issue 12.

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Where can I find the provider manuals?



Direct Link: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

May 13, 2021
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Provider Manuals

Provider Manuals

These manuals are official publications of the Virginia Department of Medical Assistance Services (DMAS) and their contents are - to the extent appropriate - incorporated by reference into participation agreements signed by providers enrolled in the Virginia Medicaid Program. DMAS is not responsible for the content or accuracy of reproductions, in whole or in part, of these manuals from any other source.

Manuals issued by DMAS are periodically revised and updated.

These Manuals are not exhaustive of Medicaid law and should not be relied upon as a legal authority. The provider should always rely on its own counsel to ensure compliance with the Medicaid laws.

[Link to list of updates and revisions to Provider Manuals.](#)

Accessing Provider Manuals.

Click on the manual you wish to view or print. This will take you to a Table of Contents for that particular manual.

Click on the title of the chapter you wish to view or print. This will load that chapter into the Acrobat Adobe Reader. You must have the Adobe Acrobat Reader downloaded and installed on your computer in order to view and print the provider manuals. If you do not have this installed, follow the instructions found at the bottom of the Table of Contents of each chapter or at the bottom of the manual Table of Contents page. All manual chapters are in Portable Document Format and require the use of this free reader.

Available Manuals

- The BRAVO services are located in the newly named “Mental Health Services Manual” within the
- Select from pull down menu for: Mental Health Services Manual, and then click on Appendix E.

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Where can I find the provider manuals?



From our main website: www.dmas.Virginia.gov

Member and Provider Services

<http://www.dmas.virginia.gov/for-providers/>

- Under Providers Menu, select “Behavioral Health”

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Where can I find the provider manuals?



<https://www.dmas.virginia.gov/for-providers/behavioral-health/>

Behavioral Health

Providing an array of behavioral health and addiction and recovery treatment services

Overview

Virginia Medicaid provides an array of behavioral health and addiction and recovery treatment services through Managed Care Organizations (MCO) through CCC Plus and Medicaid 4.0, and through the Behavioral Health Service Administrator, which are operated by CHS. You can find notices related to regulatory and manual updates, including open for public comment periods, as posted on the Virginia Regulatory Journal. Click on at <http://www.dharm.virginia.gov>

Resources - Behavioral Health

Regulations / Provider Manual ID	Training and Resources ID	Enhancements ID
State regulations related to behavioral health services and provider manuals on the Virginia Medicaid Portal	Child Training and Outreach, Virginia Behavioral Health Administrators, Licensing, Credentialing, Registration and Transportation Resources	Background, Stakeholder Presentations, Implementation, Workgroups and Enhancement Image File

- Scroll down to Resources
- Select “Regulations/Provider Manual”

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Where can I find the provider manuals?



<https://www.dmas.virginia.gov/for-providers/behavioral-health/regulations-provider-manual/>

An Agency of the Commonwealth of Virginia

Virginia Medicaid
Department of Medical Assistance Services

Applicants ▾ Members ▾ **Providers ▾** Appeals ▾ COVID-19 ▾ Open Data ▾ About Us ▾

Home > For Providers > Behavioral Health > Regulations / Provider Manual

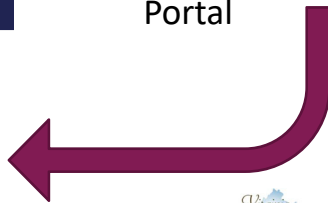
Regulations / Provider Manual

Provider Manuals

The following Manuals and Supplements can be found on the DMAS Provider web portal.

- Community Mental Health Rehabilitative Services
 - Peer Recovery Support Services Supplement
 - Behavioral Therapy Program Supplement
- Psychiatric Services
 - Temporary Detention Orders Supplement
 - Peer Recovery Support Services Supplement
- Residential Treatment Services
 - Peer Recovery Support Services Supplement
- Addiction and Recovery Treatment Services
 - Peer Recovery Support Services Supplement
 - Opioid Treatment Services

- Click on link for Provider Web Portal



Virginia Medicaid

Home | Provider Services | Provider Resources | COVID-19 | Documentation | FAQ | Provider Enrollment

Provider Manuals

These manuals are official publications of the Virginia Department of Medical Assistance Services (DMAS) and their contents are - to the extent appropriate - incorporated in, controlled and administratively enforced by, and are enforceable as part of the Virginia Medicaid Program. DMAS is not responsible for the content or accuracy of non-DMAS materials in whole or in part, or those created for any other source.

Manuals created by DMAS are periodically reviewed and updated.

These Manuals are not subject to a Public Law and should not be relied upon for a legal authority. The provider should always rely on the law issued by courts applicable to the jurisdiction.

[Link to list of updates and revisions to Provider Manuals.](#)

Accessing Provider Manuals.

Click on the manual you wish to view or print. This will take you to a Table of Contents for that particular manual.

Click on the Table of Contents to view or print. This will take you to the Manual Access Screen. You must have the Access Manual Number that you are authorized to view or print in order to view and print the provider manual. If you do not have the Access Manual Number that you are authorized to view or print, you will be unable to view or print the manual. All manual content is subject to change without notice and is subject to change without notice.

Available Manuals

MENTAL HEALTH-INTENSIVE OUTPATIENT SERVICES

Provider Manual Overview



Intensive Outpatient Services



Service Definition

- Highly structured clinical programs designed to provide a combination of interventions



- Focused, time-limited
- Integrate evidence-based practices
- For youth (ages 6-17 years) and adults (18 years +)
- Youth under 6 eligible under EPSDT based on medical necessity
- Focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment.

- 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.

Intensive Outpatient Services



When is this the most appropriate service?

- For youth (ages 6-17)
 - The individual would benefit from focused, clinical intervention that takes place **6-19** hours a week across several days. *For example:*
- For adults (ages 18 and up)
 - The individual would benefit from focused, clinical intervention that takes place **9-19** hours a week across several days. *For example:*

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	3 hours	4 hours	4 hours	4 hours	4 hours	

- The individual would benefit from weekly medication management
- Treatment plan would focus on tapering down intensity over time, so if the above schedule represented where an individual started in "dosage" they might taper over the course of several weeks to:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	2 hours		2 hours		2 hours	

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	3 hours	4 hours	4 hours	4 hours	4 hours	

- The individual would benefit from weekly medication management
- Treatment plan would focus on tapering down intensity over time, so if the above schedule represented where an individual started in "dosage" they might taper over the course of several weeks to:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	3 hours		3 hours		3 hours	

Intensive Outpatient Services



Critical Features

- Structured schedule
- Coordinated, Individualized Service Plan that includes all components
- 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.
- Critical features of MH-IOP include:
 - Integration of evidence-based practices
 - *Costs built into the rate, though no specific practices are endorsed or required at this time by DMAS*
 - The promotion of behavior change in the individual's natural environment
 - The inclusion of rigorous quality assurance mechanisms



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Intensive Outpatient Services



Required Activities / Service Components

- LMHP, LMHP-R, LMHP-RP, LMHP-S, NP or PA conduct initial assessment consistent with components required by **Comprehensive Needs Assessment** (CNA, see Chapter 4)
 - If a PA or non-psychiatric NP conducts, the CNA only counts towards MH-IOP
- **Individual Service Plan** required during the duration of services and should be current
 - Treatment planning should be collaborative but directed and authorized by LMHP, LMHP-R, LMHP-RP, LMHP-S, NP or PA



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Intensive Outpatient Services



Required Activities / Service Components

- Individualized treatment planning
 - 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 (**2 hours required per week**)
 - Skill restoration / development
 - Health literacy counseling / psychoeducational activities
 - Care coordination & referral for consultation, adjunctive, or step-down service providers
 - Peer Support and/or Family Support Partner Services
- **Flexible** inclusion of:
 - Medication management (see billing guidance; 0.75 hours a month are covered in per diem)
 - Occupational therapy, when it is directly related to the behavioral health goals (if necessary)
 - Psychological assessment / testing (as necessary)

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Intensive Outpatient Services



Service Component	Prescribed "dosage" or frequency requirement
ANY SERVICE COMPONENTS	2 MUST BE DELIVERED PER DAY
Individual/Group/Family Therapy	2 sessions per week
Skills restoration / development groups	3 sessions per week
Medication Management	1 time per week
Updated clinical assessment (consistent with CNA)	Every 90 days of consecutive service
Care Coordination	As needed
Health Literacy Counseling / Psychoeducation	As needed
Crisis Treatment	As needed
Peer Recovery Support Services	As needed
Occupational Therapy	As needed
Psychological Assessment / Testing	As needed
Treatment Planning	As needed

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Intensive Outpatient Services



Let's Talk about Crisis

Crises are generally most effectively handled in the context of an established relationship, given that relationship is a positive one.

- Treatment = QMHP and LMHP and during hours of program
- Intervention = LMHP after hours



- **All types of LMHP staff may bill new Psychotherapy for Crisis CPT codes if providing crisis intervention outside of program hours**

- *If it is outside of program hours, does not count as one of the two required service components per day*

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Intensive Outpatient Services



Let's Talk about Crisis

- Crisis System will be enhanced in December, so there will be changes to some of the terminology at that time
 - New crisis system aligned with the CRISIS NOW model
 - Integrated implementation with 988 and Marcus Alert legislation
 - Virginia will move towards single 988 crisis number as individual crisis lines are rolled in or phased out of the system infrastructure
 - New services to include: Mobile Crisis Intervention, Community Stabilization, Residential Crisis Stabilization, 23 hour bed

- Additional crisis services will become available, and this manual will be updated to reflect those services and their recommended interaction with MH-IOP delivery



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Intensive Outpatient Services



Provider Qualifications & Staffing Requirements

- **Licensed** by DBHDS as a provider of Mental Health Intensive Outpatient Services
- **Accredited** by either:
 - Joint Commission
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - Council on Accreditation (COA)
 - *Invoice evidence of starting the credentialing process is sufficient for documentation; there will be a 2 year waiver period to allow providers an opportunity to establish full accreditation for this service and MCOs will monitor providers for evidence of active steps toward accreditation.*
- **Credentialed/Contracted** with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.
- 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.
- Staffing should not exceed a 1 staff : 5 individual ratio
- Clinical supervision of staff should not exceed 1 supervisor : 6 direct care staff members



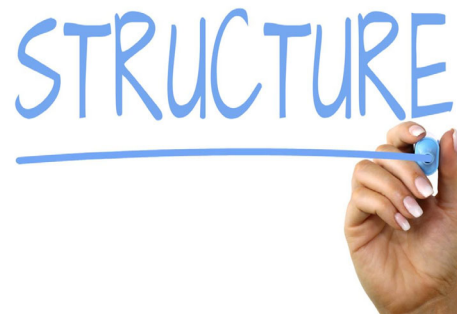
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Intensive Outpatient Services



Provider Qualifications

- Clinic-type setting
- May be co-located in schools as long as services occur in school-based clinic setting
- Should not be disruptive of school day
- Care coordination is key
- Highly structured programs



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Intensive Outpatient Services



Provider Qualifications & Staffing Requirements

- A multidisciplinary treatment team is comprised, *at a minimum*, of the following:
 - Qualified Mental Health Professional (QMHP);
 - Licensed Mental Health Professional (LMHP), LMHP-R, LMHP-RP, or LMHP-S;
 - Certified Peer Recovery Specialist;
 - Clinical/Medical Director/Supervisor – Licensed Clinical Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist
 - Physician/Nurse Practitioner/Physician Assistant (To provide assessments and medication management)
 - Occupational Therapists (For specialty programs, provided at least 2 days per month)



Intensive Outpatient Services



Providers: Who is allowed to do what?

Service Component	Provider Type
Conduct an Initial Assessment consistent with the components required in the Comprehensive Needs Assessment documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. Individual Service Plans (ISPs) shall be required during the entire duration of services and must be current.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician
Individual, group, and family therapy	LMHP, LMHP-R, LMHP-RP, LMHP-S,
Skills Restoration/Development, Crisis Treatment and Care Coordination	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E
Health literacy counseling / psychoeducational interventions (medication management)	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.
Peer recovery support services	Registered Peer Recovery Specialist



Intensive Outpatient Services



Service Limitations

- MH-IOP may not be authorized concurrently with:
 - Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0
 - Opioid Based Outpatient Treatment Services
 - Mental Health Partial Hospitalization Programs
 - Psychosocial Rehabilitation
 - Therapeutic Day Treatment
 - Intensive In-Home Services
 - Therapeutic Group Home
 - Crisis Stabilization
 - Assertive Community Treatment
 - Psychiatric Residential Treatment or inpatient admission.
- *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.*

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Intensive Outpatient Treatment



Activities NOT authorized for reimbursement:

- Time spent in any activity that is not a covered service component;
- Transportation;
- Staff travel time;
- Time spent in documentation of individual and family contacts, care coordination, and clinical interventions;
- Time spent in snacks or meals;
- Time when the individual is not present at the program;
- Time spent in educational instruction; nor
- Supervision hours of the staff.
- 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.



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Intensive Outpatient Services



Initial Service Authorization

- The Managed Care Organizations (MCOs) and Fee for Service contractor will respond to the service authorization according to their contract requirements of 3 calendar days.
- Service authorization forms and information on Medicaid MCOs processes is located at <https://www.dmas.virginia.gov/providers/managed-care/cccp-plus/provider-resources/cmhrs-transition/>.
- Separate initial from concurrent
- 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 day of receipt.

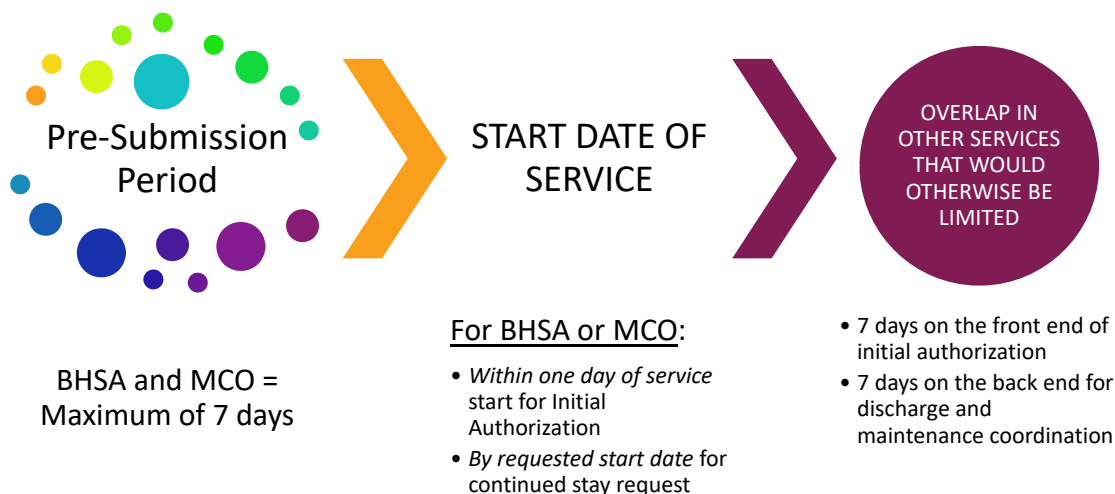
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Service Authorization (SA) Timelines



Allowances across authorization milestones



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Service Authorization Forms



Initial Service Authorization

- ***NEW AND IMPROVED* Adobe Forms**
- Best efforts made to:
 - Make form fields more functional
 - Reduce duplication of information
 - Organize with clinical mindset and most logical way to tell the individual's story
 - Linking of content to corresponding elements in the Comprehensive Needs Assessment
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision for December 1, 2021 update

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 MENTAL HEALTH INTENSIVE OUTPATIENT (MH-ICOP-38480) and
 MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM (MH-ICOP-10033)
INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) is relevant and can be used for efficiency. There will also be sections in this form pertaining to information from the CNA that, unless provided, must be obtained prior to the start of services.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Service Type:	
Member ID:		Provider NPI #:	
Member Date of Birth:	Male Female Other	Provider Phone:	
Gender:	Male Female Other	Provider Email:	
Member POC NPI #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name and Contactable Phone #	
*The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.			

Type of Service Authorization Request:
 (Check Box) Mental Health Intensive Outpatient (38480)
 (Check Box) Mental Health Partial Hospitalization Program (10033)

Request for Approval of Services:
 If the member is currently in this service, start date of service: _____
 Proposed/Requested service information:
 From _____ (date), To _____ (date), for a total of _____ units of service.
 Days to provide _____ hours of service per week.

Primary ICD-10 Diagnosis _____

Secondary Diagnoses _____

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact service? Yes No If yes, explain below: _____



Service Authorization Forms



Continued Stay Service Authorization

- ***NEW AND IMPROVED* Adobe Forms**
- Best efforts made to:
 - Pair directly with updated Comprehensive Needs Assessment and ISP Information
 - Minimal form submission + most recent assessment and Individualized Service Plan
 - Any substantive changes in circumstances, goals or plan can be submitted with an additional progress note in provider's choice of format
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision for December 1, 2021 update

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 MENTAL HEALTH INTENSIVE OUTPATIENT (MH-ICOP-38480) and
 MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM (MH-ICOP-10033)
CONTINUED STAY Service Authorization Request Form

Please be mindful of notes throughout this form that provide reference to where information requested herein aligns with documentation from the updated Comprehensive Needs Assessment (CNA) and/or Individualized Service Plan.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Service Type:	
Member ID:		Provider NPI #:	
Member Date of Birth:	Male Female Other	Provider Phone:	
Gender:	Male Female Other	Provider Email:	
Member POC NPI #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name and Contactable Phone #	
*The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.			

Type of Service Authorization Request:
 (Check Box) Mental Health Intensive Outpatient (38480)
 (Check Box) Mental Health Partial Hospitalization Program (10033)

Initial date of admission _____ Average units provided per week: _____
 Request for Approval of Continued Services:
 If the member is currently in this service, start date of admission: _____
 Proposed/Requested service information:
 From _____ (date), To _____ (date), for a total of _____ units of service.
 Days to provide _____ hours of service per week.

Primary ICD-10 Diagnosis _____

Secondary Diagnoses _____

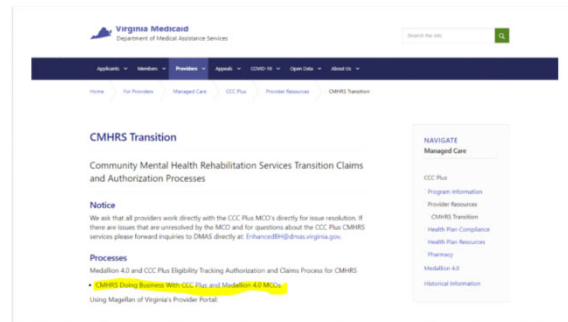
Medication Update	Start	Frequency	For any changes, note if New, Ended or Changed in dose/frequency from last authorization.
Name of Medication			



Service Authorization Processes

Fee for Service Vendor and Managed Care Organizations

- FFS: Magellan BHSa
- Forms
 - <https://www.magellanofvirginia.com/for-providers/provider-tools/forms/>
- Provider Portal
 - <https://www.magellanprovider.com/MagellanProvider/do/LoadHome>
- Managed Care Organizations
- <https://www.dmas.virginia.gov/for-providers/managed-care/ccp-plus/provider-resources/cmhrs-transition/>



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Intensive Outpatient Services



Service Authorization

- **One Unit = One day of service**
- 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 BHSa Utilization Management (UM) staff when the minimum sessions have not been provided. Documentation should be submitted at the time of the next service authorization request.
 - *If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the BHSa UM staff to reassess for another Level of Care or model to better meet the individual's needs.*
- An updated assessment conducted by a LMHP LMHP-R, LMHP-RP, LMHP-S 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.



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Intensive Outpatient Services



Medical Necessity Criteria: Admission Criteria

- Individuals must meet all of the following criteria:
 - Prior to the start of services, the following must occur:
 - Assessment inclusive of the components of the CNA is completed to document the individual's diagnosis(es) and describe how service needs match the level of care criteria;
 - This assessment must support a diagnosis from the current version of the Diagnostic and Statistical Manual (DSM) that is reasonably expected to respond to this treatment approach.
 - Persistent or increasing symptoms in the last 30 days associated with their primary DSM disorder that have contributed to:
 - Decreased functioning in home, school, occupational or community settings
 - Led to negative consequences and difficulties maintaining supportive, sustaining relationships with identified family and peers
 - Interventions at lower levels of care or alternative, community-based services have been attempted but have been unsuccessful at addressing the symptoms and supporting recovery to baseline levels of functional capacity



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Intensive Outpatient Services



Medical Necessity Criteria: Admission Criteria Continued

- Individuals must meet all of the following criteria (continued):
 - Risk for admission to hospital or residential crisis stabilization
 - Acute intensification of symptoms BUT *no immediate danger to self or others*
 - Does **not** require 24 hours treatment or medical supervision
 - Stepping down from inpatient hospitalization, residential crisis stabilization, or partial hospitalization and is *no longer at immediate risk* to self or others nor requires 24-hour treatment or medical supervision



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Intensive Outpatient Services



Medical Necessity Criteria: Admission Criteria Continued

- Individuals must meet all of the following criteria (continued):
 - 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;
 - The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team;
 - The individual can reliably attend, and actively participate in, all phases of the treatment program;
 - The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and
 - 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.



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Intensive Outpatient Services



Exclusion Criteria

- 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;
- Imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;
- The individual's psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;
- 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;
- The individual requires a level of structure and supervision beyond the scope of the program;
- The individual has medical conditions or impairments that need immediate attention;
- 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
- Presenting issues are primarily due to Substance Use Disorder; in this case member should be evaluated for Addiction Recovery Treatment Services.

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Intensive Outpatient Services



Continued Stay Criteria

There is evidence that the individual remains in need of services....

- The individual continues to meet admission criteria;
- Another less intensive level of care would not be adequate to administer care;
- Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care;
- The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals;

That evidence is monitored and documented in the plan and goals...

- The individualized treatment plan, updated every 30 days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan;
- Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;

Necessary additional supports are considered and recovery/discharge planning is ongoing....

- A psychiatric medical evaluation documents that medication options have been considered or initiated;
- 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
- 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.

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Intensive Outpatient Services



Continued Stay Criteria (continued)

- 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:
 - There is no less intensive level of care available in which the objectives can be safely accomplished;
 - 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
 - The individual is scheduled for discharge, but community-based aftercare plan is missing critical components.
- Individuals may be authorized to participate in < 9 hours a week for adults and < 6 hours a week for youth as a transitional step down to lower level services for 1-2 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 member's ISP*

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Intensive Outpatient Services



Discharge Criteria

IOP is no longer most appropriate level of care...

- 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;
- The individual's ISP goals have been met, and an appropriate aftercare treatment plan has been established;
- 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 maintain this recovery process at a lower level of treatment;

Consent or engagement is a problem...

- Required consent for treatment is withdrawn or not obtained;
- The individual does not appear to be participating in treatment plan 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;

There is a lapse in services...

- If there is any lapse in service indicative of a need for another level of care;
- If there is a lapse in service greater than 7 consecutive calendar days;
- 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.

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Intensive Outpatient Services



Billing Guidance: *Rate assumptions background*

- The per diem rate for this service is based on the assumption of 30 members participating in a program, with the following number of staff within each category:
 - 2 FTE: QMHP (QMHP-Adult (QMHP-A), QMHP-Child (QMHP-C) and QMHP-Eligible (also known as QMHP-Trainee, QMHP-E)
 - 3 FTE: LMHPs (including Licensed Mental Health Professional-Supervisee in Social Work (LMHP-S), Licensed Mental Health Psychologist (LMHP-P) Licensed Mental Health Professional-Resident in Counseling (LMHP-R), Licensed Mental Health Professional- Resident in Psychology (LMHP-RP)
 - 1 FTE: Registered Peer Recovery Specialist or Family Support Partner; and
 - 1 FTE: Clinical/Medical Director/Supervisor – LPC, LCSW, Psychologist, or Psychiatrist
- The per diem rate includes 0.75 hours per member per month of medication management by a Physician/NP/PA.
- The per diem rate includes 3 sessions of group-based delivery of skills-restoration/development (hours based on youth vs. adult) and 2 hours of therapy (individual, group or family) per individual. Individuals may be pulled out of scheduled skill-based groups to participate in their therapy sessions.
- *Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.*

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Intensive Outpatient Services

Billing Codes



Billing Code	Unit	Description	Notes	Provider Qualifications
S9480	Per Diem	Mental Health Intensive Outpatient Program	<p>Only one unit can be billed per day A maximum of 5 units may be billed per week.</p> <p>Per Diem Rate includes the following service components, to be monitored and provided weekly :</p> <ul style="list-style-type: none"> - assessment - treatment planning - health literacy counseling / psychoeducation - therapy (individual, group and family) - skills restoration / development - crisis treatment (as needed) - peer recovery support services - care coordination 	<ul style="list-style-type: none"> - Individual, group, and family therapy and crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S. - Health literacy counseling / psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist or a RN or LPN with at least one year of clinical experience. - Crisis Treatment must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E. - Skills restoration / development and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a QPPMH under the supervision of at least a QMHP-A or QMHP-C. - Peer recovery support services must be provided by a Registered Peer Recovery Specialist.

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Intensive Outpatient Services

Billing Codes



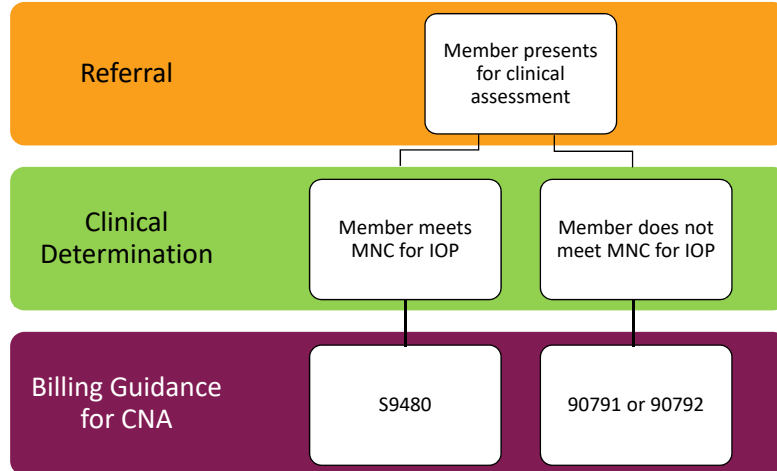
Billing Code	Unit	Description	Notes	Provider Qualifications
S9480	n/a	Comprehensive Needs Assessment	When an LMHP conducts the CNA and determines that MNC are met and the member will enter the program, they shall bill this code for the per diem.	
90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when the LMHP conducts the CNA with no medical services and determines that the member does not meet MNC and thus will not enter the service (see decision tree, below).	<ul style="list-style-type: none"> - Licensed Clinical Psychologists, including LMHP-RPs under delegation of LCP. - Licensed Psychiatrists and Physician Assistants - Licensed Nurse Practitioners
90792	n/a	Psychiatric Diagnostic Evaluation	This code should be used when the LMHP conducts the CNA with medical services and determines that the member does not meet MNC and thus will not enter the service (see decision tree, below).	<ul style="list-style-type: none"> - Licensed Psychiatrists and Physician Assistants - Licensed Nurse Practitioners
90839	up to 60 mins	Psychotherapy for Crisis	<p>This code should be used in the following circumstances:</p> <ul style="list-style-type: none"> • Outside of scheduled program hours, when any LMHP of any type delivers the service component. • If Crisis Intervention (H0036) is billed outside of the per diem, any registration and authorization requirements must be followed. 	LMHP, LMHP-R, LMHP-RP, LMHP-S
90840	+ 30 min			

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Intensive Outpatient Services

Billing Guidance Decision Tree for Comprehensive Needs Assessment (CNA)



MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAMS

Provider Manual Overview



Partial Hospitalization Programs



Service Definition

- Highly structured clinical programs designed to provide a combination of interventions



- Focused, time-limited
- For youth (ages 6-17 years) and adults (18 years +)
- Youth under 6 eligible under EPSDT based on medical necessity
- Physician Directed, like an inpatient program in many ways but available on less than 24 hour basis.
- Focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment.

- Treatment focuses on
 - symptom and functional impairment improvement
 - weekly medication management
 - 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.

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Partial Hospitalization Programs



Critical Features

- Structured schedule
- Coordinated, Individualized Service Plan that includes all components
- Emergency services available 24/7
- Programs for youth should accommodate for or integrate academic instruction (though this element is not available for Medicaid reimbursement)
- 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.

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Partial Hospitalization Programs



Required Activities / Service Components

- LMHP, LMHP-R, LMHP-RP, LMHP-S, NP or PA conduct initial assessment consistent with components required by **Comprehensive Needs Assessment** (CNA, see Chapter 4)
 - If a PA or non-psychiatric NP conducts, the CNA only counts towards MH-PHP
- **Individual Service Plan** required during the duration of services and should be current
 - Treatment planning should be collaborative but directed and authorized by LMHP, LMHP-R, LMHP-RP, LMHP-S, NP or PA



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Partial Hospitalization Programs



Required Activities / Service Components

- Initial medication evaluation must be conducted by Psychiatrist, Nurse Practitioner or Physician Assistant within 48 hours of admission.
- Care Coordination should be conducted with prior and existing, external providers



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Partial Hospitalization Programs



Required Service Components

- Individualized treatment planning;
- Daily individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others);
- Skill restoration/development
- Health literacy counseling/psychoeducational interventions;
- 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.;
- Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral;
- Crisis intervention/treatment and safety planning support available 24/7;
- Peer recovery support services, offered as an optional supplement for individuals;
- Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:
 - The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;
 - The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;
 - 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;

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Partial Hospitalization Programs



Required Service Components Per Session

- The minimum number of service hours per week is 20, and the minimum number of days per week is 5. There should be a minimum of 4 hours per daily session.
-
- The diagram consists of three levels of arrows. The top level is a long purple arrow pointing right, labeled 'At least 20 hours per week'. The middle level is a blue double-headed arrow labeled 'At least 5 days per week'. The bottom level consists of five dark blue arrows pointing right, each labeled 'At least 4 hrs/day', arranged in a row.
- **At least 3** of the following service components shall be provided per day per individual needs:
 - Daily therapeutic interventions with a planned format including individual, group or family therapy;
 - medication management (as clinically indicated; minimum of weekly);
 - Skill restoration/development
 - Health literacy counseling/psychoeducation interventions; and/or
 - Occupational and/or other therapies performed by a professional acting within the scope of their practice.
 - *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.*

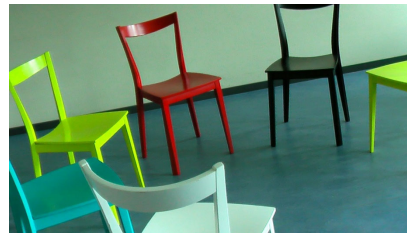
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Partial Hospitalization Programs



Required Activities / Service Components

- If an individual continues to meet with an existing outpatient therapy provider, the MH-PHP therapy provider should coordinate treatment plans.
- Group therapy has recommended maximum limit of 10 individuals per group; size may be exceeded by determination of LMHP.



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Partial Hospitalization Programs



Service Components: Caveats

- 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).
- 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.



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Partial Hospitalization Programs



Let's Talk about Crisis

Crises are generally most effectively handled in the context of an established relationship, given that relationship is a positive one.

- Crisis Intervention is slightly different for PHP vs. IOP
 - In PHP, crisis services must be offered outside of program hours but that coverage can be billed outside the per diem by LMHPs using the Psychotherapy for Crisis CPT codes
- Crisis section of this manual will be updated when crisis system is enhanced 12/1/21 to reflect guidance regarding interaction between PHP and the new crisis services.

- Crisis Intervention should be delivered by the MH-PHP staff. Additional crisis intervention support as deemed necessary by MH-PHP staff may be provided concurrently as part of a Temporary Detention Order (TDO) assessment.



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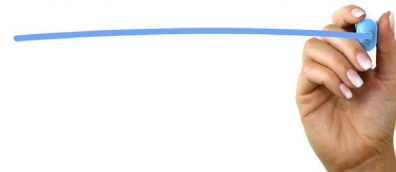
Partial Hospitalization Programs



Service Component Requirement: Assessment

- 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.

ASSESSMENT



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Partial Hospitalization Programs



Service Limitations

- MH-PHP shall not be authorized concurrently with:
 - Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0,
 - Opioid Based Outpatient Treatment Services,
 - Psychosocial Rehabilitation,
 - Therapeutic Day Treatment,
 - Intensive In-Home Services,
 - Therapeutic Group Home,
 - Behavioral Therapy,
 - Intensive Outpatient Services,
 - Crisis Stabilization,
 - 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.*
- 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.
- 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.

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Partial Hospitalization Programs



Service Limitations

- Activities that are not reimbursed or authorized include:
 - Time spent in any activity that is not a covered service component;
 - Transportation;
 - Staff travel time;
 - Time spent in documentation of individual and family contacts, care coordination, and clinical interventions;
 - Time spent in snacks or meals;
 - Time when the individual is not present at the program;
 - Time spent in educational instruction; nor
 - Supervision hours of the staff.
- 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.



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Partial Hospitalization Programs



Provider Qualifications & Staffing Requirements

- **Licensed** by DBHDS as a provider of a Mental Health Partial Hospitalization Program
- **Medicare Certified**
 - *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.*
- **Credentialed/Contracted** with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.
- 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.



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Partial Hospitalization Programs



Staff Requirements

- A multidisciplinary treatment team is comprised, *at a minimum*, of the following:
 - Board certified/board eligible psychiatrist. For children under age 14, the psychiatrist must be a board certified/board eligible child and adolescent psychiatrist; and/or
 - Licensed Nurse Practitioner; and
 - Licensed Mental Health Professional (LMHP)
 - Registered Peer Recovery Specialist



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Partial Hospitalization Programs



Providers: Who is allowed to do what?

Service Component	Provider Type
Conduct an Initial Assessment consistent with the components required in the Comprehensive Needs Assessment documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. Individual Service Plans (ISPs) shall be required during the entire duration of services and must be current.	LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician
Individual, group, and family therapy	LMHP, LMHP-R, LMHP-RP, LMHP-S,
Skills Restoration/Development, Crisis Treatment and Care Coordination	LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E
Health literacy counseling / psychoeducational interventions (medication management)	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.
Peer recovery support services	Registered Peer Recovery Specialist

Partial Hospitalization Programs



Initial Service Authorization

- The Managed Care Organizations (MCOs) and Fee for Service contractor will respond to the service authorization according to their contract requirement of 3 calendar days.
- Service authorization forms and information on Medicaid MCOs processes is located at <https://www.dmas.virginia.gov/providers/managed-care/cccp-plus/provider-resources/cmhrs-transition/>.
- Separate initial from concurrent
- 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 day of receipt.

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Partial Hospitalization Programs



Allowances across authorization milestones



BHSA and MCO =
Maximum of 7 days

For BHSA or MCO:

- *Within one day of service start for Initial Authorization*
- *By requested start date for continued stay request*

- 7 days on the front end of initial authorization
- 7 days on the back end for discharge and maintenance coordination

Partial Hospitalization Programs



Initial Service Authorization

- ***NEW AND IMPROVED* Adobe Forms**
- Best efforts made to:
 - Make form fields more functional
 - Reduce duplication of information
 - Organize with clinical mindset and most logical way to tell the individual's story
 - Linking of content to corresponding elements in the Comprehensive Needs Assessment
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision for December 1, 2021 update

Partial Hospitalization Programs



Continued Stay Service Authorization

- ***NEW AND IMPROVED* Adobe Forms**
- Best efforts made to:
 - Pair directly with updated Comprehensive Needs Assessment and ISP Information
 - Minimal form submission + most recent assessment and Individualized Service Plan
 - Any substantive changes in circumstances, goals or plan can be submitted with an additional progress note in provider's choice of format
- DMAS recommends making a provider template to save for efficiency
- Feedback welcomed and potential revision for December 1, 2021 update

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 MENTAL HEALTH INTENSIVE OUTPATIENT (MH-IOF: 08480) and
 MENTAL HEALTH PARTIAL HOSPITALIZATION PROGRAM (MH-IOF: 00035)
CONTINUED STAY Service Authorization Request Form

Please be mindful of notes through this form that provide reference to where information requested herein aligns with documentation used for related components.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:	Organization Name:	Provider NPI #:	
Member Last Name:	Organization Address:	Provider Fax NPI #:	
Member State of Birth:	Organization City, State, Zip:	Provider Phone:	
Gender:	Organization Email:	Provider Email:	
Member Birth Date:	Organization Fax:	Clinical Contact Name:	
Member Birth Address:		Phone #:	
City, State, Zip:		*The member(s) to whom the MCO can reach out to in order to gather additional necessary clinical information.	

Type of Service Authorization Request:
 Check Box: Mental Health Intensive Outpatient (08480)
 Check Box: Mental Health Partial Hospitalization Program (00035)

Initial date of admission: _____ Average units provided per week: _____
 Is inpatient services: _____ Retro Review Request? Yes No

Request for Approval of Continued Services:
 From: _____ (date), To: _____ (date), for a total of _____ units of service.

Sign to authorize _____ hours of service per week.

Primary MCO-IO Designation:

Secondary Designation(s)	For any changes, note if New, Exited or Changed in days/frequency from last authorization	
Name of Medication	Dose	Frequency

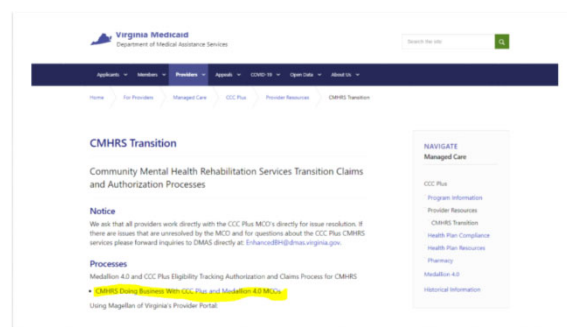
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Service Authorization Processes

Fee for Service Vendor and Managed Care Organizations

- FFS: Magellan BHTSA
- Forms
 - <https://www.magellanofvirginia.com/for-providers/provider-tools/forms/>
- Provider Portal
 - <https://www.magellanprovider.com/MagellanProvider/do/LoadHome>
- Managed Care Organizations
- <https://www.dmas.virginia.gov/for-providers/managed-care/ccp-plus/provider-resources/cmhrs-transition/>



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Partial Hospitalization Programs



Service Authorization

- **One Unit = One day of service**
- 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 BHSA Utilization Management (UM) staff when the minimum sessions have not been provided. Documentation should be submitted at the time of the next service authorization request.
 - *If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the BHSA UM staff to reassess for another Level of Care or model to better meet the individual's needs.*
- An updated assessment conducted by a LMHP LMHP-R, LMHP-RP, LMHP-S 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.



DMAS

Partial Hospitalization Programs



Medical Necessity Criteria: Admission Criteria

- Individuals must meet all of the following criteria:
 - Prior to the start of services, the following must occur:
 - Assessment inclusive of the components of the CNA is completed to document the individual's diagnosis(es) and describe how service needs match the level of care criteria;
 - This assessment must support a diagnosis from the current version of the Diagnostic and Statistical Manual (DSM) that is reasonably expected to respond to this treatment approach.
 - In the last 14 days, there has been an acute/significant/profound impairment in functioning in home, school, community or occupational settings that have led to difficulties in maintaining supportive, sustained relationships with identified family and peers due to the symptoms of their DSM disorder.



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Partial Hospitalization Programs



Medical Necessity Criteria: Admission Criteria Continued

- Individuals must meet all of the following criteria (continued):
 - Risk for admission to hospital, residential treatment or residential crisis stabilization
 - Acute intensification of symptoms BUT *no immediate danger to self or others*
 - Does **not** require 24 hours treatment or medical supervision
 - Stepping down from inpatient hospitalization, residential treatment, or residential crisis stabilization and is *no longer at immediate risk* to self or others nor requires 24-hour treatment or medical supervision



DMAS

Partial Hospitalization Programs



Medical Necessity Criteria: Admission Criteria Continued

- Individuals must meet all of the following criteria (continued):
 - 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;
 - The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team *including psychiatric interventions for medication management*;
 - The individual can reliably attend, and actively participate in, all phases of the treatment program;
 - The severity of the present symptoms cannot be safely or adequately managed at a lower level of care;
 - The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and



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Partial Hospitalization Programs



Medical Necessity Criteria: Admission Criteria Continued

- If an individual is being admitted to MH-PHP primarily for an eating disorder diagnosis, the following must also be met:
 - The individual exhibits symptoms consistent with an eating disorder diagnosis and requires at least two of the following:
 - As a result of eating disorder behaviors, weight stabilization above 80% IBW (or BMI 15-17); or
 - 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
 - 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.
 - 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.
 - 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.

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Partial Hospitalization Programs



Exclusion Criteria

- Individuals meeting any of the following are ineligible for MH-PHP:
 - The individual's functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100;
 - The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;
 - The individual's psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care;
 - 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;
 - The individual requires a level of structure and supervision beyond the scope of the program;
 - The individual has medical conditions or impairments that needs immediate attention; and/or
 - 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.
 - Presenting issues are primarily due to Substance Use Disorder; in this case the individual should be evaluated for Addiction and Recovery Treatment Services.

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Partial Hospitalization Programs



Continued Stay Criteria

There is evidence that the individual remains in need of services...

- The individual continues to meet admission criteria;
- Another less intensive level of care would not be adequate to administer care;
- Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care;
- The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals;

That evidence is monitored and documented in the plan and goals...

- The individualized treatment plan, updated every 30 days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan;
- Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;

Necessary additional supports are considered and recovery/discharge planning is ongoing...

- A psychiatric medical evaluation documents that medication options have been considered or initiated;
- 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
- 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.

If the continued stay to MH-PHP is for an eating disorder, then one of the following must also be met:

- Individual has had no stabilization of weight since admission or there is continued instability in food intake; or
- The eating disorder behaviors persist and continue to put the individual's medical status in jeopardy.

DMAS

Partial Hospitalization Programs



Continued Stay Criteria, Exceptions

- 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:
 - 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;
 - 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-based service rather than to a more restrictive setting; and/or
 - 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.).
- 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.

DMAS

Partial Hospitalization Programs



Discharge Criteria

- The individual meets discharge criteria if any of the following are met:
 - 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;
 - Required consent for treatment is withdrawn or not obtained;
 - The individual does not appear to be participating in the treatment plan (ISP) despite documented efforts to engage the individual;
 - 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 maintain this recovery process at a lower level of treatment;
- 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
- 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.

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Partial Hospitalization Programs



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.

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Partial Hospitalization Programs



Billing Guidance

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

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Partial Hospitalization Programs



Billing Guidance

Billing Code	Unit	Description	Notes	Provider Qualifications
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

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Partial Hospitalization Programs



Billing Guidance

Billing Code	Unit	Description	Notes	Provider Qualifications
90791	n/a	Psychiatric Diagnostic Evaluation	<p>90791 is used to bill for the comprehensive needs assessment when:</p> <ul style="list-style-type: none"> Staff conducting the assessment is a Psychiatrist, Nurse Practitioner, Physician Assistant, Licensed Clinical Psychologist (LCP), LMHP-RP and there are no medical services involved; OR Any qualified staff conducts the comprehensive needs assessment and determines that the individual does not meet MNC and will not enter the service; OR The comprehensive needs assessment is the only MH-PHP service provided on the day of the assessment 	<p>Psychiatrist, Nurse Practitioner, Physician Assistant, LCP, LMHP-RP</p> <p>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.</p>
90792	n/a	Psychiatric Diagnostic Evaluation	90792 is used when staff conducting the assessment is a Psychiatrist, physician assistant or nurse practitioner and there are medical services involved.	Psychiatrist, Nurse Practitioner, Physician Assistant

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Partial Hospitalization Programs



Billing Guidance

Billing Code	Unit	Description	Notes	Provider Qualifications
90839	First 60 minutes	Psychotherapy for Crisis	<p>These codes should be used when:</p> <ul style="list-style-type: none"> Staff conducting the intervention is a Psychiatrist, Physician Assistant, Nurse Practitioner, LCP, or LMHP-RP. or Any qualified staff delivers the service component outside of program hours. 	<p>Within program hours: Psychiatrist, Physician Assistant, Nurse Practitioner, LCP, or LMHP-RP</p> <p>Outside of program hours: LMHP, LMHP-R, LMHP-RP, LMHP-S</p>
90840	+ 30 minutes			
H0024 Individual	15 min	Peer Recovery Support Services	<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>	Registered Peer Recovery Specialists
H0025 Group				
CPT and Evaluation and Management Codes	Varying	Psychiatric Services	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	Psychiatrist, Physician Assistant, Nurse Practitioner, LCP and LMHP, LMHP-R, LMHP-RP, LMHP-S.

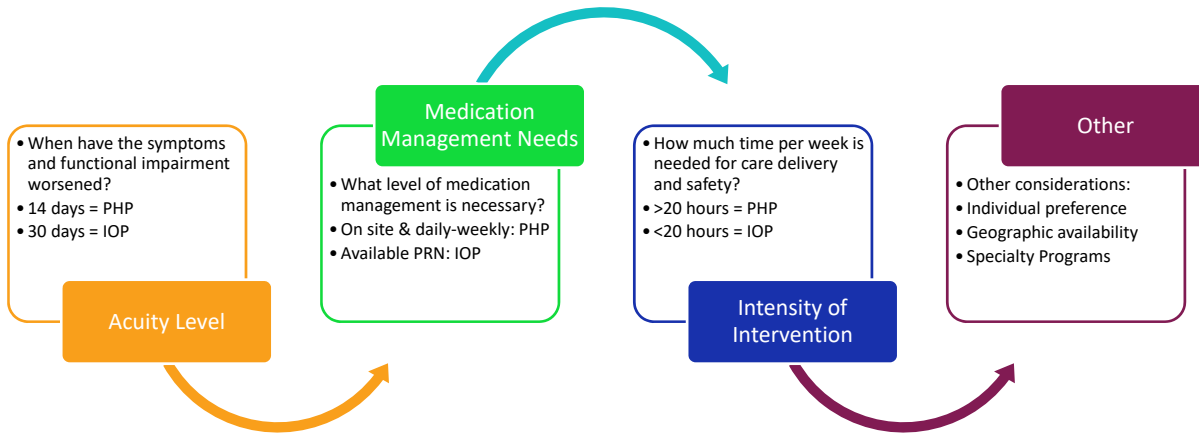
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Intensive Outpatient Services vs. Partial Hospitalization Programs



Care Coordination Considerations



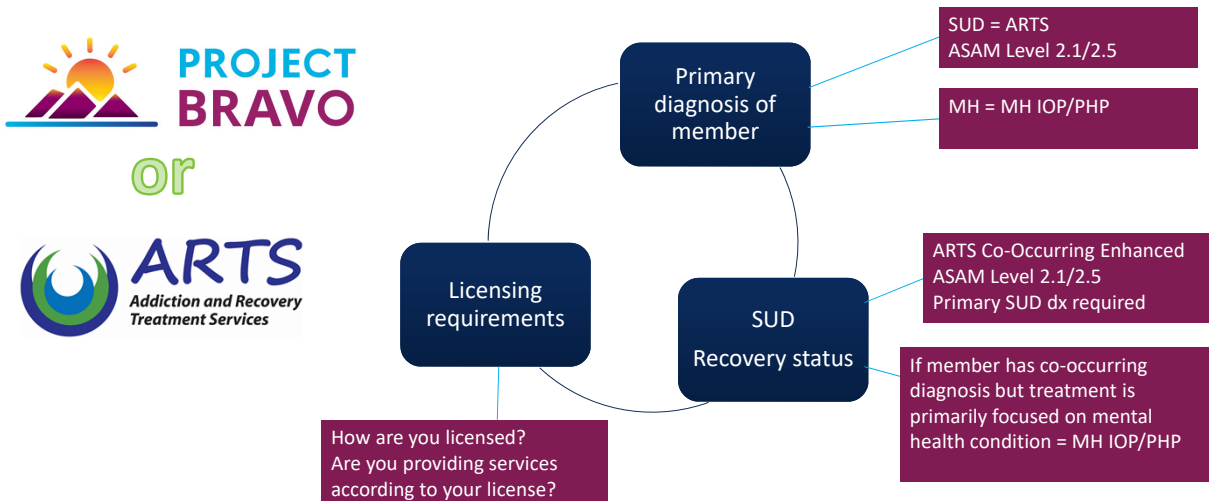
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Care Coordination with ARTS IOP-PHP



How do I determine the most appropriate setting?



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Thank you for your partnership, support and participation.

Additional Questions?

Please contact EnhancedBH@dmas.Virginia.gov