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Mental Health Skill-Building Services (MHSS)

FREQUENTLY ASKED QUESTIONS

Question	Answer
When will the changes go into effect?	Providers will be responsible for adhering to the new eligibility requirements and service parameters effective December 1, 2013. The new reimbursement rate and unit structure will go into effect July 2014.
Will Mental Health Skill-Building Services be the new name for Mental Health Support Services?	Yes. The program will still be referred to as MHSS.
Can individuals whose supervision is registered/approved with the appropriate Licensing Boards of the Virginia Department of Health Professions (DHP) perform specific duties as an LMHP-Supervisee or LMHP-Resident continue to perform the functions of a LMHP?	Yes, provided that the individual and the agency are in continuous compliance with DHP requirements for supervised practice and with Department of Behavioral Health and Developmental Services (DBHDS) licensing requirements.
Can paraprofessionals provide MHSS?	Yes, provided that they are supervised on a weekly basis by a LMHP, QMHP-A, or QMHP-C. All requirements for staffing and supervision established by DBHDS and DHP must also be met.
Mental health skill-building services, which may continue for up to six consecutive months, must be reviewed and renewed at the end of the period of service authorization by a LMHP who must document the continued need for the services. Can you clarify this?	Every six (6) months the LMHP must review the individual's plan of care and services being received in order to determine if a continuation of services is necessary. The LMHP must then document the need for the continuation of services by indicating that the individual is continuing to meet eligibility requirements and is making progress towards Individual Service Plan (ISP) goals. Though the regulations do not specify that a re-assessment must be completed at this time, it is the responsibility of the LMHP and the provider to ensure that a thorough review of the individual's progress and continuation of need is clearly documented and supported in the documentation with specific examples.
Service Eligibility Criteria	Effective December 1, 2013
Do individuals who currently have an approved service authorization need to meet the new eligibility requirements?	No. Individuals with currently approved authorizations will not need to meet the new eligibility criteria until the first reauthorization. However, should a provider suspect an individual will not meet the new eligibility criteria, the provider should help the individual prepare for an anticipated discharge or transfer to a different service. Services should not be abruptly discontinued due to the member no longer meeting the program eligibility criteria. New service authorizations with an approved start date of 12/01/13

	or later must meet the new eligibility criteria.
Will current KePRO authorizations continue, or will we need to request MHSS authorizations again on 12/01/13 based on the new criteria?	MHSS service authorizations made by KePRO that are in effect through 12/01/13 will continue to be honored under the authorization period ends. Please do NOT end date current authorizations and resubmit for a new service authorization if the current authorization has a date beyond 12/01/13.
What is the expectation from DMAS in regards to clients who are already receiving MHSS under the regs prior to 12/01/13? Will these clients be required to have another face to face assessment with a LMHP prior to services be provided under the new regs starting 12/01/13?	Individuals who currently have an authorization will continue to be reviewed under the former regulations until the time that they are due for reauthorization after 12/01/13. A new face-to-face assessment is not necessary until the reauthorization will be needed. At that time the assessment will need to be conducted using the new eligibility criteria.
Will individuals being reauthorized need to meet the two criteria that are only reviewed for the initial admittance to service?	Yes. Since eligibility changes were made to MHSS, individuals will need to meet the new eligibility criteria upon their first review for this service. This applies to individuals who are already receiving MHSS.
What are the MHSS eligibility requirements for individuals <u>age 21 and older</u> ?	The individual must meet the requirements in paragraphs 1-4 below: (1) The individual shall have <u>one</u> of the following as a primary Axis I DSM diagnosis: (a) Schizophrenia or other psychotic disorder as set out in the DSM OR (b) Major Depressive Disorder - Recurrent; Bipolar I; or Bipolar II OR (c) Any other Axis I mental health disorder that a physician has documented specific to the identified individual within the past year to include all of the following: (i) that is a serious mental illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities which are documented in the individual's medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community. (2) The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management. (3) The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization; Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential

	<p>treatment facility (RTC Level C); or Temporary Detention Order (TDO) evaluation as a result of decompensation related to serious mental illness. <u>This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service.</u></p> <p>(4) The individual shall have had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's 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. <u>This criterion shall be met upon admission to services, and not for subsequent authorizations of service.</u></p>
What are the MHSS eligibility requirements for individuals <u>under</u> the age of 21?	<p>They are the same as the requirements for individuals aged 21 and over, plus they must meet one additional criterion:</p> <p>The individual shall be in an independent living situation or actively transitioning into an independent living situation. If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition.</p>
What is the definition of an "independent living situation?"	<p>Independent living situation means a situation in which an individual, younger than 21 years of age, is not living with a parent or guardian or in a supervised setting and is providing his or her own financial support.</p>
How will providers verify and document an individual's prior history of any of the following: psychiatric hospitalization; residential crisis stabilization; Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or Temporary Detention Order (TDO) evaluation as a result of decompensation related to serious mental illness?	<p>The provider will establish and document evidence of the individual's prior psychiatric services history by contacting the prior provider or providers of health care services after obtaining written consent from the individual. The MHSS provider shall document the following minimum elements: (i) name and title of caller; (ii) name and title of professional who was called; (iii) name of organization that the professional works for; (iv) date and time of call; (v) specific placement provided; (vi) type of treatment previously provided; (vii) name of treatment provider, and; (viii) dates of previous treatment. Family member statements will not meet this requirement.</p>
What is a TDO evaluation?	<p>A TDO evaluation is a preadmission prescreening conducted by a Community Services Board (CSB)/Behavioral Health Authority (CSB/BHA) for emergency hospital placement. The evaluation itself is all that is necessary for the criteria to be met. The evaluation does not have to result in a hospitalization in order to meet the criteria.</p>

How will providers verify and document	The provider will establish and document evidence of the
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<p>that an individual has had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the 12 months prior to the assessment date?</p>	<p>psychiatric medication history by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy or after obtaining written consent from the individual. The MHSS provider shall document the following minimum elements: (i) name and title of caller; (ii) name and title of professional who was called; (iii) name of organization that the professional works for; (iv) date and time of call; (v) specific prescription confirmed; (vi) name of prescribing physician; (vii) name of medication, and; (viii) date of prescription.</p>
<p>Are there any new requirements for the MHSS assessment?</p>	<p>At admission, an appropriate face-to-face assessment must be conducted, documented, and signed and dated by a LMHP. Provider shall be reimbursed one unit for each assessment utilizing the assessment code H0032, U8 Modifier. Assessments shall be updated annually and include Axis I-V of the psychiatric diagnosis. The LMHP performing the assessment shall document the primary Axis I diagnosis on the assessment form.</p>
<p>Are there any new requirements for service reauthorization?</p>	<p>Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual meets the service eligibility requirements and 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. If the provider is unable to demonstrate this, authorization will be denied.</p>
<p>Service Limitations</p>	<p>Effective December 1, 2013</p>
<p>Can individuals who receive in-home residential services or congregate residential services through the Intellectual Disability (ID) or the Individual and Family Developmental Disabilities Support (DD) Waivers also receive MHSS?</p>	<p>No. This is a duplication of services and is not permitted.</p>
<p>Can an owner of a Group Home (Level A or B) or an assisted living facility (ALF) provide MHSS to their own residents?</p>	<p>No. Group home (Level A or B) and assisted living facility providers shall not serve as the MHSS provider for individuals residing in the providers' respective group home or assisted living facility.</p> <p>Providers may serve as the MHSS provider to other group homes and ALFs that they are not affiliated with; however, they may not bill for their own residents. (For example, if you own or manage the facility you may not provide your residents with your skill building services. Residents receiving MHSS must use an agency other than yours).</p>
<p>May an outside (unaffiliated) provider of MHSS offer services within a Level A or B group home?</p>	<p>All residents of Level A and Level B group homes are under 21, and must meet the additional eligibility criteria of: The individual shall be in an independent living situation or actively transitioning into an independent living situation. (If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition.)</p> <p>Group homes are not an independent living situation. Therefore,</p>

	<p>MHSS would be available to residents in a Level A or Level B group home, but only for the six months prior to discharge to an independent living situation. The MHSS provider would need to focus the service on the transition to independent living, including services such as (but not limited to) transportation, banking, prescription refills and responding to emergencies at home.</p> <p>MHSS could only be provided during that six-month period if certain requirements were met. The MHSS provider must collaborate with the group home to ensure that the MHSS services do not duplicate any services provided by the group home and coordination of activities must be documented in the medical record.</p> <p>Further, all Level B group homes need to comply with DBHDS licensing requirements, and all Level A group homes need to comply with DSS licensing requirements.</p>
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Can individuals who receive independent living services through the Departments of Social Services (DSS) or the Comprehensive Services Act also receive MHSS?	No. This is a duplication of services and is not permitted.
Can individuals who receive Treatment Foster Care through DSS also receive MHSS?	No. This is a duplication of services and is not permitted.
Can individuals who reside in ICF/IDs or hospitals receive MHSS?	No. This is a duplication of services and is not permitted.
Can individuals who reside in nursing facilities receive MHSS?	Individuals who reside in nursing facilities may receive MHSS, but only 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 MHSS is 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 MHSS.
Can individuals who reside in Residential Treatment Centers (Level C) receive MHSS?	MHSS is not available for residents of Residential Treatment Centers-Level C facilities. However, the MHSS assessment (H0032 with U8 modifier) may be provided in the Level C facility within the seven (7) days immediately prior to discharge.
Can individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, receive MHSS?	These individuals will be prohibited from receiving MHSS unless a physician issues a signed and dated statement indicating that the individual can benefit from this service.
Can individuals who receive personal care services or attendant care services also receive MHSS?	Only if the provider can justify why it is necessary in the individual's MHSS record. Medical record documentation shall <u>fully</u> 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 ID waiver, the DD Waiver, Early Periodic Screening, Diagnosis and Treatment services, and the Elderly or Disabled with Consumer Direction Waiver.
Reimbursement Rate and Units	Effective July 2014
What is the unit structure and rate going to be?	There will be no change to the rate structure or unit limits until July 2014. Providers must continue to reference the previous MHSS rates and units until that time. Providers will be informed in advance regarding the changes.