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CHAPTER IV

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

Magellan Health serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the behavioral health benefit programs under contract with DMAS. Magellan is authorized to create, manage, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving Medicaid-covered behavioral health services. Magellan’s authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan. DMAS shall retain authority for and oversight of Magellan entity or entities.

MEDALLION 3.0

Covered Services and Limitations

Some Medicaid enrollees may receive primary and acute care through Medicaid contracted managed care organizations (MCO), also known as the MEDALLION 3.0 Program. For these MCO enrollees, assessment and evaluation, and outpatient psychiatric and substance abuse therapy services (individual, family, and group) are handled through the individual’s MCO. MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the enrollee’s MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the enrollee’s MCO directly for information regarding the contractual, coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

The following community mental health rehabilitative services are carved-out of the MCO contracts and are covered by Magellan, for MCO enrollees, in accordance with DMAS fee-for-service established coverage criteria and guidelines. The MCOs are responsible to assist with care coordination for enrollees to assist them in being referred to carved-out services and also to cover transportation for carved-out services.

Effective April 1, 2017, the Addiction and Recovery Treatment Services program (ARTS) will be implemented for all members and enrollees. For more information, please refer to the ARTS Provider Manual.

Effective July 1, 2017, the new Residential Treatment Services program will be implemented for all members and enrollees. Magellan is responsible for management and direction of these services. For more information, please refer to the Residential Treatment Services Provider Manual.
Coverage for MEDALLION 3.0 MCO Enrollees (Medicaid, FAMIS Plus and FAMIS MOMS)

- Intensive In-home Services for Children and Adolescents
- Therapeutic Day Treatment for Children and Adolescents
- Mental Health Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance, and for Adults with Serious Mental Illness
- Mental Health Day Treatment/Partial Hospitalization Services
- Psychosocial Rehabilitation
- Mental Health Crisis Intervention
- Intensive Community Treatment
- Crisis Stabilization
- Mental Health Skill-building Services
- Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)

Coverage for FAMIS MCO Enrollees*

- Intensive In-Home Services for Children and Adolescents
- Therapeutic Day Treatment for Children and Adolescents
- Mental Health Crisis Intervention
- Mental Health Case Management for Children at Risk of Serious Emotional Disturbance Children with Serious Emotional Disturbance

Note—No other CMHRS other than those listed above are covered by DMAS for FAMIS MCO Enrollees*

Medicaid managed care organizations receive data on the community mental health rehabilitative services utilized by their members. Providers of community mental health rehabilitative services may be contacted by the managed care organizations to discuss the care of these individuals.

Definitions

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

"Adolescent or Child" means the individual receiving the services described in this manual. For the purpose of use of these terms, adolescent means an individual 12-20 years of age; a child means an individual from birth up to 12 years of age.

"At Risk of Hospitalization or Out of Home Placement” means one or more of the following: (i) within the two weeks before the intake, the individual shall be screened by an LMHP for escalating behaviors that have put either the individual or others at immediate risk of physical injury; (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when
unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health support) within the past 30 days; (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either: (a) transitioning out of residential treatment facility Level C services, (b) transitioning out of a group home Level A or B services, (c) transitioning out of acute psychiatric hospitalization, or (d) transitioning between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

“Behavioral Health Services-Children’s/EPSDT Services” that shall be covered only for individuals from birth through 21 years of age are set out in 12VAC30-50-130 B 5 and include: (i) intensive in-home services (IIH), (ii) therapeutic day treatment (TDT), (iii) community based services for children and adolescents (Level A), and (iv) therapeutic behavioral group home services (Level BTGH).

“Behavioral Health Services-Adult Services” that shall be covered for individuals regardless of age are set out in 12VAC30-50-226 and include: (i) day treatment/partial hospitalization, (ii) psychosocial rehabilitation, (iii) crisis intervention, (iv) case management as set out in 12VAC30-50-420 and 12VAC30-50-430, (v) intensive community treatment (ICT), (vi) crisis stabilization services, and (vii) mental health support services (MHSS).

"Behavioral Health Services Administrator" or "BHSA" refers to Magellan as the entity that manages and directs a behavioral health benefits program under contract with DMAS.

"Behavioral Health Authority" or "BHA" means the local agency that administers services set out in § 37.2-601 of the Code of Virginia.

"Care Coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

"Certified Pre-screener" means an employee of the local community services board or behavioral health authority, or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department of Behavioral Health and Developmental Services.

"Children's Residential Facility" or "Facility" means a publicly or privately operated facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia except:
1. Any facility licensed by the Department of Social Services as a child-caring institution as of January 1, 1987, and that receives public funds; and
2. Acute-care private psychiatric hospitals serving children that are licensed by the Department of Behavioral Health and Developmental Services under the Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse, the Individual and Family Developmental Disabilities Support Waiver, and Residential Brain Injury Services, 12VAC35-105.
"Clinical Experience" (Adult Services) means practical experience in providing direct services on a full-time basis (or the equivalent part-time experience as determined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013) to individuals with medically-documented diagnoses of mental illness or intellectual/developmental disability or the provision of direct geriatric services or full-time (or the equivalent part-time experience) special education services, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health support, (v) crisis stabilization, or (vi) crisis intervention services. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. This required clinical experience shall be calculated as set forth in DBHDS document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Clinical experience" (Children’s Services) means providing direct behavioral health services on a full-time basis or equivalent hours of part-time work to children and adolescents who have diagnoses of mental illness and includes supervised internships, supervised practicums, and supervised field experience for the purpose of Medicaid reimbursement of (i) intensive in-home services, (ii) day treatment for children and adolescents, (iii) community-based residential services for children and adolescents who are younger than 21 years of age (Level A), or (iv) therapeutic behavioral services (Level B). Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be as established by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

“Commonwealth Coordinated Care (CCC)” Commonwealth Coordinated Care is a program that offers, coordinates, and provides Medicare and Medicaid benefits by ensuring that all of the benefits currently provided under Medicare and Medicaid are combined into one plan with a designated care manager who ensures person-centered and efficient health care services are provided. CCC includes provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. Virginians presently eligible for CCC include those who are full Medicare and Medicaid beneficiaries (meaning entitled to benefits under Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits), are aged 21 or older, and live in designated regions around the Commonwealth.

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

“Counseling,” as set forth in § 54.1-3500 under the Department of Health Professions (DHP), means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distresses that interfere
with mental health. As set forth in § 54.1-3506 under the Department of Health Professions in order to engage in the practice of counseling, as defined, it shall be necessary to hold a license issued by the Board of Counseling.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors.

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” EPSDT is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children’s health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the member.

Any treatment service which is not otherwise covered under the State’s Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its agent as medically necessary.

"Failed Services" or "Unsuccessful Services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

“Home or Household” means the family residence and includes a child living with natural parents, relatives, or a legal guardian, or the family residence of the child’s permanent or temporary foster care or pre-adoption placement.

"Human Services Field" means the same as the term is defined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Independent Assessor" means a professional who performs the independent clinical assessment who may be employed by either the behavioral health services administrator, community services boards/behavioral health authorities (CSBs/BHAs) or their subcontractors.

“The Independent Clinical Assessment” (ICA), as set forth in the Virginia Independent Assessment Program (VICAP-001) form, shall contain the Medicaid individual-specific elements of information and data that shall be required for an individual younger than the age of 21 to be approved for intensive in-home (IHI) services, therapeutic day treatment (TDT), or mental health support services (MHISS) or any combination thereof.

"Individual" means the Medicaid-eligible person receiving these services and for the purpose of this section includes children from birth up to 12 years of age or adolescents ages 12 through 20 years. Individuals may also be referred to as a “member”.
"Individual Service Plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the Service Specific Provider Intake (SSPI). The ISP contains, but is not limited to, the individual's treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a minor child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.

"Licensed Mental Health Professional" or "LMHP" means a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist.

"LMHP-Resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-Resident in Psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-Supervisee in Social Work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Marketing Materials" means any material created to promote services through any media including, but not limited to, written materials, television, radio, websites, and social media.
"New Service" means a community mental health rehabilitation service for which the individual does not have a current service authorization in effect as of July 17, 2011.

"Out-of-Home Placement" means placement in one or more of the following: (i) either a Level A or Level B group home; (ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) Level C residential facility treatment services provider; (v) emergency shelter for the individual only due either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"Progress Notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes. Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the individual's status, staff interventions, and, as appropriate, the individual's progress, or lack of progress, toward goals and objectives in the ISP. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours spent in the delivery of service. The content of each progress note shall corrobore the time/units billed. Progress notes shall be documented for each service that is billed.

"Provider" means an individual or organizational entity that is appropriately licensed as required and credentialed with Magellan as a DMAS provider of community mental health and substance abuse rehabilitation services.

"Psychoeducation" means (i) a specific form of education aimed at helping individuals who have mental illness and their family members or caregivers to access clear and concise information about mental illness and (ii) a way of accessing and learning strategies to deal with mental illness and its effects in order to design effective treatment plans and strategies.

"Psychoeducational Activities" means systematic interventions based on supportive and cognitive behavior therapy that emphasizes an individual's and his family's needs and focuses on increasing the individual's and family's knowledge about mental disorders, adjusting to mental illness, communicating and facilitating problem solving and increasing coping skills.

"Qualified Mental Health Professional-Child" or "QMHP-C" means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to children who have a mental illness. To qualify as a QMHP-C, the individual must have the designated clinical experience and must either (i) be a doctor of medicine or osteopathy licensed in Virginia; (ii) have a master's degree in psychology from an accredited college or university with at least one year of clinical experience with children and adolescents; (iii) have a social work bachelor's or master's degree from an accredited college or university with at least one year of documented clinical experience with children or adolescents; (iv) be a registered nurse with at least one year of clinical experience with
children and adolescents; (v) have at least a bachelor's degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or (vi) be a licensed mental health professional.

"Qualified Mental Health Professional-Eligible" or "QMHP-E" means a person who has: (i) at least a bachelor's degree in a human services field or special education from an accredited college without one year of clinical experience or (ii) at least a bachelor's degree in a nonrelated field and is enrolled in a master's or doctoral clinical program, taking the equivalent of at least three credit hours per semester and is employed by a provider that has a triennial license issued by the department [DBHDS] and has a department [DBHDS] and DMAS-approved supervision training program. To apply for approval of the supervision training program please submit your agency’s training curriculum to the DBHDS Office of Licensing.

"Qualified Paraprofessional in Mental Health" or "QPPMH" means a person who must, at a minimum, meet one of the following criteria: (i) registered with the United States Psychiatric Association (USPRA) as an Associate Psychiatric Rehabilitation Provider (APRP); (ii) has an associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of experience providing direct services to individuals with a diagnosis of mental illness; or (iii) has a minimum of 90 hours classroom training and 12 weeks of experience under the direct personal supervision of a QMHP-Adult providing services to individuals with mental illness and at least one year of experience (including the 12 weeks of supervised experience).

"Qualified Mental Health Professional-Adult" or "QMHP-A" means a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness; including (i) a doctor of medicine or osteopathy licensed in Virginia; (ii) a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia; (iii) an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience; (iv) a social worker: an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to individuals with a diagnosis of mental illness; (v) a person with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years of clinical experience; (vi) a Certified Psychiatric Rehabilitation Provider (CPRP) registered with the United States Psychiatric Rehabilitation Association (USPRA); (vii) a registered nurse licensed in Virginia with at least one year of clinical experience; or (viii) any other licensed mental health professional.

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

"Residential Treatment Program Services" means 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, or training needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services
include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child. The service provides active treatment or training beginning at admission related to the resident's principle diagnosis and admitting symptoms. These services do not include interventions and activities designed only to meet the supportive non-mental health special needs including, but not limited to, personal care, habilitation, or academic educational needs of the resident.

“Responsible Adult” shall be an adult who lives in the same household with the child receiving IIH services and is responsible for engaging in therapy and service-related activities to benefit the individual.

“Review of ISP” means that the service provider reviews the ISP, evaluates and updates the member’s progress toward meeting the individualized service plan objectives, and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall:

- Update the goals, objectives, and strategies of the ISP, as clinically appropriate, to reflect any change in the individual’s progress and treatment needs as well as any newly identified problems;
- Be conducted in a manner that enables the individual to participate in the process;
- AND
- The review shall be documented and placed in the individual's medical record no later than 15 calendar days from the date of the review.

"Service Authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Service-Specific Provider Intake" means the face-to-face interaction, in which the provider obtains information from the child or adolescent, and parent or other family member or members, as appropriate, about the child’s or adolescent’s mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) The dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"VICAP" means the Virginia Independent Clinical Assessment Program that is required to record an individual's independent clinical assessment information. VICAP may be referred to as the Independent Clinical Assessment in this manual.

COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES
Community mental health rehabilitative services (CMHRS) are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances.

Community Mental Health Rehabilitation Services include benefits available to individuals who meet the service specific medical necessity criteria based on diagnoses made by Licensed Mental Health Professionals practicing within the scope of their licenses.

All Services must be described with sufficient detail in an Individual Service Plan based on assessed needs of the individual defined in the service specific provider intake and as defined in the individual service plan and most recent clinical supervision and review of the individuals treatment needs. These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities.

Magellan Care Management, Provider Service Coordination and Coordination with CSB and TFC Case Managers

Care Management is provided by Magellan employed clinical staff who are licensed behavioral health clinicians. The central purpose of Care Management is to help individuals receive quality services in the most cost-effective manner. The primary activities of care management include utilization management, triage and referral, opening communication between identified providers, aligning care plans, discharge planning following 24 hours levels of care, continuity of care, care transition, quality management, and independent review.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual’s health care, to improve the care.

DMAS and Magellan of Virginia agree that care coordination has two (2) main goals:
1) To improve the health and wellness of individuals with complex and special needs; and;
2) To integrate services around the needs of the individual at the local level by working to make sure members receive appropriate services and experience desirable treatment outcomes.

Examples when Magellan may provide care management to assist individuals and families include:
- Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management.
- An MCO liaison at Magellan will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care.
- Care coordination with Primary Care Physicians (PCPs).
- Assistance with transferring cases from one provider to another

Coordination Requirements of Service Providers with Case Managers

If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider
shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record. The provider shall determine who the primary care provider is and inform him of the individual's receipt of community mental health rehabilitative services. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

**Care Coordination**

"Care coordination" in the regulations defined in 12VAC30-50-130 means the same as Service Coordination defined in the DMAS manual as collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

The purpose of Care Coordination is to ensure that the individual receives all needed services and supports in the most effective and efficient manner, to provide informed and congruent treatment planning, to ensure open communication among all treating providers, and to ensure that these resources are well-coordinated and integrated.

For an individual receiving CMHR services, this activity is meant to ensure an optimal Individual Service Plan be developed based on as much information as possible related to both the member's physical and behavioral clinical needs.

Service Provider Care Coordination is done in the spirit of collaboration with the treatment team and is meant to support the member on his or her path of recovery.

Service Provider Care Coordination includes:

- Assisting the individual to access and appropriately utilize needed services and supports;
- Assisting them to overcome barriers to being able to maximize the use of these resources;
- Actively collaborating with all internal and external service providers;
- Coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer’s life);
- Assessing the effectiveness of these services/supports;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the service plan as clinically indicated and to ensure that service planning is consistent with other services being provided to the individual.

Care coordination between different providers is required and must be documented in the ISP and Progress Notes. Care Coordination serves to help align services to prevent duplication and is intended to complement the service planning and delivery efforts of each service. Providers must collaborate and share information among other health care providers and individuals who routinely come in contact with the individual, i.e. PCPs, Case Managers, Probation Officers, Teachers, etc. and who are involved with the individual’s health care and
overall wellbeing in order to improve care.

**Independent Clinical Assessment for Children’s Rehabilitative Services**

Magellan contracted with the local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) to conduct the Virginia Independent Clinical Assessment Program (“VICAP”).

Effective November 30, 2016, the Department of Medical Assistance Services (DMAS) will terminate the VICAP. The VICAP described below will no longer be part of the service authorization process for Medicaid and FAMIS children’s community mental health rehabilitative services (CMHRS). More information regarding the termination of the Virginia Independent Clinical Assessment Program can be found in the Medicaid Memo dated August 30, 2016.

For dates and service prior to November 30, 2016, each child or youth must have an independent clinical assessment prior to the initiation of Intensive In-Home, Therapeutic Day Treatment and Mental Health Skill Building (for persons aged 16-20). Children and youth who are being discharged from residential treatment (DMAS Levels A, B, or C), or from a psychiatric inpatient hospitalization do not need an independent clinical assessment to access IIH, TDT, or MHSS. They are required to have an independent clinical assessment as part of any subsequent service reauthorization.

Service lapses of greater than 31 days without member or guardian contact do not require a new independent clinical assessment prior to resuming services.

Independent assessors shall meet the DBHDS definition of a licensed mental health professional (LMHP) including persons who have registered with the appropriate licensing board and are working toward licensure (LMHP Resident, LMHP RP or LMHP-Supervisee).

**The Independent Clinical Assessment Process**

1. A parent or legal guardian of a child or youth who is believed to be in need of Intensive In-Home, Therapeutic Day Treatment or Mental Health Skill Building Services (aged 16-20) must contact the local CSB/BHA to request an independent clinical assessment. If a service provider receives a request to provide one of the affected services, the service provider must refer the parent/legal guardian to the local CSB/BHA first to obtain the independent clinical assessment. The independent clinical assessment must be completed prior to service initiation. If the child or youth is in immediate need of behavioral health treatment, the independent clinical assessor will make a referral to appropriate, currently reimbursed Medicaid emergency services in accordance with 12 VAC 30-50-226 and may also contact the child or youth’s MCO to alert the MCO of the child’s needs with parental or guardian consent.

2. Once the CSB/BHA is contacted by the parent or legal guardian, the independent clinical assessment appointment will be offered within five (5) business days of the request for IIH Services and within ten (10) business days of the request for TDT and MHSS services. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian. CSBs/BHAs will attempt to accommodate working schedules of parents and legal guardians. Medicaid transportation
may be used to transport the child or youth and parent/legal guardian to the independent clinical assessment appointment.

3. The independent clinical assessor will conduct the independent clinical assessment with the child or youth and the parent or legal guardian using a standardized format and make a recommendation for the most appropriate, medically necessary services, if indicated. Only the parent or legal guardian and child or youth will be permitted in the room during the independent clinical assessment. Recommendations may include community mental health rehabilitative services, psychiatric, or outpatient behavioral health services.

4. The independent clinical assessor will inform the parent or legal guardian about the recommended behavioral health service options and their freedom of choice of providers. This discussion must be documented by the independent clinical assessor.
   a. The family or legal guardian will be asked if they have a service provider in mind for the recommended service(s).
   b. If a service provider has been identified, the independent assessor will note the choice of service provider on the Choice form.
   c. The independent assessor will ask the parent or legal guardian to sign a release of information if the parent agrees to share clinical assessment information with the chosen service provider(s).
   d. If a service provider has not been identified, the independent assessor will provide the parent or legal guardian with instructions on finding and selecting a provider using the Magellan website or by directly assisting the parent or guardian with contacting a Magellan Care Manager. For outpatient behavioral health services, the independent clinical assessor will refer the parent or legal guardian to the child or youth’s MCO or the parent or guardian may contact the primary care physician.

5. If the individual is in immediate need of treatment the independent clinical assessor shall refer the individual to the appropriate enrolled Medicaid emergency services providers in accordance with 12VAC30-50-226 and shall also alert Magellan and the individual’s managed care organization.

6. If the parent or legal guardian disagrees with the ICA recommendation, the parent or legal guardian may appeal the recommendation or the parent or legal guardian may request that a service provider perform his own evaluation. If after conducting a service-specific provider intake the service provider identifies additional documentation previously not submitted for the ICA that demonstrates the service is medically necessary and clinically indicated, the service provider may submit the supplemental information with a service authorization request to Magellan. Magellan will review the service authorization submission and the ICA and make a determination. If the determination results in a service denial, the individual, parent or legal guardian, and service provider will be notified of the decision and their appeal rights pursuant to Part I (12VAC30-110-10 et seq.).

7. The independent clinical assessor will electronically submit the independent clinical assessment summary data within one (1) business day of completing the assessment into Magellan web portal service authorization system. The independent clinical assessment will be effective for a 30 day period from the date the assessment was completed with the child. The independent clinical assessor will complete assessment documentation within three (3) business days of the assessment.
8. If a community mental health rehabilitative service has been recommended, the parent or legal guardian may choose and contact a CMHRS service provider. Prior to the initiation of services, the CMHRS service provider must request a copy of the fully completed independent clinical assessment document. If the parent or legal guardian consents to the release of information, the independent clinical assessor will mail, fax or send a copy of the full independent clinical assessment to the service provider within five (5) business days of the request. The service provider (supported by the independent clinical assessment) will then conduct a service specific provider intake for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Skill building Services (H0032, U8) and develop an initial service plan. Service providers may choose to conduct a service specific provider intake prior to receiving a copy of the independent clinical assessment if it can be confirmed that the ICA has already been completed.

9. If the independent assessment is greater than 30 days old, a new ICA must be obtained prior to the initiation of IIH services, TDT, or MHSS for individuals younger than 21 years of age. If the child was screened and determined to be “at risk” for physical injury, the service provider must complete the intake within 14 days from when the individual was deemed “at risk” of physical injury. Refer to the IIH and TDT service requirements for more detail.

10. If the selected service provider concurs that the child meets criteria for the service recommended by the independent clinical assessor, the selected service provider will submit a service authorization request to Magellan. A copy of the fully completed independent clinical assessment must be in the service provider’s medical record for the individual. The service provider’s service specific intake for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Skill building Services (H0032, U8) must not occur prior to the independent clinical assessment.

11. If within 30 days after the ICA a service provider identifies the need for services that were not recommended by the ICA, the service provider shall contact the independent assessor and request a modification. The request for a modification shall be based on a significant change in the individual’s life that occurred after the ICA was conducted. Examples of a significant change may include, but shall not be limited to, hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent or legal guardian.

12. If the independent clinical assessment is greater than thirty (30) days old, another independent clinical assessment must be obtained prior to the initiation of a new CMHRS service.

Service-Specific Provider Intake
The Service-Specific Provider Intake is the initial face-to-face interaction encounter in which the provider obtains information from the individual, and parent/caregivers or other family members about the individual’s mental health status and presenting problem(s). The intake serves to gather information to assess the needs and preferences of the individual as it relates to the delivery of a specific CMHRS service.
Service-specific provider intakes shall be required prior to developing an Individual Services Plan (ISP) and shall be required as a reference point for the ISP during the entire duration of services. Services based upon incomplete, missing, or outdated (more than a year old or not reflective of the individuals current level of need) intakes/re-assessments and ISPs shall be denied reimbursement.

**Service-Specific Provider Intakes for all Mental Health Services shall be conducted by a licensed mental health professional (LMHP); or**

LMHP “Types” including:
- LMHP-supervisee in social work or LMHP-S;
- LMHP-resident or LMHP-R; or
- LMHP-resident in psychology or LMHP-RP

A service specific provider intake must be completed prior to initiating each of the following services:
- Intensive In-home Services for Children and Adolescents
- Therapeutic Day Treatment for Children and Adolescents
- Mental Health Crisis Intervention* (only if an ISP is developed-refer to service details)
- Mental Health Crisis Stabilization
- Mental Health Day Treatment/Partial Hospitalization Services
- Psychosocial Rehabilitation
- Intensive Community Treatment
- Mental Health Skill-building Services
- Levels A & B Child and Adolescent Group Homes

MH intakes do not require the same credentials as the direct MH services. MH Case Management intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services. Providers must adhere to licensing rules as they relate to service provision: [http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section650/](http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section650/)

For services that require a service authorization, the service specific provider intake must be used to determine the medically necessity for each service requested on behalf of the individual.

The Service Specific Provider Intake must contain a documented history of the severity, intensity, and duration of behavioral health care problems and issues and shall contain all of the following elements:

All fifteen elements must be addressed in the service specific provider intake to qualify for reimbursement.

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.
2. Behavioral Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

3. Previous Interventions by providers and timeframes and response to treatment: include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.

4. Medical Profile: Describe significant past and present medical problems, illnesses and injuries, known allergies, current physical complaints and medications. As needed, conduct an individualized fall risk assessment to indicate whether the individual has any physical conditions or other impairments that put her or him at risk for falling. *All children aged 10 years or younger should be assessed for fall risks based on age-specific norms.*

5. Developmental History: Describe the individual as an infant and as a toddler: individual’s typical affect and level of irritability, medical/physical complications/illnesses; interest in being held, fed, played with and the parent’s ability to provide these; parent’s feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

6. Educational/Vocational Status: School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.

7. Current Living Situation, Family History and Relationships: Describe the daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family’s functioning should be listed along with a list of all family or household members.

8. Legal Status: Indicate individual’s criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

9. Drug and Alcohol Profile: Describe substance use and abuse by the individual and/or family members; specify the type of substance with frequency and duration of usage.

10. Resources and Strengths: Document individual’s strengths, preferences, extracurricular, community and social activities, extended family; activities that the individual engages in or are meaningful to the individual.

11. Mental Status Profile-May include the DMAS “At Risk of Physical Injury Screening Tool” (DMAS P502) or other clinical tools used if they apply

12. Diagnosis: The documentation of a diagnosis must include the DSM diagnostic code & description as documented by the LMHP that provided the diagnosis
13.9. Professional Service Specific Intake Summary and Clinical Formulation includes a documentation of medically necessary services as defined by the service provider which:
   a. Defines if there are any additional clinical issues that may need to be addressed that were not identified in the VICAP as appropriate to the service being requested,
   b. Compares the presenting issues identified in the VICAP to those identified during the intake,
   c. Identifies as much as possible, the causes of presenting treatment issues, and
   d. Identifies and discusses treatment options, outcomes, and potential barriers to progress, so that an individual specific service plan can be developed.

14.10. Recommended Care and Treatment Goals

15.11. Dated signatures of the clinicians and case managers* who completed the intake.
   *For case management services only: A dated signature of the case manager who completed the intake is required.

The Service Specific Provider Intake must be completed annually for all services or more frequently as service needs change.

**Individual Services Plan (ISP) Requirements**
Community Mental Health Rehabilitative Services require an Individualized Service Plan which is completed by the servicing provider. The ISP is a comprehensive and regularly updated document that integrates both physical and behavioral health, service coordination, and integrated care goals specific to the needs of the individual being treated and meeting the defined specific service requirements.

The "Individual Service Plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment. A comprehensive ISP is person-centered, includes all planned interventions, aligns with the member's identified needs, care coordination needs, is regularly updated as the member's needs and progress change, and shows progress throughout the course of treatment. The ISP contains, but is not limited to, the individual's treatment or training needs, the individual's goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services.

The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided.

The ISP shall be updated annually and as the needs, goals and progress of the individual changes. An ISP that is not updated either annually or as the needs and progress of the individual change shall be considered outdated. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete and not meeting the reimbursement requirements.
If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the ISP and the progress notes.

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

All ISPs shall be completed, signed, and contemporaneously dated by the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E preparing the ISP within 30 days of the date of the completed intake (except for crisis intervention and crisis stabilization services which have specific rules on ISP development). The member’s signature shall also be obtained. A child’s or adolescent’s ISP shall also be signed by the parent/legal guardian. If the member or guardian is unable or unwilling to sign the ISP, then the service provider shall document the reasons why the individual was not able or refuses to sign the ISP.

Every three months*, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review the ISP, evaluate and update the member’s progress toward meeting the individualized service plan objectives. This must occur in a manner in which the individual may participate in the process.

The outcome of the review shall be documented. If the review identifies any changes in the individual’s progress and treatment needs, the goals, objectives, and strategies of the ISP must be updated to reflect any changes in the individual’s progress and treatment needs as well as any newly-identified problems.

Documentation of the ISP review must be added to the individual’s medical record no later than 15 days from the calendar date of the review as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E, and the individual and/or guardian, when a minor child is the recipient.

*Every 3 months shall be defined as every 90 calendar days.

**Individual Specific Treatment Goals and Objectives**

Goals and Intervention/Strategies should be based on the individuals presenting areas of needs as identified in the SSPI.

Goals:
- Should reflect an individualized specific overview of the objectives and will address the larger presenting needs. Goals are longer term than objectives

Objectives:
- Should demonstrate shorter term, measurable, achievable, action-oriented, strength-based activities that the individual/family will engage in toward completion of the goal.

Intervention/Strategies:
- Should define specific steps that the provider and individual will engage in toward the attainment/achievement of each objective.
Interventions are developed based on the individual’s specific strengths and needs (i.e. developmental level, level of functioning, academic/literacy ability, interests, etc.). Interventions should clearly reflect service coordination. Parent and Caregiver objectives included in IIIH services must be related to increasing functional and appropriate interpersonal interactions with the individual authorized to receive services and must include the individual-specific program purpose of the goals to be achieved within the authorized time period;

**Frequency:**
- The ISPs must include the recommended service frequency needed to accomplish the goals and objectives that will meet the needs identified in the SSPL.
- The ISP must be reviewed, at a minimum, every 3 months to determine if the goals and objectives meet the needs of the individual.
- The ISP shall be updated annually and as the needs, goals and progress of the individual changes.

**Discharge Goal:**
- All ISPs shall include an individualized discharge plan. Describe the discharge planning to summarize an estimated timetable to achieving the goals and objectives in the service plan, include discharge plans that are specific to need of the individual at the time the service needs are reviewed.

**Care Coordination and Continuity of Care:**
- All ISPs should clearly include care coordination as necessary to improve the care.
- All ISPs should clearly identify all current professionals involved in the individual’s care and with whom is actively coordinated during the duration of the service (i.e. educational, psychiatric, medical, case management, probation, etc.)
- Care coordination activities must be defined related to the specific treatment needs and the related service goals and objectives and describe any psycho-educational or care coordination strategies as they relate to other care providers and persons (other CMHRs services, Outpatient/Clinic Services, Foster Care, Judicial or Educational related staff, Relatives, etc.) who routinely come in contact with the individual.

**Additional Service Requirements for All Services**
- LMHPs must adhere to the practice guidelines outlined by the ethical guidelines of the assigned professional board governing that license.
- Professional clinical services must be provided by a LMHP, LMHP-R, LMHP-RP or an LMHP-S.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual’s receipt of community mental health rehabilitative services including efforts to schedule well visits for kids and as needed physician visits for adults.
- If an individual receiving CMHR services is also receiving case management services the provider **must** collaborate with the case manager and provide notification of the provision of services. In addition, the provider **must** send written monthly updates to the
case manager on the individual’s progress. A discharge summary **must** be sent to the case manager within 30 days of the service discontinuation date.

- Service providers and case managers who are using the same electronic health record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of the information in the electronic health records.

- The provider must maintain a copy of the entire fully completed Independent Clinical Assessment in each individual’s file. After the Independent Clinical Assessment is completed and prior to admission, a face-to-face service specific provider intake must be conducted and documented.

- Progress notes must contain individual-specific documentation that contains the unique differences particular to the individual’s circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider’s professional staff who have prepared the notes. Individualized and case-specific progress notes are part of the minimum documentation requirements and shall convey the individual’s status, staff interventions, and, as appropriate, the individual’s progress, or lack of progress, toward goals and objectives in the ISP.

- The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. Progress notes shall be documented for each service unit that is billed. The content of each progress note shall corroborate the time and specifically document the service provided to support each of the units billed.

- DMAS shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual’s circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.

- Staff travel time is not reimbursable.

**Marketing Requirements**

Providers shall comply with marketing requirements at 12VAC30-130-2000. Effective July 1, 2016, review and approval of marketing and promotional materials transitioned to Magellan. Violations of marketing requirements could result in Magellan network contract termination if the marketing plan was not approved in writing by Magellan.

1. Marketing and promotional activities (including provider promotional activities) shall comply with all applicable federal and state laws.
2. Marketing and promotional materials must include the following: Clear, written descriptions of the Medicaid or FAMIS behavioral health service; eligibility requirements for the service; application fees and other changes; and all other necessary information for beneficiaries and their families to make an informed decision about enrollment into the service.

3. Provider marketing and promotional materials, including but not limited to, written materials, television, radio, websites, and social media shall be distributed only in the service locations approved within the license issued by the Office of Licensing at the Department of Behavioral Health and Developmental Services (DBHDS).

4. Providers must receive approval from Magellan for all marketing materials and any changes prior to use or dissemination. This applies only to providers of community-based mental health services listed in the Community Mental Health Rehabilitative Services (CMHRS) manual and Early Periodic Screening, Diagnostic, and Treatment (EPSDT) supplement. Any efforts to mislead, confuse, or defraud potentially eligible members or misrepresent the service being offered is prohibited and could result in Magellan network contract termination if the marketing plan was not approved in writing by Magellan.

5. To ensure compliance with these requirements, the provider shall submit to Magellan a complete marketing plan. This may be submitted along with any marketing and informational materials for Magellan to review. Once submitted, Magellan will review and approve, pend, or reject marketing material within 30 calendar days of receipt of the request.

6. Providers failing to implement Magellan's required changes, or those which use unapproved or disapproved materials, shall be subject to termination of the provider agreement pursuant to 12VAC30-130-2000 E.

Marketing Limits and Prohibitions

1. Providers shall not offer cash or noncash incentives to their enrolled or prospective members for the purposes of marketing, retaining beneficiaries within the providers' services, or rewarding behavior changes in compliance with goals and objectives stated in beneficiaries' individual service plans.

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

   a. Engage in any marketing activities that could misrepresent the service, Magellan or DMAS;
b. Assert or state that the beneficiary must enroll with the provider in order to prevent the loss of Medicaid or FAMIS benefits;

c. Conduct door-to-door, telephone, unsolicited school presentations, or other cold call marketing directed at potential or current beneficiaries;

d. Conduct any marketing activities or use marketing materials that are not specifically approved by Magellan;

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

f. Collect or use Medicaid or FAMIS confidential information or Medicaid or FAMIS protected health information (PHI), as that term is defined in Health Insurance Portability and Accountability Act of 1996 (HIPAA), that may be either provided by another entity or obtained by marketing provider, to identify and market services to prospective beneficiaries;

g. Violate the confidential information or confidentiality of PHI by sharing or selling or sharing lists of information about beneficiaries for any purposes other than the performance of the provider's obligations relative to its DMAS provider agreement;

h. Contact, after the effective date of disenrollment, beneficiaries who choose to disenroll from the provider except as may be specifically required by DMAS;

i. Conduct service assessment or enrollment activities at any marketing or community event; or

j. Assert or state (either orally or in writing) that the provider is endorsed either by the Centers for Medicare and Medicaid Services, DMAS, or any other federal or state governmental entities.

Termination of Providers for Violating Marketing Requirements

Providers that (i) conduct any marketing activity that is not specifically approved by Magellan, (ii) violate any of the prohibitions in this section, or (iii) fail to meet requirements shall be subject to termination of their provider agreements for the services affected by the marketing plan/activity. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

Transportation Benefits

- Provider transportation of the individual receiving services is not reimbursable.
Fee-for-Service (FFS) members with transportation benefits receive services through the Non-Emergency Medical Transportation (NEMT) broker. The NEMT program serves members going to Medicaid covered services, including psychiatric appointments. Transportation services must be “preauthorized” by the FFS NEMT broker. Members assigned to a Managed Care Organization (MCO) or are not included as parts of any CMHRS service please contact the MCO for transportation services. Individual providers and agencies may seek mileage reimbursement through the FFS transportation broker or MCO for services under which transportation is covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements in this chapter.

If you have any FFS transportation questions, need to check transportation eligibility, want to make transportation arrangements or discuss the gas reimbursement process please contact LogistiCare at (866) 386-8331. For more additional information regarding the NEMT program please refer to the DMAS NEMT website http://transportation.dmas.virginia.gov. Individuals enrolled in an MCO must contact the individual’s MCO directly in order to arrange transportation.

Service Authorization
For more service detail please refer to the Service Limit Chart in Appendix C.

All services which do not require service authorization require registration. This registration shall transmit to DMAS or its contractor (i) the individual’s name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider’s name and NPI, a provider contact name and phone number, and email address.

Service Authorization is required for the following services:

- Intensive In-Home (IIH) Services for Children and Adolescents (H2012)
- Community Residential Treatment, Level A (H2022 HW (CSA) H2022 HK (non-CSA))
- Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) H2020 HK (non-CSA)
- Therapeutic Day Treatment for Children up to age 21 (H0035)
- Day Treatment / Partial Hospitalization (H0035)
- Intensive Community Treatment (H0039)
- Psychosocial Rehabilitation (H2017)
- Mental Health Skill-building Services (H0046)

Registration is required for the following services:

- Crisis Intervention
- Crisis Stabilization
- Mental Health Case Management

SERVICE CRITERIA AND DEFINITIONS

Intensive In-Home Services (IIH) for Children and Adolescents (H2012)

Service Definition
Intensive in-home services (IIH) for children and adolescents under age 21 shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual.

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

Beginning on January 30, 2015 children who meet the medical necessity criteria to receive IIH services may also simultaneously be approved for either Mental Health Case Management or Treatment Foster Care Case Management services.

Medical Necessity Criteria
Individuals receiving IIH Services must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual’s functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the individual's residence. The service-specific provider intake shall describe how the individual's clinical needs put the individual at risk of out-of-home placement and shall be conducted face-to-face in the individual's residence.

To qualify for Intensive In-Home reimbursement individuals must MEET ALL of the criteria including Diagnostic, At Risk, Family Involvement and Level of Care.

Diagnostic Criteria
Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities.

The diagnosis must be the primary clinical issue addressed by services and meet the following criteria:

**MEET ONE:**  
The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.

At Risk Criteria
The impairments experienced by the member are to such a degree that they meet the criteria for being at risk of out of home placement as defined in the below section.

**MEET TWO:**

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization* or out-of-home placement** because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary resulting in being at risk for out of home placement.

c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior resulting in being at risk for out of home placement.

*At Risk of Hospitalization
Means one or more of the following:

(i) Within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted: REFER to Emergency Services for Assessment if necessary;

(ii) The parent/guardian is unable to manage the individual’s mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;

(iii) A representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of or consultant to the IIH services or therapeutic day treatment (TDT) provider, has recommended an out of home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;

(iv) The individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days;

(v) The treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:

a. Transitioning (within the last 30 days) out of residential treatment facility Level C services,

b. Transitioning (within the last 30 days) out of a group home Level A or B therapeutic group home services,

c. Transitioning (within the last 30 days) out of acute psychiatric hospitalization, or

d. Transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

**Out of Home Placement:
Means placement in one or more of the following:
(i) either a Level A or Level B therapeutic group home;
(ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services;
(iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care;
(iv) Level C Psychiatric residential treatment facility;
(v) emergency shelter for the individual only due either to his mental health or behavior or both;
(vi) psychiatric hospitalization; or
(vii) juvenile justice system or incarceration.

Level of Care:
The service-specific provider intake shall describe how the individual meets either subdivision a or b of this subdivision

MEET ONE:
These services shall be provided in this level of care when the clinical needs of the individual put him at risk for out-of-home placement, as these terms are defined in this section:

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

Family Involvement:

MEET BOTH:

a. At least one parent/legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family.
b. In the instance of this service, a responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities to benefit the individual.

Discharge Criteria
Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

Reimbursement shall not be made for this level of care if the following applies:

a. The individual is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms.
b. The level of functioning has improved with respect to the goals outlined in the ISP and the individual can reasonably be expected to maintain these gains at a lower level of treatment.
c. The child is no longer in the home.
d. There is no parent or responsible adult actively participating in the service.
Discharges shall also be warranted when the service documentation does not demonstrate that services meet the IIH service definition or when the services progress meets the “failed services” definition.

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

**Service Requirements**

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the service provider, the provider shall discharge the individual. If the individual continues to need services, then a new intake/admission shall be documented and a new service authorization shall be required.

- An individual service plan shall be fully completed, signed, and dated by either a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and individual's parent/guardian within 30 days of initiation of services. The ISP shall meet all of the requirements as defined in 12VAC30-50-226.

- It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. The ISP, as defined in 12VAC30-50-226, shall be updated as the individual’s needs and progress changes and signed by either the parent or legal guardian and the individual.

**Required Activities when individual is screened and determined to be “AT Risk of Physical Injury”:**

For all individuals that have been screened by an LMHP and meet criteria “i” of the “At Risk Criteria” they are deemed “at risk for physical injury” and the service-specific intake and service authorization process must be managed by the provider according to the following requirements:

1. If the individual is deemed at risk of physical injury or the risk screening determines there is a need for immediate intervention, the provider will work with the appropriate entities (parents, local CSB, local hospital) to come up with a safety plan and conduct an emergency services assessment to assess for the most appropriate level of care. *(The individual should always be immediately referred to the local CSB Emergency Services Program if he/she is presenting imminent risk to self or others.)*
2. Once the individual is referred for community based services the Service Specific Provider Intake must be completed by the provider selected by the individual’s caregivers. If the SSPI is not completed within 14 calendar days of the LMHP who deemed the individual to be a physical danger to self or others, an additional risk screening must be completed.

3. This risk screening must be done by an LMHP. It may be the same LMHP who performs the service-specific intake for IIH or TDT.

4. If an Independent Clinical Assessment (VICAP) was done, the original VICAP assessor may update that assessment if they are available to do so. The risk screening will be submitted along with the Service Request Application to Magellan for review.

5. If the service request is submitted to Magellan for a child who is at risk of physical danger to self or others more than 14 days after the VICAP, the case will be pended and the submitting provider will be contacted and asked to submit a risk screening to Magellan within three business days.

6. Once the risk screening is received, the information will then be reviewed and a decision made.

7. If the provider does not submit the additional requested information, the service may not be authorized.

- Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per individual/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive services.

- Emergency assistance shall be available to the family, and delivered, as needed, by the IIH service provider 24 hours per day, seven days a week.

- All interventions and the settings of the intervention shall be defined in the ISP.

- Services shall be directed toward the treatment of the eligible individual and delivered primarily in the family’s residence with the individual present.

- As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP.
Observational sessions in the school setting must be defined in the ISP, the sessions must have a specific clinical rationale that supports a documented service need and is clinically necessary in the school setting.

For services provided outside of the home, there shall be documentation reflecting therapeutic treatment as set forth in the ISP provided for that date of service in the appropriately signed and dated progress notes.

**Covered Services:**
- Individual and family counseling;
- Training to increase appropriate communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.);
- Services shall also be used to facilitate the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. The individual and responsible parent/guardian shall be available and in agreement to participate in the transition.

**Service Coordination**

**Service Limitations:**
- Services that meet the definition of “Failed Services” will not be eligible for reimbursement approval.
- IIH may not be billed prior to 7 days from the day of discharge from any Level A, Level B, Level C residential treatment service or inpatient hospitalization.
- Outpatient therapy must be either provided by the IIH provider or coordinated with another provider to align the service with ISP goals and objectives. The ISP and progress notes must reflect the need and coordination activities.
- Activities outside the home, such as trips to the library, restaurants, museums, health clubs, shopping centers, and the like, are not considered a part of the scope of services. There must be a clinical rationale documented for any activity provided outside the home. Services may be provided in the community instead of the home if this is supported by the service specific provider intake and the ISP.
- The unit of service for IIH service is one hour.
- For reimbursement of this service, a minimum of 3 hours per week of therapeutic intervention must be medically necessary for the individual, with a maximum of 10 hours per week. In exceptional circumstances only, and with appropriate supporting documentation that describes medical necessity, providers may bill for up to 15 hours per week. Magellan may authorize up to a maximum of 50 hours per calendar month based on medical necessity criteria and the needs of the individual.

The information provided for service authorization must be corroborated and in the provider’s clinical record. An approved Service Authorization is required for any units...
of service (H2012) to be paid. The process for requesting service authorization is
detailed in Appendix C of this manual. Providers under contract with Magellan should
contact Magellan directly for more information. A maximum of 26 weeks of III
Services may be authorized annually with coverage under the State Plan Option
service. Magellan stops payment when claims exceed the 26 week service limit
allowed in the regulations. If an individual is in need of services beyond the 26 weeks
limit, providers must request the service extension through Magellan under the rules
for Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

- **Therapeutic Day Treatment (TDT) for Children and Adolescents (H0035)**

  **Service Definition**
  Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and
  structured therapeutic interventions to children/adolescents with mental, emotional, or
  behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT
  service and whose symptoms are causing significant functional impairments in major life
  activities such that they need the structured treatment interventions offered by TDT. TDT
  treatment interventions are provided during the school day or to supplement to school day or
  year. The supporting diagnosis must be made by an LMHP practicing within the scope of
  his or her license. This service includes clinical evaluation, psychiatric medication education
  and management, interventions to build daily living skills or enhance social skills, and
  individual, group, and family counseling and contacts provided in a structured setting. The
  service must be provided for two or more hours per day.

  **Recommendations for Service Provision**
  Successful service provision will likely include the active engagement of the service
  provider, any involved school, and the member’s parent/guardian. The service provider
  should attempt to engage any involved school and the parent/guardian to
  reach desired outcomes. Ideally, if a school is involved, it will provide a secure space for service provision
  and liaison with the service provider. It is suggested for the parent/guardian to take an active
  role in the service provision and be in contact weekly with the provider.

  Members receiving TDT should experience improvement on measurable objectives and
goals documented in the ISP and ISP reviews that enable the member to transition to lower
intensity services TDT is intended for children/adolescents who reside in the community
with their parent(s)/ caregiver(s), in the family home or in a group home placement. TDT
should provide stabilization during the school day or to supplement to school day or year, as
medically necessary, for youth who are at risk to be placed in a higher level of care in order
to address current symptoms, or who are transitioning from an acute or residential level of
care to a home environment. Family involvement, including family counseling and contacts
from the beginning of treatment is extremely important and, unless contraindicated, should
occur at least weekly.

  **Medical Necessity Criteria**
  To qualify for Therapeutic Day Treatment reimbursement individuals must MEET
  ALL including the Diagnostic, Clinical Necessity, and Level of Care criteria

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

Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals shall meet at least two of the following:

**MEET TWO (a through c):**

a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are *at risk of hospitalization* or *out-of-home placement* because of conflicts with family or community.

b. Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.

c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

*At Risk of Hospitalization*  
Means one or more of the following:

**Meets One (i through v):**

(i) Within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted;

(ii) The parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;

(iii) A representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of or consultant to the IIH services or therapeutic day treatment (TDT) provider, has recommended an out of home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;

(iv) The individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days;

(v) The treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:

   (a) Transitioning (within the last 30 days) out of residential treatment facility Level C services,

   (b) Transitioning (within the last 30 days) out of a *therapeutic* group home Level A or B services,

   (c) Transitioning (within the last 30 days) out of acute psychiatric hospitalization,

   (d) Transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization,
outpatient psychotherapy, or outpatient substance abuse services.

**Out of Home Placement (meets criteria a):**
Means placement in one or more of the following:

- Either a Level A or Level B group home;
- Regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services;
- Treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care;
- Level C Psychiatric residential treatment facility;
- Emergency shelter for the individual only due either to his mental health or behavior or both;
- Psychiatric hospitalization; or
- Juvenile justice system or incarceration.

Level of Care:
**Therapeutic day treatment is appropriate for children and adolescents who meet at least one of the following:**

**MEET ONE (a through e)**

a. The individual must require year-round treatment in order to sustain behavior or emotional gains.
b. The individual’s behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:
   i. TDT programming during the school day; or
   ii. TDT programming to supplement the school day or school year.
c. The individual would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.
d. The individual must (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.
e. The individual is placed or pending placement in a preschool enrichment and/or early intervention program but the individual's emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted in these programs without TDT services.

Individuals receiving TDT must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual’s functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

**Discharge Criteria**
Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

- Reimbursement shall not be made for this level of care if the following applies:
  - The individual no longer meets the diagnostic, clinical necessity, or level of care criteria; or
  - The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.
  - When the individual has achieved maximal benefit from this level of care and his or her level of functioning has not improved despite the length of time in treatment and interventions attempted and the individual meets all of the discharge criteria.

**Required Activities:**

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual’s diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, new intake/admission documentation shall be prepared and a new service authorization shall be required.

- An ISP shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or QMHP-E and by the individual or the parent/guardian within 30 days of initiation of services and shall meet all requirements of an ISP as defined in 12VAC30-50-226.

- Services must be therapeutic in nature and align with the member’s ISP.

- The ISP, including the individualized discharge plan contained in the ISP, should be reviewed every 3 months at a minimum, but as frequently as medically necessary.

- The ISP must be updated between school and summer programs based on the activities being provided.

- The provider will be asked to explain what care coordination has taken place to prepare for discharge and step down to lower levels of care with every request for services.

**Required Activities when individual is screened and determined to be “AT Risk of Physical Injury”:**

For all individuals that have been screened by an LMHP and meet criteria “i” of the “At Risk Criteria” they are deemed “at risk for physical injury” and the service-specific intake and service authorization process must be managed by the provider according to the following requirements:
1. If the individual is deemed at risk of physical injury or the risk screening determines there is a need for immediate intervention, the provider will work with the appropriate entities (parents, local CSB, local hospital) to come up with a safety plan and conduct an emergency services assessment if clinically necessary to assess for the most appropriate level of care. *(The individual should always be immediately referred to the local CSB Emergency Services Program if he/she is presenting imminent risk to self or others.)*

2. Once the individual is referred for community based services the Service Specific Provider Intake must be completed by the provider selected by the individual’s caregivers. If the SSPI is not completed within 14 calendar days of the LMHP who deemed the individual to be a physical danger to self or others, an additional risk screening must be completed.

3. This risk screening must be done by an LMHP. It may be the same LMHP who performs the service-specific intake for IIH or TDT.

4. If an Independent Clinical Assessment (VICAP) was done, the original VICAP assessor may update that assessment if they are available to do so.

5. The risk screening will be submitted along with the Service Request Application to Magellan for review.

6. If the service request is submitted to Magellan for a child who is at risk of physical danger to self or others more than 14 days after the VICAP, the case will be pended and the submitting provider will be contacted and asked to submit a risk screening to Magellan within three business days.

7. Once the risk screening is received, the information will then be reviewed and a decision made.

8. If the provider does not submit the additional requested information, the service may not be authorized.

**Covered Services**

*Documentation of covered services activities shall fully disclose the details of the service rendered and align with the individual’s ISP. Covered Services include:*

- Completing diagnostic evaluations, identifying treatment needs.
- Providing individual and group therapeutic interventions and activities and family counseling and contacts based on specific TDT objectives identified in the ISP.
- Consultation, collaboration, and coordination with teachers, concurrent service providers, and others involved in the individual’s treatment to include scheduling appointments and meetings to improve care; planning and implementing individualized behavior modification programs; and monitoring treatment and ISP progress.
- Planning and implementing individualized pro-social skills interventions; e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.
• Providing feedback to the individual and direct skills training in the classroom based on specific TDT objectives identified in the ISP.

• Implementing cognitive-behavioral programming.

• Family meetings and contacts, either in person or by telephone, occurs at least once per week to discuss treatment needs and progress. Contacts with parents/guardian include at a minimum the individual’s progress, any diagnostic changes, any treatment plan changes, and discharge planning. Monitoring the individual’s medication compliance/adherence must involve the parent/guardian. The parent/guardian should be involved in any significant incidents during the school day and be informed of any changes associated with the treatment plan.

• Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day; services should include a “de-briefing” with the individual and family to discuss the incident; how to recognize triggers, identify alternative coping mechanisms and providing feedback on the use of those alternative coping mechanisms. A crisis plan should be kept onsite and in the medical record and reviewed throughout treatment.

• If the individual is on medication related to their behavioral health needs, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the individual and parent/guardian and documented. Response to medication and education, as well as compliance must also be documented. A QMHP-C must remain within the boundaries of their level of expertise and may consult with the service provider’s clinical director, consult with current prescribing physician and school personnel such as school nurse, coordinate referrals for medication evaluation, monitor compliance, and provide developmentally appropriate education to the individual regarding medication adherence and side effects. The QMHP must involve the parent/guardian to monitor the individual’s medication compliance/adherence.

Limitations
• The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., before school, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group therapeutic interventions and activities.

• Services shall be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-C or QMHP-E.

• Therapeutic group activities are limited to no more than 10 individuals.

• Medicaid will only reimburse for allowed service activities as defined in the ISP.

• Activities that are not allowed / reimbursed:
  o Inactive time or time spent waiting to respond to a behavioral situation
  o Transportation
  o Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions
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- Time required for academic instruction when no treatment activity that align with the goals and objectives in the individual’s ISP is taking place
- Time spent monitoring behavior during the classroom when no treatment activity is occurring.

- Services must not duplicate those services provided by the school, including interventions identified on the school’s IEP for the member
- It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially, with gradually reduced intensity progressing toward discharge.

**Service Units and Maximum Service Limitations**

There is a maximum of 780 units that are allowed based on medical necessity per fiscal year.

- One unit = 2 to 2.99 hours
- Two units = 3 to 4.99 hours
- Three units = 5 plus hours
- No more than three units may be billed per day.

TDT claims must be billed with an HA modifier (H0035HA). Effective 12/1/2016, claims must distinguish whether the TDT services rendered were school based TDT, after school TDT, or summer TDT with the addition of secondary modifiers UG or U7, as follows:

- School Based TDT must be billed as H0035HA
- After School TDT must be billed as H0035HA- UG
- Summer TDT must be billed as H0035HA-U7

Providers under contract with Magellan should contact Magellan directly for more information.

**Community-Based Residential Services for Children and Adolescents under 21 (Level A) - H2022 HW (CSA), H2022 HK (non-CSA)**

**Service Definition**

Community-Based Residential Services for Children and Adolescents under 21 (Level A Group Homes) are a combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and behavioral health treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan. The individual must also receive at least weekly individual psychotherapy services (provided by an LMHP or LMHP Resident/Supervisee) in addition to the therapeutic residential services.

**Medical Necessity Criteria**

- As of December 1, 2015 the eligibility criteria was changed to Medical Necessity Criteria. The old eligibility criteria was replaced with Magellan Medical Necessity Criteria.

An individual eligible for Community-Based Services for Children and Adolescents under 21 (Level A) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a qualified mental health professional.
Prior to admission to Community-Based Services for Children and Adolescents under 21 (Level A), an individual must have a valid psychiatric diagnosis and must meet specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission. The diagnosis must be current; as documented within the previous year. If a current diagnosis is not available the individual will require a mental health evaluation by either a psychiatrist or licensed clinical social worker or licensed professional counselor or a licensed psychologist prior to admission. Providers are encouraged to coordinate the evaluation through either Magellan or the individual’s Managed Care Organization to facilitate immediate access to the evaluation services and to coordinate services with the individual’s established medical and psychiatric providers.

To obtain a diagnosis through the individual’s Managed Care Organization (MCO) refer to the MCO contact information as listed in the DMAS Managed Care Member Resource Guide at: http://www.dmas.virginia.gov/Content_atchs/mc/MCRG_Member_2015_10302015_for_web.pdf

To obtain a diagnosis for individuals enrolled as Fee for Service (FFS) contact the Magellan Call Center at:

**Magellan Members**
Toll free: 1-800-424-4046
TDD: 1-800-424-4048
TTY: 711
Email: VirginiaMemberInfo@MagellanHealth.com

**Magellan Providers**
Toll Free: call 1-800-424-4536
Email: VAProviderQuestions@MagellanHealth.com

Magellan defines medical necessity as: “Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are: 1. consistent with the diagnosis and treatment of a condition and the standards of good medical practice; 2. required for other than convenience; and 3. the most appropriate supply or level of service.

Magellan is committed to the philosophy of providing treatment at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment and meet the individual’s biopsychosocial needs. Magellan uses the continuum of care as a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active and takes into consideration the individual’s stage of readiness to change/readiness to participate in treatment.

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for an individual. While the medical necessity criteria will assign the safest, most effective and least restrictive level of
care in nearly all instances, an infrequent number of individual situations may fall beyond their definition and scope. Thorough and careful review of each individual request for services, including consultation with supervising clinicians, will identify exceptional clinical needs to ensure that an individualized medical necessity review occurs for each individual.

All medical necessity decisions about proposed admission and/or treatment are made by the Magellan care manager after receiving a sufficient description of the current clinical features of the individual’s condition that have been gathered from a face to face evaluation of the individual by a qualified clinician. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual’s socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. In instances when Magellan recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan will support the individual through extra contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual’s essential needs for safe and effective treatment.

See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

Required Activities:

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual’s diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

- A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues indicated in the individual’s IPOC and the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger
management, social skills, family living skills, communication skills, and stress management. Psycho-education refers to education on mental health topics to improve the individual’s behavioral, mental, or emotional condition. The child must participate in seven (7) psycho-educational activities per week. Program activities must be documented at the time the service is rendered and must include the dated signatures of qualified staff rendering the service.

- In addition to the residential services, the child must receive at least weekly, individual psychotherapy that is provided by an LMHP, LMHP supervisee, LMHP resident, or LMHP RP. Family psychotherapy may also be provided if there is continued family involvement. Therapy sessions are limited to no more than three (3) sessions in a seven-day period, including individual, family, and group psychotherapy. If provided by a Medicaid enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized (see the Psychiatric Services Provider Manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and documentation criteria.) If the weekly psychotherapy is missed due to the individual’s illness or refusal, justification must be documented in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up a missed session.

- The facility/group home must coordinate services with other providers.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual’s receipt of this community mental health rehabilitative service.

- If an individual receiving Community Based Services for Children and Adolescents under 21 (Level A) is also receiving case management services the provider must collaborate with the case manager by notifying the case manager of the provision of Level A services and send written monthly updates on the individual’s progress. A written discharge summary must be sent when the service is discontinued.

- The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while the children/adolescents are scheduled to be asleep. To assist in assuring client safety, the agency must provide adequate supervision of residents at all times, including off campus activities.

- The program director supervising the program/group home must be at a minimum, a QMHP-C and employed full time.

- At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.

- Ensure that entry level staff are paired with a qualified paraprofessional and supervised by a QMHP as set forth in Chapter IV.

- Services may be rendered by an LMHP, LMHP Supervisee or Resident, QMHP-C, QMHP-E, and QPPMH.

Independent Team Certification
The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission; and

For CSA individuals, the Family Assessment and Planning Team’s (FAPT) identification of the need for the service and the Community Policy and Management Team’s (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the individual’s primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA individuals only, the placing agent must give the provider the name of the locality fiscally responsible for the individual. The provider will submit this information to Magellan.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent’s PCP and an LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.

A Medicaid-reimbursed admission to a Level A Group Home may only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual; and
2. Proper treatment of the child’s psychiatric condition requires services in a community-based residential program.
3. The services may reasonably be expected to improve the individual’s condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the LMHP and the physician prior to the start of services (see “Exhibits” section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

1. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that includes a licensed physician who:
   a) Has competence in diagnosis and treatment of pediatric mental illness; and
   b) Has knowledge of the individual’s mental health history and current situation.

2. For an individual who applies for Medicaid while an inpatient in the facility or program, the certification must:
   a) Be made by the team responsible for the CIPOC;
   b) Cover any period of time before the application for Medicaid eligibility.
for which claims for reimbursement by Medicaid are made; and
c) Includes the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

**Initial Plan of Care Requirements**

The Initial Plan of Care (IPOC) must be completed upon admission at least by a QMHP and must be signed and dated by the program director. (See the “Exhibits” section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The IPOC must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the child;
3. Treatment objectives with short term and long term goals;
4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.

**Comprehensive Individual Service Plan**

A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the QMHP within 30 days of authorization for Medicaid reimbursement. The CIPOC must be re-written annually. (See the “Exhibits” section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The CIPOC must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual’s situation and must reflect the need for residential psychiatric care;
2. Be based on input from school, home, other healthcare providers, the individual, and family (or legal guardian);
3. State treatment objectives that include measurable short term and long term goals and objectives, with target dates for achievement;
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;
5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual’s family, school, and community;
6. The CIPOC must be reviewed and signed by a QMHP every 30 days. The review must include:
   a. The response to services provided; and
   b. Recommended changes in the plan as indicated by the individual’s overall response to the ISP interventions; and
   c. Determinations regarding whether the services being provided continue to be
Therapeutic Passes

Therapeutic passes are permitted if the goals of the pass are part of the CIPOC. The goals of a particular visit must be documented prior to granting the pass. When the individual returns from the pass, the response to the pass must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the pass is to assess the individual’s ability to function outside the structured environment and to function appropriately within the family and community.

1) Overnight therapeutic passes may occur only after the completion and documentation of successful day therapeutic passes and as a part of the discharge plan. Outcomes of the therapeutic passes must be documented. No more than 24 days of therapeutic passes annually are allowed. Therapeutic pass time is counted from the date of admission to Medicaid covered services at the A and B levels. If an individual has successfully completed therapeutic day passes at a higher level of care in the previous placement the child/adolescent may be granted overnight therapeutic passes prior to the completion of day therapeutic passes at the new program if clinically indicated. Provision of active therapeutic services while on overnight therapeutic passes is required to bill for days away from the facility.

2) If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

3) None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a /MAGELLAN residential service authorization.

Limitations

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

DMAS does not pay for programs/facilities that only provide independent living services.

This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic educational needs of the individual.
Service authorization is required for Medicaid reimbursement.

**Service Units and Maximum Service Limitations**
The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included.

Service authorization is required for payment of all residential services billed to Magellan. Please note that the service authorization process is described in Appendix C of this manual. Providers under contract with Magellan should contact Magellan directly for more information.

**Therapeutic Behavioral Services (Level B) — H2020 HW (CSA) H2020 HK (non-CSA)**

**Service Definition**
Therapeutic Behavioral Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho education, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the ISP. The individual must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services.

**Medical Necessity Criteria**
As of December 1, 2015 the eligibility criteria was changed to Medical Necessity Criteria. The old eligibility criteria was replaced with Magellan Medical Necessity Criteria.

An individual eligible for Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is a child, under the age of 21 years, for whom proper treatment of his psychiatric condition requires less intensive treatment in a structured, therapeutic residential program under the direction of a Licensed Mental Health Professional.

Prior to admission to Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) an individual must have a valid psychiatric diagnosis and must meet specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission. The diagnosis must be current; as documented within the previous year. If a current diagnosis is not available the individual will require a mental health evaluation by either a psychiatrist or licensed clinical social worker or licensed professional counselor or a licensed psychologist prior to admission. Providers are encouraged to coordinate the evaluation through either Magellan or the individual’s Managed Care Organization to facilitate immediate access to the evaluation services and to coordinate services with the individual’s established medical and psychiatric service providers.

To obtain a diagnosis through the individual’s Managed Care Organization (MCO) refer to the MCO contact information as listed in the DMAS Managed Care Member Resource Guide at:

To obtain a diagnosis for individuals enrolled as Fee for Service (FFS) contact the Magellan Call Center at:
### Covered Services and Limitations

**Magellan Members**
- Toll-free: 1 800-424-4046
- TDD: 1 800-424-4048
- TTY: 711
- Email: VirginiaMemberInfo@MagellanHealth.com

**Magellan Providers**
- Toll-Free call 1 800-424-4536
- Email: VAProviderQuestions@MagellanHealth.com

Magellan defines medical necessity as: Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are: 1. consistent with the diagnosis and treatment of a condition and the standards of good medical practice; 2. required for other than convenience; and 3. the most appropriate supply or level of service.

Magellan is committed to the philosophy of providing treatment at the most appropriate, least restrictive level of care necessary to provide safe and effective treatment and meet the individual’s biopsychosocial needs. Magellan uses the continuum of care as a fluid treatment pathway, where individuals may enter treatment at any level and be moved to more or less intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active and takes into consideration the individual’s stage of readiness to change/readiness to participate in treatment.

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for an individual. While the medical necessity criteria will assign the safest, most effective and least restrictive level of care in nearly all instances, an infrequent number of individual situations may fall beyond their definition and scope. Thorough and careful review of each individual request for services, including consultation with supervising clinicians, will identify exceptional clinical needs to ensure that an individualized medical necessity review occurs for each individual.

All medical necessity decisions about proposed admission and/or treatment are made by the Magellan care manager after receiving a sufficient description of the current clinical features of the individual’s condition that have been gathered from a face to face evaluation of the individual by a qualified clinician. Medical necessity decisions about each individual case are based on the clinical features of the individual relative to the individual’s socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the individual. In instances when Magellan recognizes that a full array of services is not available to the individual or when a medically necessary level of aftercare does not exist (e.g., rural locations), Magellan will support the individual through extra-contractual benefits, or authorize a higher than otherwise necessary level of care to ensure that services are available that will meet the individual’s essential needs for safe and effective treatment.

See Appendix C for service authorization information. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook, or contact Magellan of Virginia at 800-424-4536 or by email to VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.
### Service Requirements

- **Prior to admission**, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual’s diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service specific provider intakes or ISPs shall be denied reimbursement.

- If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the treatment plan and the progress notes.

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues indicated in the individual’s IPOC and the CIPOC.

- Daily documentation of services provided must clearly reflect behaviors, activities, and treatment methodologies that indicate attention to and movement toward stated goals and objectives in the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. Psycho-education refers to education on mental health topics to improve the individual’s behavioral, mental, or emotional condition. The individual must participate in seven (7) psycho-educational activities per week. Program sessions must be documented at the time the service is rendered and must be signed and dated by the qualified staff rendering the service.

- In addition to the residential services, the individual must receive at least weekly, individual psychotherapy that is provided by a LMHP. Family psychotherapy may also be provided if there is continued family involvement. If provided by a Medicaid enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized in addition to the authorization for the residential services. (See *Psychiatric Services* provider manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and criteria). If the weekly psychotherapy is missed due to the individual’s illness or refusal written justification must be in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up missed sessions.

- Individuals receiving Therapeutic Behavioral Services (Level B) must also receive group psychotherapy that is provided as part of the program. If provided by a Medicaid enrolled LMHP, group psychotherapy may be billed separately and must be prior authorized in addition to the authorization for the residential services (See
Psychiatric Services provider manual, Chapter IV and Appendix C, for details on outpatient requirements and pre-authorization procedures.

- The facility/group home must coordinate services with other providers.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual’s receipt of this community mental health rehabilitative service.
- If an individual receiving Therapeutic Behavioral Services for Children and Adolescents under 21 (Level B) is also receiving case-management services, the provider must collaborate with the case manager by notifying the case manager of the provision of Level B services and send written monthly updates on the individual’s progress. A written discharge summary must be sent when the service is discontinued.
- The staff ratio must be at least 1 staff to 4 children during the day and at least 1 staff to 8 children while the children/adolescents are scheduled to be asleep. To assist in assuring client safety, the agency must provide adequate supervision of individuals at all times, including off campus activities.
- In order for Medicaid reimbursement to be approved, at least 50% of the direct care staff must meet DMAS paraprofessional staff criteria.
- Ensure that entry level staff are paired with a qualified paraprofessional and supervised by a QMHP as set forth in Chapter IV.
- These services may be rendered by an LMHP, LMHP Supervisee or Resident, QMHP C, QMHP E, and QPMPH.

Independent Team Certification
The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission, and

For CSA children, the Family Assessment and Planning Team’s (FAPT) identification of the need for the service and the Community Policy and Management Team’s (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the child or adolescent’s primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA children only, the placing agent must give the provider the name of the locality fiscally responsible for the child. The provider will be submitting this information to the service authorization contractor.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent’s PCP and a LMHP not affiliated with the residential provider. If the child or adolescent is away from home, at in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.
A Medicaid-reimbursed admission to a community residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the individual;
2. Proper treatment of the individual’s psychiatric condition requires services on in a community-based residential program; and
3. The services can reasonably be expected to improve the individual’s condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the screener and the physician prior to the start of services (see “Exhibits” section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that:
   1) Includes a licensed physician who:
      a. Has competence in diagnosis and treatment of pediatric mental illness; and
      b. Has knowledge of the individual’s mental health history and current situation.

B. For an individual who applies for Medicaid while an inpatient in the facility or program, the certification must:
   1) Be made by the team responsible for the CIPOC;
   2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and
   3) Include the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

Initial Plan of Care

The Initial Plan of Care (IPOC) must be completed upon admission by the QMHP and must be signed and dated by the program director. (See the “Exhibits” section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The IPOC must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the child;
3. Treatment objectives with short term and long term goals;
4. A listing of any medications, treatments, restorative and rehabilitative services,
activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.

Comprehensive Plan of Care
A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the LMHP within 30 calendar days of admission;
The CIPOC must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child’s situation and must reflect the need for residential psychiatric care;
2. Be based on input from school, home, other healthcare providers, the individual, and family (or legal guardian);
3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;
5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the individual’s family, school, and community; and
6. The CIPOC must be reviewed signed by the LMHP every 30 calendar days. The review must include:
   • The response to services provided;
   • Recommended changes in the plan as indicated by the individual’s overall response to the CIPOC interventions;
   • Determinations regarding whether the services being provided continue to be required; and
   • Updates must be signed and dated by the LMHP service provider.

Therapeutic Passes
Therapeutic passes are permitted if the goals of the therapeutic pass are part of the CIPOC.
The goals of a particular therapeutic pass must be documented prior to granting the pass. When the individual returns from the therapeutic pass, the response to the pass must be documented. Therapeutic passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the therapeutic pass is to assess the individual’s ability to function outside the structured environment and to function appropriately within the family and community.

1) Overnight therapeutic passes may occur only after the completion and documentation of successful day therapeutic passes and as a part of the discharge plan. Outcomes of the therapeutic pass must be documented. Therapeutic passes may not exceed more than 24 days annually. Therapeutic pass time is counted from the date of admission to Medicaid covered services at the A and B levels. If an individual has successfully completed therapeutic day passes at a higher level of care in the most recent previous placement the individual may be considered for overnight therapeutic passes prior to the completion of day therapeutic passes at the new program if clinically indicated. Provision of active
therapeutic services by the Level B provider while on overnight therapeutic passes is required to bill for days away from the facility.

2) If an individual requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 consecutive days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If an individual requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

3) None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a MAGELLAN residential service authorization.

Limitations
Magellan will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

Programs/facilities that only provide independent living services are not reimbursed.

The caseload of the clinical director must not exceed a total of 16 clients including all sites for which the clinical director is responsible. Room and board costs are not included in the reimbursement for this service.

This service does not include interventions and activities designed only to meet the supportive non mental health special needs, including but not limited to personal care, habilitation, or the academic educational needs of the members. Service authorization is required for Medicaid reimbursement.

Service Units and Maximum Service Limitations
The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the individual. Room and board costs are not included in the rate. Service authorization is required for payment of all residential services. The service authorization process is described in Appendix C of this manual. Providers under contract with Magellan should contact Magellan directly for more information.

The fiscal years will be run from July 1 through June 30.

Day Treatment/Partial Hospitalization (H0035 HR)
Service Definition
Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.
Day treatment/partial hospitalization services consist of diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for individuals with serious mental health disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment but do not require psychiatric inpatient treatment.

**Medical Necessity Criteria**

The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual’s behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

1. Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;
2. Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
3. Exhibit such inappropriate behavior that the individual requires repeated documented interventions or monitoring by the mental health, social services, or judicial system; or
4. Exhibit difficulty in cognitive ability such as difficulties with information processing, problem solving and decision making abilities such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

**Continued Stay**

Upon admission the individual must receive a clinical evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist. For continued stays of more than 90 days, each service authorization requires that the individual receive an evaluation to document medical necessity for service extensions longer than 90 calendar days. All services must be authorized based upon a face-to-face evaluation. The evaluation process shall include a review to determine if the individual continues to meet medical necessity criteria. The results of this evaluation must be presented to receive approval of reimbursement for continued services.

**Discharge Criteria**

Individuals are ready for discharge from this service when other less intensive services may achieve stabilization. Reimbursement shall not be made for this level of care if the following applies:

1. The individual is no longer in an acute psychiatric state and at risk of psychiatric hospitalization and;
2. The individual’s level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

**Required Activities**

- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- Evaluation activities including the required face-to-face evaluation to assess whether the individual meets the medical necessity criteria and to define treatment goals that would be included in the ISP for continued services.

- An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, the QMHP-A, QMHP-E, or QMHP-C and reviewed/approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 days of service initiation.

- A physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist must perform a face-to-face evaluation when services are provided longer than 90 calendar days to assess whether the individual meets the medical necessity criteria and to define treatment goals that would be included in the ISP for continued services. This evaluation must be completed no later than 90 calendar days from the start of services.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP-A or LMHP or LMHP Resident/Supervisee, by a QMHP-A, QMHP-E, LMHP, or LMHP Supervisee or Resident.

- Supervision by the QMHP-A, LMHP or LMHP Supervisee or Resident is demonstrated by a review of progress notes, the individual’s progress toward achieving ISP goals and objectives and recommendations for change based on the individual’s status. Supervision must occur monthly. Documentation that supervision occurred must be in the individual’s clinical record and signed by the QMHP-A, LMHP or LMHP Supervisee/Resident. Individual, group, or a combination of individual and group supervision is acceptable. The program must operate a minimum of two continuous hours in a 24-hour period.

**Service Units and Maximum Service Limitations**

- Day treatment/partial hospitalization services shall only be provided by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, QMHP-C, QMHP-E, or an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
Psychosocial Rehabilitation (H2017)

Service Definition

Psychosocial Rehabilitation is a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Medical Necessity Criteria

The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

Individuals must MEET BOTH Criteria A and B to qualify for reimbursement.

A. Individuals must MEET TWO of the following criteria on a continuing or intermittent basis:

   1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

   2) Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

   3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

   4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. “Cognitive” here is referring to the individual’s ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.

B. The individual must MEET ONE of the following criteria:

   1) Have experienced long-term or repeated psychiatric hospitalizations; or

   2) Experience difficulty in activities of daily living and interpersonal skills; or

   3) Have a limited or non-existent support system; or

   4) Be unable to function in the community without intensive intervention; or

   5) Require long-term services to be maintained in the community.

Covered Services

A maximum of 780 units of Partial Hospital / Day Treatment is allowable annually.

- One unit= 2-3.99 hours/day
- Two units= 4-6.99 hours/day
- Three units= 7+ hours/day
• Assessment

• Social skills training, peer support and community resource development oriented toward empowerment, recovery, and competency.

• Psycho educational activities to teach the individual about mental illness and appropriate medication to avoid complications and relapse,

• Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the individual’s understanding or ability to access community resources and this is an identified need in the intake and ISP.

• Provide opportunities to learn and use independent living skills, and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

**Required Activities**

• Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual’s diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

• An ISP shall be completed by either the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP, or the QMHP-A, QMHP-E, or QMHP-C and be reviewed/approved by either an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 calendar days of service initiation.

• Psychosocial rehabilitation services may be provided by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

• Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP to determine if the individual continues to meet the medical necessity criteria. The results of the review must be presented to receive approval of reimbursement for continued services.

• The program shall operate a minimum of two continuous hours in a 24-hour period.

**Service Limitations**

Annual limit of 936 units:

- One unit = 2 to 3.99 hours per day
- Two units = 4 to 6.99 hours per day
- Three units = 7+ hours per day.
The following services are specifically excluded from payment for psychosocial rehabilitation services:

- Vocational services,
- Prevocational services,
- Supported employment services

**Crisis Intervention (H0036)**

**Service Definition**
Crisis intervention shall provide immediate mental health care, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention services must be available 24 hours a day, seven days per week.

**Crisis Intervention Objectives**
- Prevent the exacerbation of a condition
- Prevent injury to the individual or others; and
- Provide treatment in the least restrictive setting.

**Medical Necessity Criteria**
The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Assessment time is allowed to document the medical necessity and assess the level of services needed.

There must be documentation of an immediate mental health service need with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive setting.

Crisis intervention services are provided following a marked reduction in the individual’s psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

Individuals must MEET BOTH Criteria A and B to qualify for reimbursement.

A. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.

B. Individuals must MEET TWO of the following criteria at the time of admission to the service:

1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;
2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or
4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.
Service Requirements

- An LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a Certified Pre-Screener, shall conduct a face-to-face service-specific provider intake as defined in 12VAC30-50-226.

- Crisis intervention shall be provided only by an LMHP, LMHP-Supervisee, LMHP-Resident, LMHP-RP, or a Certified Pre-Screener.

- During Emergency Custody Order (ECO) related Crisis Intervention services CSB’s may use the DMH 224-Preadmission Screening Report to document the required elements of the service specific provider intake as defined in Chapter 6 of this manual.

- An ISP shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.

- For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised by the fourth face-to-face contact to reflect the short-term counseling goals.

Covered Services

- Services may include office visits, home visits, pre-admission screenings, telephone contacts, or other client-related activities for the prevention of institutionalization.

- Note: Pre-admission screenings related to an ECO or Temporary Detention Order (TDO) are covered as crisis intervention only when the service is provided by a CSB or BHA as required by law and the encounter meets the crisis intervention service requirements. (Refer to Chapter 6 for more detail)

- The use of crisis intervention is allowed to certify necessity for an admission of an individual below the age of 21 to a freestanding inpatient psychiatric facility if the certification occurs as a result of an admission to the crisis intervention service, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met (refer to the DMAS Psychiatric Services Manual for clarification on independent team certifications).

- Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

- Crisis intervention services may be provided to eligible individuals in settings that are clinically/programmatically appropriate based on the needs identified in the service specific provider intake.
- Crisis intervention may involve contacts with the family or significant others with or without the individual present.
- If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.
- Client-related activities provided in association with a face-to-face contact are reimbursable.
- Assessment of the crisis situation,
- Provision of short-term clinical care and counseling designed to stabilize the individual or family unit,
- Providing access to further immediate assessment and follow-up services;
- Service Coordination to include linking the individual and family with ongoing care to prevent future crises.

**Service Limitations**
- Registration is required for reimbursement of this service within one business day from the provision of services or completion of the service-specific provider intake whichever comes first.
- A unit of service is 15 minutes of Crisis Intervention.
- A maximum of 720 units of Crisis Intervention may be provided annually.

**Intensive Community Treatment (H0039)**

**Service Definition**
Intensive Community Treatment (ICT) is an array of mental health services for individuals with significant mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. ICT has been designed to be provided through a designated multi-disciplinary team of mental health professionals and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community.

ICT is available either directly or on call 24 hours per day, seven days per week and 365 days per year.

**Medical Necessity Criteria**
To qualify for ICT, the individual must meet at least one of the following criteria:

1. The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness, or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.
2. The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance
abuse disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within ICT as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

**Continuation of Services:**
ICT may be reauthorized for up to an additional 26 weeks annually based on written intake and certification of need by a licensed mental health provider LMHP, LMHP-S, LMHP-R, and LMHP-RP to determine if the individual continues to meet the medical necessity criteria. The results of the review must be presented to receive approval of reimbursement for continued services.

**Service Requirements**
- Prior to admission, an appropriate service-specific provider intake, as defined in 12VAC30-50-130, shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.

- Psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting will be provided to individuals who are best served in the community.

- ICT may be billed if the individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

- An individual service plan must be fully developed by the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E and approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 days of the initiation of services.

- ICT may be provided based on an initial service specific provider intake. This service may be provided for a maximum of 26 weeks with a limit of 130 units available annually.

- Continuation of service may be reauthorized at 26-week intervals based on written service specific provider re-assessment and certification of need by a LMHP.

- ICT services may only be rendered by a team that meets the requirements of 12VAC35-105-1370.

- Service Coordination to ensure there is no duplication in services or billing and to ensure continuity of care.
The purpose of ICT Service Coordination is to ensure that the individual receives all needed services and supports; that these resources are well-coordinated and integrated; and that they are provided in the most effective and efficient manner possible.

ICT Service Coordination includes assisting the individual to access and appropriately utilize needed services and supports; assisting them to overcome barriers to being able to maximize the use of these resources; actively collaborating with all internal and external service providers; coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer’s life); assessing the effectiveness of these services/supports; preventing duplication of services or the provision of unneeded interventions; and revising the service plan as clinically indicated.

Service Units and Limitations
- ICT services may be billed if the individual is brought to the clinic by ICT staff to see the psychiatrist. Documentation to support this intervention must be in the individual’s clinical record.
- Billing is prohibited during the same time period as outpatient psychotherapy and psychiatric services unless designated as part of the plan of care to transition services to a lower level of care.
- As part of ICT, psychotherapy and medication management are generally expected to be provided outside the clinic, hospital, or office setting. In preparation for transition to a lesser level of care, if an ICT member goes to the clinic independently (as part of the plan of care for transitioning to less intensive services) psychotherapy and medication management services may be billed as ICT services. The ICT plan of care must continue to document the need for the intense level of services provided in ICT. (If the individual regularly attends office based medical appointments that are no more than twenty five percent of billed ICT time, the need for continuance of ICT services based on resistance and/or inability to benefit from a lesser level of intensity than ICT shall be documented in the clinical record). Time billed for psychotherapy, medication management, and other clinic services may not exceed twenty-five percent of the total time billed for ICT during this transition period. The transition period is limited to a maximum of eight (8) weeks.
- The annual unit limit shall be 130 units with a unit equaling one hour.

Crisis Stabilization (H2019)
Service Definition
Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Medical Necessity Criteria
The service-specific provider intake must document the need for crisis stabilization services. To qualify for this service, individuals must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.

Individuals must **MEET** at least **TWO** of the following criteria at the time of admission to the service:

1. Experiencing difficulty in establishing and maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization or homelessness or isolation from social supports.
2. Experiencing difficulty in activities of daily living (ADLs) such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.
3. Exhibiting such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are or have been necessary.
4. Exhibiting difficulty in cognitive ability (such that the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior).

**Individuals may not receive Crisis Stabilization when they meet the exclusion criteria below:**

**Exclusion Criteria:**
Service is neither appropriate nor reimbursed for:

**MEET ONE**

1. Individuals with medical conditions which require hospital care;
2. Individuals with a primary diagnosis of substance abuse;
3. Individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to self or others.

**Required Activities**

- An LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or a Certified Pre-Screener, shall conduct a face-to-face service-specific provider intake as defined in 12VAC30-50-226. If the intake is completed by the pre-screener it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within one business day.

- The program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

- The Individual Service Plan (ISP) must be developed or revised within three calendar days of admission to this service. The LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, certified pre-screener, QMHP-A, QMHP-C, or QMHP-E shall develop the ISP.

- Services are provided by a QMHP-A, QMHP-C, or QMHP-E, an LMHP, LMHP Supervisee or Resident, or a Certified Pre-Screener.
Services may be authorized for up to a 15-day period per crisis episode following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

Crisis stabilization may be provided up to 15 **consecutive days in each episode**, up to 60 days annually. Daily service provision is limited to the times when the individual meets the clinical necessity and service definition requirements.

**Service Limitations**

- DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all beds located within the program/facility, regardless of whether or not the services are billed Medicaid. If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart) the bed count will only apply to each residence. Each residence that is 16 beds or less and not categorized as an IMD will be eligible for Medicaid reimbursement.

- A billing unit is one hour.

- Room and board, custodial care, and general supervision are not components of this service.

- Service may be provided in any of the following settings, but shall not be limited to: (1) the home of an individual who lives with family or another primary caregiver; (2) the home of an individual who lives independently; or (3) community based programs licensed by DBHDS to provide crisis stabilization or emergency services which are not institutions for mental disease (IMDs).

- The services must be provided consistent with the ISP in order to receive Medicaid reimbursement.

- Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

- The provision of this service to an individual shall be registered with Magellan within one calendar day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination. See 12VAC30-50-226 B for registration requirements.

- Individuals may not receive IIH or ICT while receiving Crisis Stabilization services since both of those services include crisis response.

**Mental Health Skill Building Services (H0046)**

**Service Definition**

Mental health skill-building services shall be defined as goal directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS shall include goal directed training in the
following areas in order to qualify for reimbursement: (i) functional skills and appropriate behavior related to the individual’s health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition. Providers shall be reimbursed only for training activities defined in the ISP related to these areas, and only where services meet the revised service definition, service eligibility, and service provision criteria and guidelines as described in the regulations and this manual.

Medical Necessity Criteria
An Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for MHSS services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

For adult members 21 and older an Independent Clinical Assessment is not required.

1. Individuals qualifying for Mental Health Skill-building Services must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized goal-directed training to achieve or maintain stability and independence in the community.

2. Individuals age 21 and over shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

   A. The individual shall have one of the following as a primary Axis I DSM mental health diagnosis:
      1) Schizophrenia or other psychotic disorder as set out in the DSM-5,
      2) Major Depressive Disorder—Recurrent;
      3) Bipolar I; or Bipolar II;
      4) Any other Axis I mental health disorder that a physician has documented specific to the identified individual within the past year to that includes 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 that 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.

   B. The individual shall require individualized goal-directed training in order to acquire acquiring or maintain self-regulation of basic living skills such as symptom management; adherence to psychiatric and physical health and medication treatment plans; development and appropriate use of social skills and personal support system; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; or money management; and use of community resources.

   C. The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or non-residential crisis stabilization, (iii) ICT or Program of Assertive Community Treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC Level C) as a result of...
decompensation related to the individual’s serious mental illness; or (v) a temporary detention order (TDO) evaluation pursuant to the Code of Virginia §37.2-809(B) evaluation as a result of decompensation related to serious mental illness. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

D. The individual shall have had a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the assessment - service specific provider intake 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. This criterion shall be met upon admission to services, and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

D.

3. Individuals younger than 21 years 18-21 years of age shall meet all of the above medical necessity criteria listed in paragraphs 1 through 2 (A-D) in order to be eligible to receive mental health skill-building services and the following:
The individual shall not be in a supervised setting as described in §63.2-905.1 of the Code of Virginia. 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 own financial support.

Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance abuse disorder. If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Mental Health Skill-Building Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider intake, the ISP, and the progress notes.

Required Activities

1. For individuals under 21, the provider must maintain a copy of the fully completed Independent Clinical Assessment in each individual’s file.
1. **A Service Specific Provider intake shall be required at the onset of services.** The service specific provider intake (H0032, U8) must be conducted face-to-face by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The service specific provider intake, as defined in 12VAC30-50-130, shall document the individual’s behavior and describe how the individual meets criteria for this service. The service specific provider intake may be completed no more than 30 days prior to the initiation of services and must indicate that service needs can best be met through mental health skill-building services. The LMHP, LMHP-R, LMHP-RP, LMHP-S performing the intake shall document the primary mental health diagnosis on the intake form.

Service-specific provider intakes shall be repeated upon any lapse in services of more than 30 calendar days. Services of any individual that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service in the individual's medical record.

Service authorization is not required to bill for the face-to-face service specific provider intake (Note Chapter V for the service specific provider assessment code and billing instructions). Providers under contract with Magellan may contact Magellan for more information.

2. **The service specific provider intake must be updated annually.** A review of Mental health skill-building services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least 6 months of Mental health skill building services to determine the continued need for this service. Every six months, the LMHP, LMHP-R, LMHP-S or LMHP-RP must review the individual ISP and services being received in order to determine if a continuation of services is necessary. The LMHP, LMHP-R, LMHP-S or LMHP-RP 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 ISP goals. Clinically it may be helpful for the LMHP, LMHP-R, LMHP-S or LMHP-RP to complete a new service specific provider intake to review clinical progress and assess the medical necessity of continuing MHSS. However, DMAS regulations do not specifically require the provider to complete a service specific provider intake every six months when providing MHSS. Providers may bill for service hours or bill for the service specific provider intake to complete the six month MHSS review requirement. **The service specific provider intake must be updated annually.**

3. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C, or QMHP-E shall complete, sign and date the Individualized Service Plan (ISP) within 30 days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual’s ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall include the dated signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C, or QMHP-E and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of
service. If the individual refuses to sign the ISP, this shall be noted in the individual’s medical record documentation.

4. Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C, or QMHP-E shall review with the individual in manner in which he may participate with the process, the ISP with the individual, modify as appropriate, and update the ISP. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual’s progress and treatment needs as well as any newly identified problem. This review shall be documented. Documentation of this review shall be added to the individual’s medical record no later than 15 calendar days from the date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C, or QMHP-E and the individual. The ISP must be rewritten annually.

5. The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.

6. Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

7. If the provider knows of or has reason to know of the individual’s non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual’s ISP. If the care is delivered by the qualified paraprofessional QPPMH, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any non-adherence to the prescribed medication regimen. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-adherence concerns. The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician: a. name and title of caller; b. name and title of professional who was called; c. name of organization that the prescribing professional works for; d. date and time of call; e. reason for care coordination call; f. description of medication regimen issue or issues that were discussed; and g. resolution of medication regimen issue or issues that were discussed.

8. Documentation of prior psychiatric services history shall be maintained in the individual’s mental health skill building services medical record. The provider shall document evidence of the individual’s prior psychiatric services history, as required above under eligibility and medical necessity requirements, by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Family member statements shall not suffice to meet this requirement. The provider shall document the following minimum elements: a. name and title of caller; b. name and title of professional who was called; c. name of organization that the professional works for; d. date and time of call; e. specific placement provided; f. type of treatment previously provided; g. name of treatment provider; and f. dates of previous treatment.
Providers may use their own records to validate prior history, however they must clearly document in the MHSS note where in the electronic record substantiating information (e.g. doctors’ order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found. If an individual sees a psychiatrist outside of the agency and the medication area of the record is documented to reflect the psychiatric history and prescribed medications, then in that section of the record each of the required elements in the regulation including: the worker who checked the record, what record was viewed and the person who wrote the note that was viewed, the name of the organization that the record belongs to, the date and time the record was reviewed, the specific placement provided, the type of treatment previously provided, the name of the treatment provider, and the dates of the previous treatment must be provided. A MHSS note directing the reader to refer to another section of the individual’s medical record with the same provider agency will be accepted as meeting the requirement. Again, it must clearly document in the MHSS note where in the electronic record substantiating information can be found.

9. The provider shall document evidence of the psychiatric medication history, as required by above under eligibility—the medical necessity requirements by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy after obtaining written consent from the individual. Prescription lists or medical records, including discharge summaries, obtained from the pharmacy or current or previous prescribing provider of health care services that contain the following minimum elements: a name and title of the caller, b name and title of prior professional who was called, c name of the organization that the professional works for, d date and time of call, e specific prescription confirmed, f name of prescribing physician, g name of medication, and h date of prescription shall be sufficient to meet this criteria. Family member statements shall not suffice to meet this requirement.

The MHSS regulations outline specific documentation requirements in order to satisfy the criteria for validating medication history. Examples include either photocopies of the prescription information from the bottle or contacting the prior provider. Providers may use their own records to validate medication history (doctors’ order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date), however they must clearly document in the MHSS note where in the electronic record substantiating information can be found.

In the absence of such documentation, the current provider shall document all contacts (i.e. telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements: (i) name and title of the caller, (ii) name and title of prior 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.

10. Only direct face-to-face contacts and services to an individual shall be reimbursable.
11. Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

12. Any services provided to individuals that are strictly vocational in nature shall not qualify for Medicaid reimbursement. However, support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

13. Room and board, custodial care, and general supervision are not components of this service and are NOT eligible for Medicaid reimbursement.

14. Provider qualifications. The enrolled provider of mental health skill-building services shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, Resident/Supervisor, QMHP-A, QMHP-C, QMHP-E or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A or QMHP-C will supervise the care weekly if delivered by the qualified paraprofessional. Documentation of supervision shall be maintained in the MHSS record.

15. 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 an LMHP who must document the continued need for the services.

16. Mental health skill-building services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.

17. If MHSS is provided in a group home (Level A or B), Therapeutic Group Home or assisted living facility, there shall be a yearly limit of up to 416 units per fiscal year and a weekly limit of up to 8 units per week, with at least half of each week’s services provided outside of the group home or assisted living facility. The ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

Limitations and Exclusions

1. Therapeutic Group Home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the providers’ respective facility. Individuals residing in facilities may, however receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside. “Affiliated” means any entity or property in which a group home or assisted living facility has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.
2. MHSS shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS) waivers.

3. MHSS shall not be reimbursed for individuals who are also receiving Independent Living Skills Services, the Department of Social Services (DSS) Independent Living Program, Independent Living Services, or Independent Living Arrangement or any CSA-funded independent living skills programs.

4. Medicaid coverage for MHSS shall not be available to individuals who are receiving Treatment Foster Care.

5. Medicaid coverage for MHSS shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities (ICF/IDs) or hospitals.

6. Medicaid coverage for MHSS shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of MHSS.

7. Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Centers - Level C facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.

8. MHSS shall not qualify for Medicaid reimbursement if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS), the Elderly or Disabled with Consumer Direction Waiver, and the EPSDT services.

9. Medicaid coverage for MHSS shall exclude services that are considered not to be duplicative of other reimbursed services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C, or QMHP-E to avoid duplication of services.

10. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving Medicaid coverage for MHSS unless their physicians issues a signed and dated statement indicating that this service would benefit the individual by enabling them to achieve and maintain community stability and independence.
11. Individuals who are not diagnosed with a serious mental disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the Medicaid coverage for MHSS services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health support services for individuals with disorders not identified in Axis I, such as personality disorders and other mental health disorders that may lead to chronic disability, will not exclude provided that the individual have a primary Axis I DSM diagnosis listed above and the provider can document and describe how the individual is expected to actively participate in and benefit from services, and where the remaining MHSS service criteria and guidelines are satisfied.

12. Academic services are not reimbursable.

13. Vocational services are not reimbursable. Support services and activities directly related to assisting a client to cope with a mental illness in the work environment are reimbursable. Activities that focus on how to perform job functions are not reimbursable.

14. Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.

15. Only direct face-to-face contacts and services to the individual members are reimbursable.

16. Staff travel time is excluded.

**Service Units and Maximum Service Limitations**

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day
- Three units = 5 to 6.99 hours per day
- Four units = 7+ hours per day

Time may be accumulated to reach a billable unit. Service delivery time must be added consecutively to reach a billable unit of service. The provider shall clearly document details of the services provided during the entire amount of time billed.

Authorization is required for Medicaid reimbursement. These services may be authorized for up to six consecutive months.

A maximum of 372-520 units of MHSS may be authorized annually with coverage under State Plan Option service. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30. Providers under contract with Magellan of Virginia should consult the National Provider Handbook, the Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or by email to:
MHSS (H0046) requires service authorization before any services (beyond the service specific provider intake) are reimbursed. The provider’s service specific provider intake will continue to be allowed to be billed without service authorization.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement. Providers under contract with Magellan may contact Magellan directly for more information.

**SUBSTANCE ABUSE TREATMENT SERVICES**

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

**Mental Health Case Management (H0023) Service Definition**

Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services.

Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

**Population Definitions**

The following Department of Behavioral Health and Developmental Services definitions are referred to in the discussion of the appropriate populations for Mental Health Case Management services.

1. **Serious Mental Illness**

   Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

   a. **Diagnosis**

      There must be a major mental disorder diagnosed using the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**. These disorders are:
schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy these criteria.

b. **Level of Disability**
   There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:
   1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
   2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
   3) Has difficulty establishing or maintaining a personal social support system.
   4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
   5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. **Duration of Illness**
   The individual is expected to require services of an extended duration, or the individual’s treatment history meets at least one of the following criteria:
   1) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).
   2) The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

2. **Serious Emotional Disturbance**
   Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM-IV, or the child must exhibit all of the following:
   a. Problems in personality development and social functioning that have been exhibited over at least one year’s time; and
   b. Problems that are significantly disabling based upon the social functioning of most children that age; and
   c. Problems that have become more disabling over time; and
   d. Service needs that require significant intervention by more than one agency.

Children diagnosed with Serious Emotional Disturbance and a co-occurring substance abuse or developmental disability diagnosis are also eligible for Case Management for Serious Emotional Disturbance.

3. **At Risk of Serious Emotional Disturbance**
Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:

a. The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or
b. Parents, or persons responsible for the child’s care, have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or

c. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

**Eligibility Criteria**
The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

- There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent.

- The individual must require case management as documented on the ISP, which is developed by a qualified mental health case manager and based on an appropriate service specific provider assessment and supporting documentation.

- To receive case management services, the individual must be an “active client,” which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 days.

**Required Activities**
The following services and activities must be provided:

- A comprehensive service specific provider assessment must be completed by a qualified mental health case manager to determine the need for services. The CM service specific provider assessment is part of the first month of CM service and requires no service authorization.

- Service specific provider assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such).

- This service specific provider assessment then serves as the basis for the ISP.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual’s receipt of community mental health rehabilitative services, specifically mental health case management.
The ISP must document the need for case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review.

Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.

Linking the individual to needed services and supports specified in the ISP.

Provide services in accordance with the ISP.

Coordinating services and treatment planning with other agencies and providers.

Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.

Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual’s functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.

Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.

A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the individual’s condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual’s satisfaction with services, to determine any unmet needs, and to generally evaluate the member’s status.
Case Management services are intended to be an individualized client-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was consumer-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

- The ISP shall be updated at least annually.

**Service Units and Maximum Service Limitations**

- A billing unit is one calendar month.

  Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the face to face visit, or the date the monthly summary note has been documented, or a specific date service was provided. In order to support the 1 billing unit per calendar month, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. Providers are NOT to span the month for SPO CM services.

- Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

- Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

- No other type of case management, from any funding source, may be billed concurrently with targeted case management.

- Reimbursement for case management services for individuals age 21-64 in Institutions for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.
• There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical facilities. Case management services may not be provided for institutionalized individuals who are age 65 and older and under age 21. Services rendered during the time the individual is not admitted to the IMD may be billed, even if during the same month as the admission to the IMD.

• To bill for case management services for individuals that are in an acute care psychiatric units, two conditions must be met. The services may not duplicate the services of the hospital discharge planner, and the community case management services provided to the individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

• Case management services for the same individual must be billed by only ONE type of case management provider. See Chapter V for billing instructions.

While service authorization for this service is not required, registration of this service with Magellan is required. If the individual qualifies for case management through a different population definition (‘at risk’, SED, or SMI) a new registration is required. Providers under contract with Magellan should contact Magellan directly for more information.

Case Management Agency Requirements
1. The service specific provider intake and subsequent re-assessments of the individual’s medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider intake must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired
outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included. The ISP is defined in the “Exhibits” section at the end of this chapter.

6. Case management records must include the individual’s name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual’s needs.

**Monitoring and Re-Evaluation of the Service Need by the Case Manager**

The case manager must continuously monitor the appropriateness of the individual’s ISP and make revisions as indicated by the changing support needs of the individual. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.

This quarterly re-evaluation must be documented in the case manager’s file. The case manager must have monthly activity regarding the individual and a face-to-face contact with the individual at least once every 90 days.

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

**Service Registration**

Any included covered behavioral health service that does not require a Service Authorization must be registered with Magellan of Virginia. This registration is a means of notifying Magellan that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers should register the start of any new service within two (2) business days of the service start date. A list of services requiring registration is available on the DMAS website at [http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx](http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx) under Behavioral Health Services Administrator.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan include:

- the individual's name and Medicaid/FAMIS identification number;
- the specific service to be provided, the relevant procedure code, begin date of the service, and the amount of the service that will be provided; and
- the provider's name and NPI, a provider contact name and phone number, and email address.

Claim payments will be delayed if the registration is not completed.

**QUALIFIED MEDICARE BENEFICIARIES (QMBs) - COVERAGE LIMITATIONS**
Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the individual’s co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message “QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE.” The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Providers under contract with Magellan should contact Magellan directly for more information.

QUALIFIED MEDICARE BENEFICIARIES (QMBs) - EXTENDED COVERAGE LIMITATIONS

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message “QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED.” These individuals are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

Providers under contract with Magellan should contact Magellan directly for more information.

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

As described in Chapters I and VI, the Medicaid Program may designate certain individuals to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the individual’s Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these individuals only,

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;
- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with the non-designated primary provider in delivering the necessary services; and
- For other services covered by DMAS, which are excluded from the CMM Program requirements.

The mental health services described in this chapter are excluded from the CMM Program, and none of the specific CMM provisions apply to these services. However, mental health providers are encouraged to coordinate treatment with the primary physician whose name appears on the individual’s eligibility card as other services and medications are monitored routinely.
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