Contents

Section 1. Definitions

Refer to Appendix A and the Telehealth Supplement for definitions of terms used in this Appendix. The following definitions are specific to Coordinated Specialty Care (CSC).

Comprehensive Assessment of Needs and Strengths (CANS Lifetime): is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services for both adults and youth. The CANS Lifetime was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

Encounter: means a face-to-face interaction with an individual that includes at least 15 minutes of at least one required service component.

Face-to-face: means the service component may be delivered via telemedicine if clinically appropriate. Refer to the Telehealth Services Supplement for the definition of telemedicine and requirements for service delivery through telemedicine.

In-Person: means physically in the presence of the individual/caregiver.

Licensed Mental Health Professional (LMHP): means the same as defined in 12VAC35-105-20. LMHPs shall be a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner. LMHPs are fully licensed to practice independently.

Natural Supports: means individuals in a person's life who provide informal, unpaid assistance, encouragement, and connection as part of an ongoing relationship, rather than as part of a formal service delivery arrangement. Natural supports may include family members, caregivers, friends, neighbors, faith community members, coworkers, peers, and others chosen by the individual. Natural supports are identified by the individual and engaged in services only with the individual's consent. For youth, natural supports shall include at minimum one caregiver or legally authorized representative.

One-to-one: means a service delivery method in which one qualified provider delivers services directly to one individual receiving services at a time. In one-to-one service provision, the provider's full attention, clinical focus, and billable time are directed exclusively to that individual throughout the encounter. One-to-one service provision may occur in-person or via telemedicine, consistent with the requirements set forth in this Appendix and the Telehealth Supplement and shall take place in any approved service setting. One-to-one service provision does not include encounters in which services are delivered simultaneously to multiple individuals, such as group service delivery.

Serious Mental Illness (SMI) (Adults): means an individual over the age of 18 having, within the past year, a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual's life and ability to function.

Supervision: is a relationship-based education and training process that is work-focused and manages, supports, develops, and evaluates the work of a staff person. It is a structured professional relationship where a more experienced mental health professional (the supervisor) oversees the work of a less experienced or newer professional or paraprofessional (the supervisee), with the primary goal of fostering growth and learning.

Section 2. Service Definition and Critical Features

Coordinated Specialty Care is an evidence-based treatment approach that supports the recovery of youth and young adults experiencing an initial onset of psychosis. CSC provides coordinated, targeted treatment in the early stages of mental illness through integrated medical, psychological, and rehabilitative interventions. The goal of early psychosis intervention is to identify young individuals in the early stages of psychosis, minimize barriers to treatment, and facilitate successful engagement in treatment while fostering resilience. The CSC team employs a multi-disciplinary approach with supportive interventions occurring in clinic, community, and home settings as clinically indicated.

Critical Features of CSC include:

1. Early identification and treatment
2. Integrated multidisciplinary team
3. Individual, Group, and Family Psychotherapy
4. Psychiatric Services including medication management
5. Rehabilitation skill building
6. Peer Recovery Support Services
7. Family engagement and support
8. Care Coordination

Section 3. Required Service Components

CSC services are individualized based on the needs, strengths, and preferences of the individual as identified in the ISP. Allowances for telemedicine, group delivery of service, and services provided without the individual present are indicated in each service component below and in the billing requirements section. The staff-to-individual ratio for service components allowed to be provided in a group shall not exceed one staff to ten individuals.

3.1 Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)

Assessment means an in-person interaction in which the provider obtains information from the individual and family/caregivers, as appropriate, about the individual's current behavioral health status and behaviors as well as the history of the severity, intensity, and duration of behavioral health conditions and behavioral and emotional issues and diagnosis of mental health conditions. Assessment includes assisting the individual and family/caregivers, as appropriate, with identifying strengths and needs, resources, and natural supports used in developing individualized goals and objectives to address functional deficits associated with their mental illness.

1. Prior to starting services, a comprehensive and age-appropriate behavioral health assessment inclusive of the Virginia CANS Lifetime shall be completed to determine medical necessity for the service and to support a service authorization.
2. The assessment shall be conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S in-person with the individual in the individual's home or another location of the individual's/family's choice. Assessments completed by a LMHP-R, LMHP-RP, or LMHP-S require a LMHP co-signature within seven business days.
3. The LMHP, LMHP-R, LMHP-RP, or LMHP-S completing the assessment shall be certified to administer the Virginia CANS Lifetime Assessment.
4. The assessment shall be provided on a one-to-one basis.

5. Assessments inclusive of the Virginia CANS shall be performed at least once every 365 days until discharge.

3.2 Treatment Planning

Treatment Planning means the development of a person-centered ISP that is specific to the individual's unique treatment needs, developed with the individual, in consultation with the individual's natural supports, as appropriate. The ISP is what directs collaborative behavioral health treatment. The ISP shall be actively utilized with the individual/family/caregiver during each encounter. (See Chapter IV for additional ISP requirements.)

1. Treatment planning shall be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
2. Treatment planning shall be provided on a one-to-one basis with the individual and their natural supports.
3. CSC services shall be incorporated into a person-centered ISP documenting activities and evidence-based interventions to prevent, correct, or ameliorate conditions identified during the initial CANS Lifetime.
4. The ISP is required during the entire duration of services and shall be current.
5. The ISP shall be authorized and overseen by an LMHP.
6. Needs identified in the CANS Lifetime shall be associated with identified goals and objectives as set forth in the ISP. Subsequent assessments and needs shall be reflected in updated ISPs with updated goals and objectives.
7. At a minimum, the ISP shall be signed within 30 days of admission and 15 days of an ISP review by:
    a. The individual and the individual's legally authorized representative.
    b. The LMHP Team Leader overseeing the services.
8. The ISP shall be developed, reviewed, and updated in collaboration with the individual and natural supports through a team approach under collaborative behavioral health services.
    a. ISP Reviews and Updates:
        i. ISPs shall be formally reviewed at a minimum of every 90 calendar days or more frequently depending on the individual's needs. The ISP review shall be completed in-person with the individual. The review must be signed by, at a minimum, the individual, any of the CSC team members participating in the ISP review, and the LMHP team leader. Refer to Chapter IV for additional guidance and documentation requirements for the 90-calendar day review as well as additional quarterly review requirements.
        ii. When it is determined that an individual is making limited to no progress or has limited or no engagement in services, the LMHP Team Leader, in collaboration with the CSC team, the individual, and the individual's natural supports, shall review and update the ISP to increase the possibility that the individual will make progress achieving the identified goals and objectives. If the individual continues to make limited to no progress, the LMHP Team Leader shall consider if a referral to a different service may improve progress and coordinate care with the individual's MCO.
        iii. Following initial authorization, if a youth is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP shall be updated to assure individual/family/caregiver involvement before reauthorization of services is considered.

3.3 Psychiatric Services

A psychiatrist, psychiatric nurse practitioner, or a nurse practitioner or physician assistant working under the supervision of a psychiatrist shall provide the following:

1. A comprehensive psychiatric evaluation completed as soon as possible but no later than 30 calendar days after admission.
2. Medication prescription monitoring.
3. Provider policies and protocols for psychiatric services in CSC must be in line with the Coordinated Specialty Care model regarding antipsychotic dosing protocols and guidelines as well as access to clozapine when there is no response to first-line antipsychotic medication.
4. Participation of the licensed prescriber on the team shall be documented to include, but is not limited to:
    a. Involvement in team meetings.
    b. Seeing individuals with other team clinicians.
    c. Accessibility for consultation by the team during the work week.
    d. Sharing health records with the team.
5. Psychiatric services shall be provided on a one-to-one basis.
6. Psychiatric services may be provided via telemedicine if deemed clinically appropriate and in consultation with the psychiatric services provider, LMHP Team Leader, and individual.

3.4 Psychotherapy

Psychotherapy 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. All family therapy services furnished are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the individual's plan of care, and for the purpose of assisting in the individual's recovery. The individual is present during family therapy except when it is clinically appropriate for the individual to be absent in order to advance the individual's treatment goals.

1. Psychotherapy shall be provided by a LMHP, LMHP-S, LMHP-R, or LMHP-RP acting within their scope of practice.
2. Psychotherapy shall be provided in accordance with the frequency identified in the ISP.
3. Psychotherapy may be provided in a group if deemed clinically appropriate and in consultation with the LMHP Team Leader and the individual.
4. Psychotherapy may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Team Leader and individual.

3.5 Family Engagement and Support

Family education and support includes outreach and education to help families support the individual. This component can be provided by any team member acting within their scope of practice. Health literacy counseling is a type of family education and support as described in Section 3.5.1.

1. Family Engagement and Support shall be provided in accordance with the frequency identified in the ISP.
2. Family Engagement and Support may be provided through telemedicine and in groups if deemed clinically appropriate and in consultation with the LMHP Team Leader and individual.

3. Groups are limited to ten individuals at one time.

3.5.1 Health Literacy Counseling

Health literacy counseling means counseling on mental health and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects, and the importance of compliance and adherence.

This component can be provided by one of the following professionals acting within their scope of practice: LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Occupational Therapist, CSAC, CSAC-supervisee, or an RN or LPN with at least one year of clinical experience involving medication management.

1. Health Literacy Counseling shall be provided in accordance with the frequency identified in the ISP.
2. Health Literacy Counseling may be provided through telemedicine and in groups if deemed clinically appropriate and in consultation with the LMHP Team Leader and individual.

3.6 Rehabilitation Skill-Building

Rehabilitation skill-building means facilitating wellness and autonomy through the restoration of skills, as set forth in the ISP, in symptom management, interpersonal relationships, communication, problem solving, coping skills, and community integration.

CSC may include employment/instructional supports if the activities being provided are focused on management of symptoms of mental illness and recovery. CSC team members work with individuals at the worksite or instructional setting to implement appropriate interventions to support an individual's employment or instructional goals as described in the ISP. Interventions include helping an individual develop skills to address symptoms associated with a mental illness that interfere with seeking, obtaining, or maintaining employment or successfully completing training necessary for employment.

Rehabilitation skill-building activities such as assistance with social skills, communication skills, problem solving skills, and community living skills necessary for an individual to be successful within the community are covered when provided by a qualified team member.

Rehabilitation skill-building shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, Occupational Therapist, CSAC, CSAC-supervisee, or RPRS.

1. Rehabilitation Skill-Building shall be provided in accordance with the frequency identified in the ISP.
2. Rehabilitation Skill-Building may be provided through telemedicine and in groups if deemed clinically appropriate and in consultation with the LMHP Team Leader and individual. All consultation shall be documented in the individual's medical record.

3.7 Care Coordination

CSC Care Coordination is a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services identified in the ISP developed with the individual and family/caregivers as appropriate. Care coordination also includes consultation, collaboration, and coordination among community resources and other health providers including collateral contacts to improve restorative care, identify and access needed activities and supports, and align service plans.

1. Care coordination shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, QMHP-T, CSAC, CSAC-supervisee, RN, LPN, or RPRS.
2. Care Coordination shall be provided in accordance with the frequency identified in the ISP.
3. Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
4. Care Coordination shall be provided on a one-to-one basis.

3.8 Crisis Support

Crisis Support means an intervention to assist the individual and their natural supports in developing the capacity to prevent a crisis episode or reduce the severity of a crisis episode. Crisis support includes crisis planning, crisis avoidance, and crisis intervention. Crisis support assists the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location. Crisis support also includes the development and ongoing review and update of a crisis plan to assist the individual and their natural supports with identifying a potential behavioral health crisis and steps to manage the crisis and restore stability and functioning after distress or crisis.

CSC providers shall prioritize the utilization of internal crisis support resources and preventative interventions as the primary response to behavioral health crises. Crisis support shall be delivered in a manner that builds the individual's capacity to recognize and respond to their own distress and to seek help independently when needed. Individuals shall be educated on how to access crisis resources directly and on their own, including the 988 Suicide and Crisis Lifeline (available by call, text, or chat). Contacting 988 independently is encouraged and shall be supported as a first-line self-initiated crisis resource. The individual's capacity to self-initiate appropriate crisis contacts is a core goal of crisis support and shall be reflected in the crisis plan.

1. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP, or QMHP-T.
2. Crisis support shall be available 24 hours per day, seven days per week, 365 days per year, to provide immediate assistance to the individual experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.
    a. The CSC team shall be available at a minimum of 8 hours per day, five days per week, to provide immediate assistance to the individual experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.
    b. The CSC Provider agency may utilize triage and coordination policies and procedures across other service areas provided by the same provider (e.g., a single provider after-hours number) if they have policies and procedures in place to ensure that crisis plans are available in real-time to the individual answering the after-hours call.
3. Crisis supports shall be provided on a one-to-one basis with the individual and their natural supports.
4. The modality of crisis response—in-person, face-to-face via telemedicine, or audio-only—shall be determined by the individual's documented needs, preferences, and the requirements of their crisis plan. In-person response shall be provided when the individual's crisis plan indicates it is necessary and when the clinical situation requires it. Any use of telemedicine or audio-only in lieu of in-person response shall be clinically justified, documented and for the benefit of the individual.

5. In-person crisis support shall be provided by the CSC provider prior to any referral by the CSC provider to Comprehensive Crisis and Transition Services (Mental Health Services Manual, Appendix G) unless the referral is due to an acute crisis situation with safety concerns. If a referral to another type of service to assist with the acute crisis situation (911, 988, Emergency Room, CSB Emergency Services, 23-Hour Crisis Stabilization, Residential Crisis Stabilization Unit) is made by the CSC provider, the CSC provider shall remain engaged with the individual and directly collaborate with other service providers involved during the crisis situation. Individual that are receiving CSC are not eligible to receive Community Stabilization.
6. If a CSC provider-initiated referral to an external crisis resource is made (including 911, 988, Mobile Crisis Response, Emergency Room, CSB Emergency Services, 23-Hour Crisis Stabilization, or Residential Crisis Stabilization Unit), the CSC provider shall document in the individual's record: (a) the in-person or telehealth crisis support interventions attempted prior to the referral; (b) the clinical rationale for the referral, including why internal crisis support was insufficient and why immediate safety concerns required additional support; (c) the time, location, and specific crisis support interventions provided; and (d) actions taken to ensure continuity of care and the individual's timely transition back to CSC services following stabilization. The referring provider shall ensure the current ISP and crisis plan are transmitted to the receiving service provider at the time of referral.
7. CSC Providers are required to collaborate with the individual and their natural supports to develop a crisis plan.
    a. The individual's crisis plan shall identify the CSC provider as a primary crisis contact, and individuals shall be encouraged to contact their CSC provider prior to contacting 911 or emergency services when it is safe to do so.
8. The crisis plan shall:
    a. Be completed and signed by all team members and the individual or legal representative no more than 30 calendar days after admission.
    b. Be reviewed and updated on an ongoing basis to reflect the individual's current needs and circumstances.
9. The crisis plan shall, at a minimum, include:
    a. Warning signs
    b. Preventative and Recovery Strategies
    c. Crisis Resources/Professional Contacts
    d. Current Medications
    e. A clear step-by-step sequence of actions to take when a crisis situation occurs

The use of Comprehensive Crisis and Transition Services will be monitored by the individual's MCO.

3.9 Peer Recovery Support Services

Peer recovery support services mean strategies and activities that include person-centered, strength-based planning to promote the development of self-advocacy skills; empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the plan of care.

1. Peer recovery support services shall be provided by a RPRS. The RPRS shall be supervised by a professional who has completed the DBHDS Peer Recovery Specialist Training.

2. Providers may use staff working on obtaining experience necessary to become a registered peer recovery support specialist. Only time provided by a registered peer recovery specialist, however, may count towards encounter billing requirements.
3. Peer recovery support services shall be provided in accordance with the frequency and mode of delivery identified in the ISP.
4. ISP goals related to peer recovery support services shall be based on the individual's identified recovery needs and achieving maximum independence and autonomy in the community.
5. Peer recovery support services may be provided through telemedicine and in groups if deemed clinically appropriate and in consultation with the LMHP Team Leader and individual.

Section 4. Provider Qualification Requirements

CSC providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual.

4.1 Coordinated Specialty Care Staffing Requirements

Services are provided through a team-based approach under collaborative behavioral health services (as defined in § 54.1-3500). It is the responsibility of the LMHP Team Leader to ensure that any non-LMHP staff practice within the scope of their education, training, and expertise and are not providing any services that require licensure.

CSC teams shall operate from a single office location licensed by DBHDS as opposed to a collection of satellite locations to promote team coordination and collaboration.

CSC is delivered by a multidisciplinary team. In accordance with 12VAC35-105-1429, the team shall have qualified staff who fulfill the following roles:

1. Team Leader
2. Psychiatric Provider
3. Therapist
4. Family Education and Support Specialist
5. Care Coordinator
6. Supported Employment Specialist
7. Supported Education Specialist
8. Community Education and Outreach Specialist

4.1.1 Required Team Members

Staff are considered a member of the team if they fulfill one or more of the roles outlined in Section 4.1 and attend at least 3 out of 4 weekly team meetings per calendar month.

Teams shall include at a minimum the following team members, who may fulfill one or more of the above roles:

1. LMHP Team Leader
    a. The LMHP Team Leader shall be a full-time employee.
    b. The team leader shall be a LMHP with at least three years of experience in the provision of mental health services.
    c. The LMHP Team Leader shall hold a Virginia license from the Virginia Department of Health Professions that qualifies them as a LMHP.

   d. LMHP Team Leader shall have the ability to provide in-person services.
   e. LMHP Team Leader shall have the ability to provide consultation to CSC team members when needed.
   f. The LMHP Team Leader shall oversee all aspects of team operations and shall routinely provide direct services to individuals in the community. The team leader will monitor, oversee, and supervise the team-based process.
2. Psychiatric Provider
   a. A psychiatrist or psychiatric nurse practitioner shall be available to the team to provide assessments and medication management. A nurse practitioner with sufficient training and mental health experience may also serve in this role, or a nurse practitioner or physician assistant working under the supervision of a psychiatrist.
   b. The psychiatric provider does not need to be a full-time staff member but shall have sufficient time to serve as a fully integrated team member who attends clinical team meetings.
3. Therapist
   a. There shall be at least one additional LMHP, LMHP-R, LMHP-RP, or LMHP-S in addition to the LMHP Team Leader.
4. At least one CSC team member shall have training in working with individuals with substance use disorders.
5. Peer Recovery Support Specialist
   a. There shall be at least one Registered Peer Recovery Support Specialist (RPRS).
6. Additional staff may include QMHPs, QMHP-Ts, CSACs, CSAC-supervisees, occupational therapists, RNs, and LPNs who provide services within their scope of practice.

4.2 Caseload Requirements

The team caseload shall not exceed a 1:20 staffing ratio.

Caseload shall be calculated by dividing the total number of individuals currently being served by the CSC team by the total number of FTEs providing direct clinical services, with the exception of the prescriber. This includes therapists, peer recovery support specialists, co-occurring substance use disorder specialists, family education and support specialists, care coordinators, supported employment/education specialists, and community education and outreach specialists. It also includes the team leader if the team leader provides direct services (if the team leader provides direct services as 50% of a full-time role in addition to administrative duties, they shall be included as 0.5 FTE in the calculation). Staff members with no direct service or clinical role shall not be included. Only staff members who meet Medicaid qualifications for CSC reimbursement shall be included. Student interns shall not be included, even if they have their own caseload. For team members with other responsibilities outside of the CSC team, only count the percentage devoted specifically to CSC services.

Prescriber caseload shall not exceed a 0.2:40 ratio (0.2 FTE of prescriber time to 40 individuals served).

4.3 Staff Training Requirements

CSC services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competence to provide the range of practices. All CSC team members are required to receive initial and annual training in core and evidence-based practices that support the

implementation of ethical, person-centered, high-fidelity CSC practice, as defined in the Addington Fidelity Scale 2021 as approved by DMAS and DBHDS.

Each CSC team staff member shall successfully complete the CSC trainings as well as FEP-specific evidence-based training for specific roles on the team and shall understand the roles of others on the team. Required training for all members of the team shall include the programmatic training required by Navigate, On TrackNY, or another similar nationally recognized program specific to CSC training.

4.4 Supervision and Team Meeting Requirements

4.4.1 Multidisciplinary Team Meetings

Multidisciplinary team meetings shall occur weekly and shall include at a minimum:

1. Date, time, and location of meeting.
2. Names and disciplines of all attendees (psychiatrist, therapist, case manager, supported employment/education specialist, peer specialist, family advocate, etc.).
3. Names of team members absent.
4. Name of meeting facilitator/chair.
5. Active Client Roster Review (admissions and caseloads): any supervision needs.
6. Treatment Plan Updates: progress toward individualized recovery goals; any modifications to treatment plans (with rationale).
7. Team Decision-Making and Action Items: specific decisions made by the team and the rationale.
8. Discussion of High-Risk and Priority Cases: crisis plan updates, hospitalizations/discharge planning.
9. Transition and Discharge Planning: clients being considered for step-down or graduation from CSC.
10. Weekly team meeting documentation shall be stored in a HIPAA-compliant location.

4.4.2 Clinical Supervision

Clinical Supervision is the provision of guidance, feedback, and training to team members to ensure that quality services are provided to individuals (e.g., following evidence-based practices, negotiating ethical quandaries, managing transference and counter-transference) and maintaining and facilitating the supervisee's competence and capability to best serve individuals in an effective manner. Clinical supervision is a critical factor in determining the appropriate acquisition of evidence-based practices by supervised staff.

The following clinical supervision activities may be delivered within CSC:

1. Meeting as a group (separately from the weekly team meeting) or individually to discuss specific clinical cases.
2. Field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills).
3. Reviewing and giving feedback on specific tools (e.g., quality of assessments, treatment plans, progress notes) to better capture and document clinical content.
4. Didactic teaching and individual and group cross-training.
5. Formal in-office individual supervision (includes both impromptu and scheduled supervision).

All CSC team members are required to receive and participate in clinical supervision. All clinical supervision shall be documented in the staff's employment file.

The RPRS shall be supervised by a professional who has completed the DBHDS Peer Recovery Specialist Training.

4.5 DBHDS Licensing Requirements

Providers are required to be:

1. Licensed by DBHDS as a provider of Mental Health Center-Based Coordinated Specialty Care (CSC) Service (License #03-022). The DBHDS license shall be active and in good standing (conditional or triannual).
2. Completion of the DBHDS program readiness checklist will be required to be submitted with the DBHDS license application for review.

4.6 DMAS Provider Enrollment

Providers are required to be enrolled with DMAS with provider type 156 (Behavioral Health Services) or 456 (Behavioral Health Clinic and Services) and provider specialty 928 (Coordinated Specialty Care) prior to the provision and reimbursement of services.

4.7 Evidence-Based Program (EBP) Finder Enrollment and Maintenance

All CSC teams shall be listed in the EBP Finder (ebpfinder.org). The EBP Finder is an online tool supported by DMAS and DBHDS and is used by service coordinators and payers to determine provider eligibility for contracting and reimbursement. Eligibility is based on fidelity monitoring scores. The EBP Finder is developed and managed by the Center for Evidence-based Partnerships (CEP-Va) and all CSC providers are required to update their agency information as part of enrollment and maintenance, on a quarterly basis.

4.8 Fidelity Monitoring

All CSC teams shall undergo the standardized rating process using the *First Episode Psychosis Services Fidelity Scale and Manual (Addington, D.E. (2021). First episode psychosis services fidelity scale and manual. LCR Publishing Services, an imprint of University of Calgary Press. ISBN 978-1-77385-209-6)*, as determined by DMAS and DBHDS. Fidelity reviews are based on the 35-item scale. A total score of less than 123 is considered "poor" fidelity and shall impact a team's listing in the EBP Finder and eligibility for reimbursement for services.

Section 5. Medical Necessity Criteria

5.1 Admission Criteria

All of the following shall be met:

5.1.1 Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements

1. Individual shall be assessed using the CANS Lifetime tool within 30 days prior to admission.
2. The level of need for the individual shall be assessed at a Level of Need four or greater on the CANS Lifetime.
3. Assessment shall document specific functional deficits requiring Coordinated Specialty Care.
4. The CANS Lifetime shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service shall demonstrate a clinical

necessity for the service arising from a mental, behavioral, or emotional illness that results in functional impairments in major life activities.

5.1.2 Age Requirements

The individual shall be between the ages of 15–30 at initial admission to CSC. Service authorization requests for individuals 31 or over may be submitted after a lapse in CSC services if it's been less than three years since the initial admission to CSC services. Individuals under the age of 15 shall be reviewed for medical necessity under Early Periodic Screening, Diagnosis and Treatment (EPSDT) regulations.

5.1.3 Diagnostic Criteria

The individual shall meet all of the following criteria (a–c):

1. The individual shall have a primary diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, other specified schizophrenia spectrum or other psychotic disorder or affective disorder with psychosis, specifically bipolar disorder with psychotic features or major depression with psychotic features, can also be used for admission.
2. Duration of untreated psychosis (DUP): at least one week but less than 24 months from first emergence of psychotic symptoms. The individual is experiencing symptoms such as auditory or visual hallucinations, delusions, and thought disorder that cause significant functional impairment.
3. Individuals may also have a co-occurring diagnosis of a substance use disorder or neurodevelopmental disorder.

5.1.4 Functional Impairment Criteria

Documented functional impairment shall be present in at least 2 of the following domains (a-e):

a. Symptom Management – shall meet at least three of the following:

i. Symptom recognition: Cannot identify when experiencing hallucinations, delusions, or mood changes; denies obvious symptoms.
ii. Insight deficits: Does not understand connection between symptoms and functional problems; refuses to acknowledge mental health condition.
iii. Coping strategy deficits: Cannot implement basic coping skills during symptom exacerbation; becomes overwhelmed by routine stressors.
iv. Treatment adherence: Frequent medication non-compliance (>25% of doses missed), missed appointments ≥3 times in 2 months, or refusal to engage in recommended treatments.
v. Crisis management: Cannot identify warning signs of relapse; inappropriate responses to crisis situations; frequent emergency interventions needed.
vi. Symptom interference: Symptoms directly prevent completion of daily activities ≥3 days per week; cannot function when symptomatic.

b. Educational/Vocational Functioning – shall meet at least one of the following:

i. Academic decline: GPA drop ≥ 1.0 point or failure of ≥ 2 courses in current/most recent semester.
ii. School disruption: Truancy ≥ 20% of school days, suspension, or inability to attend classes regularly.
iii. Employment issues: Job loss within 6 months, inability to maintain employment ≥ 20 hours/week for individuals seeking work, or repeated workplace conflicts/performance issues.

iv. Vocational incapacity: Unable to engage in job training, volunteer work, or age-appropriate productive activities.
v. Educational discontinuation: Dropped out of school or unable to pursue planned educational goals.

c. Social/Interpersonal Functioning – shall meet at least two of the following:

i. Family relationships: Significant conflict requiring family intervention, inability to communicate appropriately with family members, or complete withdrawal from family interactions.
ii. Peer relationships: Loss of ≥ 2 significant friendships, inability to make new age-appropriate friendships, or social isolation with < 5 hours of social contact per week.
iii. Romantic relationships: Inability to maintain intimate relationships, inappropriate sexual behavior, or complete avoidance of romantic connections when developmentally expected.
iv. Social reciprocity: Inability to read social cues, inappropriate social responses, or marked difficulty with social communication.
v. Group participation: Cannot participate in group activities, team sports, clubs, or other social organizations previously enjoyed.

d. Independent Living Skills – shall meet at least two of the following:

i. Personal care: Poor hygiene maintenance ≥ 3 days/week, inability to manage grooming independently, or neglect of basic health needs.
ii. Household management: Cannot perform basic cleaning, laundry, or meal preparation; unsafe living conditions due to neglect.
iii. Financial management: Inability to budget, pay bills, or manage money appropriately; excessive spending or inability to make purchases.
iv. Transportation: Cannot use public transportation, unable to drive safely, or cannot navigate community independently.
v. Healthcare management: Misses medical appointments, cannot manage medications independently, or unable to access healthcare services.
vi. Time management: Cannot maintain daily routines, frequently late or miss important commitments, or inability to plan daily activities.

e. Community Integration – shall meet at least two of the following:

i. Resource utilization: Unable to access libraries, recreational facilities, community centers, or other age-appropriate community resources independently.
ii. Community participation: Cannot participate in religious, cultural, or community events; withdrawn from community activities previously enjoyed.
iii. Civic engagement: Unable to engage in age-appropriate civic activities (voting, community service, local events).
iv. Service navigation: Cannot independently access mental health services, social services, or other support systems without significant assistance.
v. Safety awareness: Poor judgment regarding personal safety in community settings; inability to recognize dangerous situations.
vi. Community mobility: Afraid to leave home, gets lost in familiar areas, or cannot navigate community environments independently.

5.2 Continued Stay Criteria

The length of stay for CSC services is on average two to three years of service provision.

Individuals shall meet all of the following:

1. The individual continues to meet admission criteria except for the age requirement, as long as the individual was between the ages of 15-30 at admission.
2. CSC participation remains necessary due to continued risk that without the service, the individual is at risk for at least one of the following:
    a. Compromised engagement in or ability to manage medication in accordance with the ISP.
    b. Increased use of crisis services.
    c. Inpatient psychiatric hospitalization.
    d. Decompensation of social and recreational skills (e.g., communication and interpersonal skills, forming and maintaining relationships).
    e. Decompensation in functioning related to activities of daily living.
    f. Disruption in the individual's community supports due to the individual's challenges with symptoms and functioning (health, legal, transport, housing, finances, etc.).
    g. Decompensation of vocational skills or vocational readiness.
3. The ISP includes evidence suggesting that the identified problems are likely to benefit from continued CSC participation and the goals are consistent with the components of this service.
4. Care coordination and discharge planning are documented and ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts shall include communication with potential future service providers, community partners, and resources related to school, occupational, or other community functioning.

5.3 Discharge Criteria

Individuals shall be discharged when they meet one of the following:

1. The individual has successfully completed the CSC program. This is on average between two and three years. The individual has successfully transitioned to a lower level of care that is adequate to support recovery.
2. The individual does not meet continued stay criteria.
3. The individual chooses to be discharged from the program or does not participate in treatment for six months.

Section 6. Exclusions and Service Limitations

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

1. Services not in compliance with the CSC fidelity standards are not reimbursable.
2. Individuals with a sole diagnosis of neurodevelopmental disorder or substance use disorder are not eligible for services.
3. Psychotic symptoms primarily attributable to:
    a. Substance-induced psychotic disorder (F1x.5x) as primary diagnosis or sole diagnosis.
    b. Psychotic disorder due to another medical condition (F06.x) as primary diagnosis or sole diagnosis.

4. Established chronic mental illness with treatment history exceeding 24 months at initial request for authorization.
5. In addition to the non-reimbursable activities listed in Mental Health Services, Chapter IV, the following are not reimbursable:
    a. Services not in compliance with the Mental Health Services Manual shall not be billed to Medicaid.
    b. The provider shall ensure that treatment is the active delivery of an intervention identified on an individual's treatment plan. Passive observation of an individual without an intervention is not a billable activity.
    c. Phone contacts including attempts to reach the individual by telephone to schedule, confirm, or cancel appointments are not reimbursable.
    d. Completion of paperwork when the individual and/or their family/caregiver are not present is not reimbursable.
    e. Requiring the individual to be present to complete documentation in order to bill for services is not permitted or reimbursable.
    f. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the individual and/or their family/caregiver are not present.
    g. Team member research on behalf of the individual.
6. Admission and Concurrent Services Limitations:
    a. Individuals receiving CSC shall not receive the following services:
        i. Applied Behavior Analysis
        ii. Assertive Community Treatment
        iii. Community Psychiatric Support and Treatment – Community (Adult or Youth)
        iv. Community Stabilization
        v. Functional Family Therapy
        vi. Multisystemic Therapy
        vii. Psychiatric Residential Treatment Facility (PRTF).
        viii. Targeted Case Management
        ix. Short-term service authorization overlaps are allowable as approved by the FFS service authorization contractor or MCO during transitions from one service to another for care coordination and continuity of care.
    b. The authorization of additional behavioral health services not included in the list above is determined by the CANS Lifetime assessment/identified level of need in collaboration with the individual and their Managed Care Organization or FFS contractor.
    c. Early and Periodic Screening, Diagnostic and Treatment policies apply to all youth under the age of 21.
7. Other Limitations:
    a. Group size is limited to a team member to individual ratio of one to ten.
    b. The following employment supports are not reimbursable covered Medicaid services components in the CSC Program:
        i. Skills training related to a specific job (how to operate equipment, use computer programs, fill customer orders, etc.).
        ii. Team member presence in the workplace to assist with supervision or teaching of routine work duties.

iii. Approaching potential employers to "job develop" without the beneficiary present or without a specific beneficiary for the position.
iv. Presentations to the business community to seek partnerships in hiring.

Section 7. Service Authorization

7.1 General Requirements

1. Service authorization is required.
2. Providers shall submit service authorization requests within one business day of admission for preservice authorization requests and by the requested start date for concurrent service authorization requests. If submitted after the required time frame, the start date of the authorization will be based on the date of receipt.
3. The LMHP, in collaboration with the individual, family/caregiver, and CSC team members, shall request services based on each individual's CANS Lifetime assessment/reassessment, treatment history, individual service plan, progress toward accomplishing goals/objectives, level of individual/family/caregiver engagement, individual choice/preference, and level of need. The intensity, frequency, and duration for any requested service shall be individualized.
4. All service authorization requests will initially start with the standard 6 calendar month timeframe and the corresponding units required in Section 7.2.
5. If an individual is not making progress toward meeting ISP goals and objectives for 18 calendar months, the service authorization timeframe may decrease to 3 calendar months as determined by the MCO or FFS contractor.
6. If a provider is requesting and providing services within the permissible amount based on the assessment and individuals are recovering, the MCO may waive the service authorization requirement.
7. Interventions recommended shall not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request.
8. The individual's MCO/FFS service authorization contractor conducting the service authorization review may approve the requested service(s) or may recommend a more clinically appropriate service based on their review.

Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Cardinal Care MCO processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

7.2 Service Authorization Period and Unit Allocation

All service authorizations shall be issued for a **six (6) month period**. Each authorization shall include the following service units:

1. **H2040:** Six (6) units per authorization period and
2. **H2041:** Thirty (30) units per authorization period, limited to a maximum of five (5) units per calendar month. Unused units do not roll over to the subsequent calendar month and shall be forfeited at the end of each calendar month in which they are not utilized. H2041 shall not be billed in the same calendar month as H2040.

7.2.3 Minimum Service Requirement

The individual shall receive no fewer than twenty-four (24) consecutive months of service. Service authorizations shall be issued in six (6) month increments within that period to ensure the individual is

progressing toward ISP goals and objectives and to facilitate the required collaboration between MCOs and providers.

7.3 Preservice Authorization

The following information shall be submitted with the preservice authorization request:

1. Complete service authorization request form.
2. Completed and signed Initial Assessment including the completed CANS Lifetime.
3. Completed and signed Initial ISP.
    a. Shall include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.

7.4 Concurrent Authorization

The following information shall be submitted with the concurrent authorization request:

1. Complete service authorization request form.
2. Current addendum to the initial assessment (can be a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria.
3. Updated ISP:
    a. Shall include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.
    b. Youth: Following initial authorization, if an individual is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP shall be updated to assure family/caregiver involvement before reauthorization is considered.
    c. Adults: Following initial authorization, if an individual is not progressing and/or engaged, the ISP shall be updated to assure engagement and progress before reauthorization is considered.

Section 8. Additional Documentation Requirements and Utilization Review

1. The progress note shall clearly document that the services provided are related to the individual's goals, objectives, and interventions in the treatment plan, and are medically necessary and clinically appropriate.
2. Each service/progress note shall document the specific interventions delivered including a description of what materials were used when teaching a skill.
3. Service/progress notes shall include:
    a. Each individual's response to the intervention, noting if progress is or is not being made.
    b. Observed behaviors if applicable and a plan for the next scheduled contact with the individual.
    c. Sufficient detail to support the length of the contact.
    d. Content specific enough so a third party will understand the purpose of the contact and that supports the service and claims data.
    e. Progress notes shall be completed and signed by the team member who delivered the service. It is not permissible for one team member to deliver a service and another to document or sign the corresponding progress note.
4. An LMHP shall review documentation of non-LMHP team members at least every 30 calendar days as evidenced by a progress note in the individual's chart written by the LMHP or a co-

signature on the non-LMHP team member's progress notes. Non-LMHP team members include LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, CSACs, CSAC-supervisees, RNs, LPNs, and RPRSs.

Refer to Chapters IV and VI of this manual for additional documentation and utilization review requirements.

Section 9. Billing Requirements

9.1 General Billing Requirements

1. Providers bill **per encounter** (H2041) during calendar months when fewer than six encounters are provided during the month.
2. Providers bill **per member per month** (H2040) for a calendar month when six or more encounters are provided during the month.
3. Providers shall not bill H2041 and H2040 in the same calendar month.

9.2 In-Person Service Provision Requirements

1. Per member per month services (H2040): At least four encounters per calendar month shall be provided in-person.
2. Per encounter services (H2041): at least half of encounters per calendar month shall be provided in-person.

9.3 One-to-One Service Provision Requirements

1. Per member per month services (H2040):
    a. At least four encounters per calendar month shall be provided on a one-to-one basis (may include natural supports).
    b. Additional encounters may be provided in a group with one staff member providing services to multiple individuals.
    c. Additional encounters may be provided with family/caregivers (one-to-one or group) without the individual present when the service is provided for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the ISP.
2. Per encounter services (H2041):
    a. At least half of encounters per calendar month shall be provided on a one-to-one basis (may include natural supports).
    b. Additional encounters may be provided in a group setting with one staff member providing services with multiple individuals.
    c. Additional encounters may be provided with family/caregivers (one-to-one or group) without the individual present when the service is furnished for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the ISP.

9.4 CANS Lifetime Reassessments and Updates

Annual reassessments to the CANS Lifetime assessment may be billed using H0031. H0031 shall only be billed once per every 365 calendar days per member.

Periodic updates to the CANS Lifetime assessment completed in the course of routine service delivery shall not be billed with H0031. Such updates shall be billed using H2040 or H2041.

9.5 Billing Codes

Billing Code	Unit	Description	Requirements to Bill	Provider Qualifications
H2040	Per Member Per Month	Coordinated specialty care, team based, for first episode psychosis, per month	A CSC team shall provide six or more encounters per calendar month in order to bill the per member, per month rate (H2040).	Service components shall be provided by a qualified provider (see Provider Qualification and Staff Requirements section).
H2041	Per Encounter	Coordinated specialty care, team based, for first episode psychosis, per encounter	A team shall bill the individual encounter rate (H2041) for all encounters that occurred during a calendar month if the encounters add up to 5 or less during the calendar month.	Service components shall be provided by a qualified provider (see Provider Qualification and Staff Requirements section).
H0031	Flat rate per initial assessment and annual reassessment	Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)		LMHP, LMHP-R, LMHP-S, LMHP-RP