The Department of Medical Assistance Services
Coordinated Specialty Care (CSC)

1. Definitions

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

Affiliated means any entity or property in which a DMAS enrolled provider has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.

Comprehensive Assessment of Needs and Strengths (CANS Lifetime): 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 n face-to-face interaction with an individual that includes at least 15 minutes of one required service component.

Licensed Mental Health Professional or **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.

Licensed Mental Health Professional-type or LMHP-type means A LMHP-Resident in Counseling (LMHP-R), LMHP-Resident in Psychology (LMHP-RP) or LMHP-Supervisee in Social Work (LMHP-S). LMHP residents/supervisees shall only perform activities where indicated as allowed by a LMHP-R, LMHP-RP or LMHP-S.

Early Serious Mental Illness: The initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual's functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

One-on-one: means a service component is provided with one staff person providing services with one individual.

Serious Mental Illness (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.

Serious Emotional Disturbance (Youth): someone under the age of 18 having, within the past year, a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

Supervision is relationship-based education and training that is work-focused and which 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.

1. Core Functions of Supervision

Supervision serves three primary functions:

Educational/Clinical Function: Supervisors are responsible for imparting knowledge, refining skills, and promoting professional development. The supervisor teaches therapeutic skills and helps the staff and

collaborative behavioral health team develop self-awareness to better the therapeutic interactions with individuals participating in services.

Regulatory Compliance/Case Oversight Function: Objectives of the agency/organization's policy and public accountability are transformed into practice standards. This ensures compliance with regulations, documentation requirements, and organizational protocols. The supervisor provides education and oversight as part of a collaborative behavioral health service to guide treatment planning and monitor outcomes.

Supportive Function: Daily work with individuals experiencing symptoms of a mental illness can be inherently distressing, so a key aspect of supervision is often helping staff to learn to manage the emotional demands of the work. Supervision has been found to increase provider competence and decrease stress.

2. Key Components of Supervision

Supervision encompasses multiple roles where the supervisors are a teacher, coach, consultant, mentor, evaluator, and administrator; the supervisor provides support, encouragement, and education to staff.

The process involves regular meetings between supervisor and supervisee to discuss individual cases, treatment strategies, ethical considerations, professional development needs, and service decision-making. Supervision makes sure that the care provided meets the standards in terms of safety and effectiveness, and that any concerns related to the individual participating in services are addressed.

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

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.

2. Service Definition/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

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.

1. Per member per month services: At least five encounters per calendar month shall include at least one covered service component:
    a. Provided in-person
    b. Provided one-on-one with the individual.
2. Per encounter services: at least half of encounters per calendar month shall include at least one covered service component:
    a. Provided in-person
    b. Provided one-on-one with the individual.
3. Support for family/caregivers may be provided 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.

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

Assessment means the face-to-face 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's 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 one business day.
3. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the assessment shall be certified to administer Virginia CANS Lifetime Assessment
4. The assessment shall be provided on an individual basis with team member(s) providing services with one individual.
5. Assessments inclusive of the Virginia CANS shall be performed at least once every 365 days until discharge.
6. In addition to the above timeframes, assessments shall also be performed any time there is a significant change to the individual's circumstances.

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. (see Chapter IV for ISP requirements)

1. Treatment planning shall be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.
2. 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.
3. The ISP is required during the entire duration of services and shall be current..
4. 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.
5. Treatment planning shall be provided on an individual basis with team member(s) providing services with one individual and their natural supports.
6. The ISP shall be authorized and overseen by an LMHP.
7. At a minimum, the ISP shall be signed by:
    a. The individual and the individual's legally authorized representative.

b. The CSC team members working with the individual; and
c. The LMHP Team Leader overseeing the services.

8. 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.
    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, 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. The ISP is what directs collaborative behavioral health treatment. The ISP shall be actively utilized with the individual/family/caregiver during each encounter.
        iii. Assessing the individual's level of progress and improved functioning may be assessed utilizing a variety of methods including: ratings on standardized assessment tools, checklists, direct observation, role-play, self-report, improved grades, improved attendance at school or work, improved medication adherence, feedback from the individual, family/caregiver, teacher, and other natural supports, and reduced psychiatric hospitalizations, emergency room, and/or residential treatment services utilization.
        iv. When it is determined that an individual is making limited to no progress or is not engaged, 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.
        v. 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:

- A comprehensive psychiatric evaluation completed as soon as possible but no later than 30 calendar days after admission;
- Medication prescription monitoring;
- Psychiatric Services shall occur at a minimum once every 30 calendar days. Contact with the individual shall occur at least twice a month for the first six months and then taper in frequency as appropriate for the individual served.
- Participation of the psychiatrist or psychiatric nurse practitioner on the team shall be documented such as, involvement in team meetings, treatment planning, recommendations to improve psychiatric engagement, and assessment of medical and psychiatric needs.
- Psychiatric services shall be provided on an individual basis with team member(s) providing services with one individual.
- 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. The LMHP, LMHP-S, LMHP-R or LMHP-RP to individual ratio shall not exceed
    a. One LMHP, LMHP-S, LMHP-R or LMHP-RP to six youth
    b. One LMHP, LMHP-S, LMHP-R or LMHP-RP to six adults
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 the next service component.

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.

3.6 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. Services are provided with family/caregivers when it is for the direct benefit of the individual.

This component can be provided by the 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.

3.7 Rehabilitation Skill-Building

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

Supported employment and education support are not Medicaid covered services but this component can include treatment integrated services that promote education or vocational success. 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 these activities can be 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, 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.

3.8 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 individual service plan (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 the restorative care, identify and access need 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 and 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 an individual basis with team member(s) providing services with or for one individual.

3.9 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 management 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.

1. Crisis support shall be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or QMHP-T.
2. CSC providers are required to develop with the individual, crisis mitigation plans, which shall **not** include use of or referral to Comprehensive Crisis and Transition Services (Mental Health Services (Mental Health Services Manual, Appendix G).
3. 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.
4. Crisis Supports shall be provided on an individual basis with team member(s) providing services with one individual and their natural supports.
5. In-person crisis support shall be offered and available 24 hours per day, seven days per week, 365 days per year. The individual's needs and preference shall be the determining factor regarding whether crisis supports are provided in-person, face-to-face (telemedicine), or audio-only.
6. Any use of telemedicine shall be for the clinical benefit of the individual.
7. In-person crisis support shall be provided by the CSC provider prior to any referral to a Comprehensive Crisis and Transition Services (Mental Health Services Manual, Appendix G).
8. The use of Comprehensive Crisis and Transition Services will be monitored by the individual's MCO.

3.10 Peer Recovery Support Services

Peer recovery support services means 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. Groups are limited to ten individuals.

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-licensed 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. The team shall have qualified staff who fulfill the following roles:

1. Team Leader
2. Psychiatrist / Licensed Psychiatric Medical Professional
3. Therapist
4. Co-occurring Substance Use Disorder Specialist
5. Family Education and Support Specialist
6. Care Coordinator
7. Supported Employment/Education Specialist
8. Community Education and Outreach Specialist

4.1.1 Required team members

An individual is considered a member of the team if they fulfill one or more of the following roles and attend the majority (over 50%) of team meetings.

Teams shall include at a minimum the following credentialed team members that 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 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. 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 meet DBHDS criteria for a co-occurring disorder specialist (LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP or CSAC with training or experience working with adults with co-occurring serious mental illness and substance use disorder.)
5. Peer Recovery Support Specialist
   a. There shall be at least one Registered Peer Recovery Support Specialist (RPRS).

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 30 individuals.

4.3 Staff Training Requirements

CSC services shall be provided by a team of individuals who have strong clinical skills, professional qualifications, experience, and competency to provide the range of practices. All CSC team members are expected to receive initial and ongoing 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 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 role on the team as well as understand roles of others on team. Required training for all members of the team shall include the programmatic training required by Navigate or On TrackNY.

4.4 Supervision and Team Meeting Requirements

The team leader shall maintain documentation of both supervision and training activities, including cross-training activities.

All team members, other than the psychiatric provider and LMHP Team Lead, shall receive ongoing clinical supervision from CSC team clinical leadership, with the CSC LMHP Team Leader as the primary clinical supervisor. The majority of team members shall receive scheduled clinical supervision bi-weekly, either in individual or group format; no staff shall go without a supervision session in a given calendar month.

The psychiatric provider and LMHP Team Leader shall receive clinical consultation at least monthly from an agency administrator/prescriber.

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 may be delivered within CSC:

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

In addition to supervision, the whole CSC team shall meet at least weekly to discuss each team member's role in the individual's care and review each individual's progress towards achieving ISP goals.

4.5 Department of Behavioral Health and Developmental Services (DBHDS) Licensing Requirements

Providers are required to be:

1. Licensed by DBHDS as a provider of: To Be Determined. The DBHDS license shall be active and in good standing (conditional or triannual).
2. Completion of DBHDS program readiness check list will be required to be submitted with the DBHDS license for review.

4.6 DMAS Provider Enrollment (provider type and specialty type)

Providers are required to be enrolled with DMAS with provider type 156 or 456 and provider specialty (To Be Determined) 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 First Episode Psychosis Fidelity Scale (FEPS-FS) as determined by DMAS and DBHDS. Fidelity reviews are based on the 33-item scale. A total score of less than 116 is considered "poor" fidelity and would impact a team being listed in the EBP Finder.

5. Medical Necessity Criteria

5.1 Admission Criteria

All of the following shall be met:

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements**
   a. Individual shall be assessed using the CANS Lifetime tool within 30 days prior to admission.
   b. At least two CANS Lifetime domains scoring ≥ three (actionable needs requiring intervention)
   c. The level of need for the individual shall be assessed at a Level of Need four or greater on the CANS Lifetime.

d. Assessment shall document specific functional deficits requiring Coordinated Specialty Care.
e. 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

2. Age Requirements

a. The individual shall be between the ages of 15-30 at admission. Individuals under the age of 15 shall be reviewed for medical necessity under Early Periodic Screening, Diagnosis and Treatment regulations.

3. Diagnostic Criteria: shall meet all criteria a-d.

a. The individual shall have a primary diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, other specified schizophrenia spectrum or other psychotic disorder. Affective disorder with psychosis, specifically bipolar disorder with psychotic features and major depression with psychotic features can also be used for admission.
b. 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 causes significant functional impairment.
c. Individuals may also have a co-occurring diagnosis of a substance use disorder or neurodevelopmental disorder.

4. **Functional Impairment Criteria:** Documented functional impairment in at least 2 of the following domains:

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 misses 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 services provision.

Individuals shall meet all of the following:

1. The individual continues to meet admission criteria.
2. Another less intensive level of care would not be adequate to support recovery.
3. 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 individual's challenges with symptoms and functioning (Health, Legal, Transport, Housing, Finances, etc.).
g. Decompensation of vocational skills or vocational readiness.

4. 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.
5. 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 should 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 below:

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.

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 will not be 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
5. The following are not reimbursable:
    a. Services not in compliance with the Mental Health Services Manual may 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. Comprehensive Crisis and Transition Services:

i. The CSC provider or any affiliated provider or business of the CSC provider shall not provide Mobile Crisis Response (except Community Services Board code mandated Emergency Services as billed via Mobile Crisis Response pursuant to section §37.2-800 et. seq. and section §16.1-335 et seq. of the Code of Virginia), 23-Hour Crisis Stabilization or Residential Crisis Stabilization to any individual receiving CSC.

b. Individuals receiving CSC may not receive the following services:
    i. Applied Behavior Analysis,
    ii. Addiction and Recovery and Treatment Services (ARTS) Levels: ASAM 2.1-3.7
    iii. Assertive Community Treatment,
    iv. Community Stabilization,
    v. Functional Family Therapy,
    vi. Mental Health Partial Hospitalization Program,
    vii. Mental Health Intensive Outpatient,
    viii. Multisystemic Therapy,
    ix. Psychiatric Residential Treatment Facility (PRTF) or
    x. Therapeutic Group Home (TGH) services.
    xi. 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.

c. 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.

7. Other Limitations:
    a. Group size is limited to a team member to individual ratio of one to six for youth and one to ten for adults.
    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.

7. Service Authorization

Service authorization is required. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt.

Prior to submitting an authorization request, the LMHP in collaboration with the individual, family/caregiver, natural supports, and the CSC team, shall request services based on each individual's assessment/reassessment, treatment history, treatment plan, progress toward accomplishing goals/objectives, level of individual/family engagement, individual choice/preference and level of need. The intensity, frequency, and duration for any requested service shall be individualized.

The decision regarding the most effective interventions is based on an individual's assessed needs, availability of treating providers in the individual's geographic area, individual preference, and other factors including an individual's readiness for change and individual/family level of engagement. Interventions recommended shall not be limited to the services delivered by the provider or provider agency conducting the assessment and

submitting the authorization request. The member's MCO conducting the 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 Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

7.1 Level of Need:

Service Authorization Requests shall not exceed the following:

Level of Need	Service Type	SA Timeframe – not to exceed	Units (PMPM or encounter) – not to exceed
4-6	CSC	180 calendar days	6 units of H2040 **or** 36 units of H2041 Both procedure codes shall not be billed in the same calendar month.

7.2 Preservice Authorization

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

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

7.3 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.

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. The content shall be specific enough so a third party will understand the purpose of the contact and supports the service and claims data.
e. The only team member who may complete a progress note is the team member who delivered the service. It is not permissible for one team member to deliver the service and another team member to document and/or sign the progress notes.

4. An LMHP shall review documentation of non-licensed 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-licensed team member's progress notes. Non-licensed team members include LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHPs, QMHP-Ts, CSACs, CSAC-supervisees, RNs, LPNs RPRSs.

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

9. Billing Requirements

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

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 seven 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 6 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 assessment	Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)		LMHP, LMHP-R, LMHP-S, LMHP-RP

CSC and Targeted Case Management may not be billed for the same individual in the same calendar month.