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Definitions

Refer also to Appendix A for terms used in the Appendix

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.

Mental Health Case Management (H0023)

Population Definitions

The following Department of Behavioral Health and Developmental Services (DBHDS) definitions are applied by the Community Services Boards in admission and continued stay determinations for Mental Health Case Management.

Serious Mental Illness 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. Individuals with serious mental illness who have also been diagnosed as having a substance use disorder or developmental disability are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

1. **Diagnosis**
   The person must have a major mental disorder diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM). These disorders are schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of Adjustment Disorder (F43.20-F43.25) or DSM codes associated with "Other Conditions that May Be a Focus of Clinical Attention" cannot be used to satisfy these criteria.

2. **Level of Disability**
   There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least **two** of the following criteria on a continuing or intermittent basis. The person:

   a. Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history;
   b. Requires public financial assistance to remain in the community and

may be unable to procure such assistance without help;
c. Has difficulty establishing or maintaining a personal social support system;
d. Requires assistance in basic living skills such as personal hygiene, food preparation, or money management; or
e. Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

3. **Duration of Illness**
The individual is expected to require services of an extended duration, or the individual's treatment history meets at least **one** of the following criteria.

a. The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization), or
b. The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Serious Emotional Disturbance means 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. or the child must exhibit **all** of the following:

1. Problems in personality development and social functioning that have been exhibited over at least one year's time; and
2. Problems that are significantly disabling based upon the social functioning of most children that age; and
3. Problems that have become more disabling over time; and
4. Service needs that require significant intervention by more than one agency.

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

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

1. The child exhibits behavior or maturity that is significantly different from most children of that age and is not primarily the result of developmental disabilities; or
2. Parents or persons responsible for the child's care have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or
3. The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living

in poverty, parental neglect, physical or emotional abuse, etc.).

MHCM Level of Care Guidelines	
Service Definition	Mental health case management (MHCM) is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services. MHCM includes the assessment, development of a person-centered Individual Service Plan (ISP), referral to appropriate services, service planning, and monitoring of the services provided pursuant to the ISP. MHCM does not include the provision of direct clinical or treatment services. If an individual has been assessed as having co-occurring mental health and substance use disorders (SUD), the case manager may include activities in the ISP to address both the mental health and substance use disorders, as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the assessment, the ISP, and the progress notes. Refer to Chapter IV for assessment, ISP and progress notes requirements. In accordance with section 1902(a) (23) of the Social Security Act, each MHCM provider must ensure that the provision of MHCM services does not restrict the individual's free choice of providers.
Required Activities	The following activities are required and shall be provided: **Case Management Engagement:** The case manager shall provide required case management activities in accordance with the individuals ISP. Minimum case management engagement shall include: 1. At a minimum, the case manager shall engage in a monthly case management required activity related to the individual's ISP. 2. Face-to-face requirements: A minimum of two case management required activities shall be conducted face-to-face with the individual every 90 calendar days. At least one of the two case management required activities conducted face-to-face every 90 calendar days shall be conducted in-person with the individual at a community location other than the CSB location.

Assessment:

An assessment must be completed by a qualified mental health case manager to determine the need for services or included as a recommended service on a Comprehensive Needs Assessment conducted by a Licensed Mental Health Professional (LMHP), LMHP-R, LMHP-RP or LMHP-S. If completed by a qualified case manager who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the assessment is conducted as part of the first month of case management service. Case Management assessments and intakes must be provided in accordance with the provider requirements defined in DBHDS licensing regulations for case management services. The assessment serves as the basis for the ISP.

Service/Supports Planning and Monitoring:

Using the results of the assessment and the stated goals of the individual, the case manager shall develop the ISP in a person-centered manner.

1. The ISP shall document the need for case management and be fully completed within 30 calendar days of initiation of the service.
2. The individual and their family/caregiver as appropriate shall be involved in the ISP development and in all reviews and updates to the ISP.
3. The ISP goals and objectives shall be developed with the individual's input and based on needs identified in the initial assessment. The ISP must include activities such as ensuring the active participation of the individual and working with the individual, family/caregiver and others to develop those goals.
4. The ISP shall specify the goals, objectives and interventions that address the holistic treatment and support needs of the individual (mental health, medical, social, educational, etc.).
5. Subsequent assessments and identified needs shall be reflected in updated ISPs with updated goals and objectives.
6. The case manager shall continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. The case manager shall ensure that services are provided in accordance with the ISP and adequately addressing the individual's needs through monitoring and follow-up activities.

The case manager shall:

a. Include the individual, family/caregivers, service providers or other collaterals as often as necessary;

b. Monitor service delivery as needed through contacts with service providers as well as periodic site visits and home visits to ensure that services are being furnished in accordance with the individuals ISP. At a minimum, the case manager must meet with the individual and family/caregiver at a community location other than the CSB once every 90 calendar days;

c. Communicate with collateral contacts to promote implementation of the service plan and community integration and

d. Revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers change.

7. At a minimum, the case manager shall review the ISP every three calendar months to determine whether service goals and objectives are being met, the individual's satisfaction with services, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three calendar months.

8. The review is due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled 90 calendar days from the month the review was due and not the date of actual review.

9. The ISP shall be updated, at a minimum of, every 365 calendar days.

Case Management with Service Providers

The case manager shall:

1. Link the individual to needed services and supports specified in the ISP. Activities shall include linking the individual with medical, social, educational providers or other programs and services that are capable of providing needed services and supports to address identified needs and achieve goals specified in the ISP.

2. Coordinate services and service planning with other agencies and providers involved with the individual.

	3. Enhance community integration by contacting other entities to arrange community access and involvement including opportunities to learn community living skills, and use vocational, civic, and recreational services. 4. Notify and document the attempts to notify the primary care provider or pediatrician of the individual's engagement in mental health case management.
MHCM Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Individuals must meet the following criteria: 1. The individual shall meet the DBHDS criteria for serious mental illness, serious emotional disturbance in children, or child at risk of serious emotional disturbance. 2. Documentation provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S must include the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child. Documentation may be provided by any LMHP, LMHP-R, LMHP-RP or LMHP-S familiar with the individual. 3. The individual must require case management as documented in the ISP, which is developed by a qualified mental health case manager (12VAC30-50-420 – 12VAC30-50-430) and based on an appropriate assessment and supporting documentation.
Continued Stay Criteria	Individuals must meet the following criteria: 1. Documentation of the individual's participation and engagement in MHCM includes at a minimum: a. progress toward accessing needed services is documented at the expected pace given the presence of medical/physical conditions, stressors, and level of support, as evidenced by engaging in identified services and supports, b. documented progress toward meeting ISP goals and objectives c. improving severity of symptoms and functional impairment, and continued progress is expected. 2. If progress is not being made, the individual has been re-assessed, treatment needs have been re-evaluated, an alternative ISP has been developed, and medically necessary referrals to the new services have been made. 3. The individual and case manager are engaged in coordination of care with other providers, involving family members where indicated, and evidence of coordination is documented. For children, the family is participating in services identified in the ISP, and is collaborating with the case manager to coordinate services on the child's behalf.

Discharge Criteria	The individual shall be discharged if: 1. Continued stay criteria is not met **or** 2. The individual no longer meets DBHDS criteria for serious mental illness, serious emotional disturbance in children, or child at risk of serious emotional disturbance.
Exclusions and Service Limitations	No other type of case management, from any funding source, may be billed concurrently with mental health case management. Limited services are available to individuals in institutions (see billing requirements section)
MHCM Provider Participation Requirements	
Provider Qualifications Requirements	The mental health case management provider must be: 1. A Community Services Board (as established in § 37.2-500); and, 2. Licensed by DBHDS as a provider of MH Case Management Service for Adults (16-004) or MH Case Management Service for Children and Adolescents (16-005); and 3. Enrolled with DMAS as provider class type (PCT) 156 or 456 with provider specialty (PS) 900.
Staff Qualification Requirements	Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. Per DMAS regulation (12VAC30-50-420 – 12VAC30-50-430), persons providing mental health case management services must have knowledge of: 1. Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, developmental disability, and substance abuse treatment programs; 2. The nature of serious mental illness, developmental disability, and substance abuse depending on the population served, including clinical and developmental issues; 3. Different types of assessments, including functional assessments, and their uses in service planning; 4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; 5. The service planning process and major components of a service plan; 6. The use of medications in the care or treatment of the population served; and 7. All applicable federal and state laws, regulations, and local

	ordinances. Persons providing case management services must have skills in: 1. Identifying and documenting an individual's needs for resources, services, and other supports; 2. Using information from assessments, evaluations, observation, and interviews to develop Individual Service Plans; 3. Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and 4. Coordinating the provision of services by public and private providers. Persons providing case management services must have abilities to: 1. Work with team members, maintaining effective inter- and intra-agency working relationships 2. Work independently, performing position duties under general supervision; and 3. Engage and sustain ongoing relationships with individuals receiving services.
Staff Caseload Requirements	Active individuals on a case load means that the individual has an ISP in effect which requires, at a minimum, monthly case management engagement related to the ISP and that the case manager is meeting minimum face-to-face case management required activities as described in the service requirements section. CSBs shall categorize the intensity of need of the individuals they serve as either high, medium or low based on the needs of the individual and the number of hours of case management service required monthly. Categories shall be reviewed at a minimum of every 90 calendar days. A general guideline is provided below. The following tiers shall be used in determining the level of need for case management services, frequency of case management services and size of staff caseloads: **Functional Impairment Domains to Evaluate** **1. Communication abilities** (language, cognitive, sensory)

2. **Transportation access** and mobility
3. **Financial management** and insurance navigation
4. **Social support systems** and family involvement
5. **Housing stability** and community integration
6. **Technology access** and digital literacy
7. **Previous service experiences** and system navigation history

Factors That May Increase Intensity Level

1. Multiple chronic conditions requiring complex care coordination
2. Recent major life changes (housing, employment, family status)
3. History of service discontinuation or "no-shows"
4. Limited English proficiency or cultural barriers
5. Lack of natural supports or social isolation
6. Financial barriers to service access
7. Geographic barriers (rural location, limited local services)

Factors That May Decrease Intensity Level

1. Strong natural support systems
2. Stable housing and income
3. Previous successful service engagement
4. Good health literacy and system knowledge
5. Reliable transportation
6. Established relationships with key providers
7. Cultural/linguistic match with available services

1. **High Intensity of Need**

Individuals may experience or display:

a. **Severe functional impairments** significantly limiting ability to navigate service systems independently, **multiple complex service needs** across medical, social, educational, and other domains and **frequent service coordination challenges** requiring intensive monitoring and advocacy to include but is not limited to:

i. Unable to independently schedule, attend, or follow through with appointments
ii. Requires assistance with basic service navigation (transportation, paperwork, communication)
iii. Multiple failed attempts to access services without support
iv. Complex medical/social needs requiring coordination across 5+ service providers
v. Housing instability or homelessness impacting service access (couch surfing, utilizing shelter system, staying somewhere and not on the lease)
vi. Legal guardian or conservatorship issues affecting service decisions
vii. Language barriers or cognitive limitations requiring

	intensive advocacy viii. History of "falling through cracks" of service systems 2. **Medium Intensity of Need** Individuals may experience or display: a. **Moderate functional impairments** affecting consistent service access, **some service coordination needs** with consistent routine monitoring required and **intermittent challenges** in maintaining service engagement requiring moderate monitoring and advocacy to include but is not limited to: i. Can access some services independently but needs support for complex navigation ii. Occasional missed appointments or service disruptions iii. Needs assistance coordinating between 2-4 service providers iv. Benefits from structured planning and reminders v. Some difficulty with paperwork, insurance issues, or system requirements vi. Periodic transportation or scheduling challenges vii. Needs support understanding service options and making informed choices viii. Stable housing but may need assistance with service-related tasks or unstably housed (couch surfing, utilizing shelter system, staying somewhere and not on the lease) ix. Increased risk factors (i.e., prostitution; serious fall risk, more serious SUD, domestic violence, etc.) x. Language barriers (requires utilization of Propio or certified American Sign Language (ASL) interpreter) xi. Generally hard to engage, younger individuals/first episode of psychosis (18–25 year old) 3. **Low Intensity of Need** Individuals may experience or display: a. **Mild to moderate functional impairments** that occasionally interfere with service access, **some service coordination needs** that require periodic structured support and **intermittent barriers** to maintaining consistent service engagement to include but is not limited to: i. Can access most services independently but benefits from ongoing support structure ii. Needs assistance with service coordination during transitions or changes iii. Generally stable service engagement with occasional lapses or challenges iv. Requires support when navigating new or unfamiliar service systems v. May have some difficulty with complex paperwork or insurance processes

	vi. Transportation or scheduling challenges that arise periodically vii. Benefits from education about service options and system navigation viii. Stable housing but may need assistance during service-related complications ix. Has some natural supports but benefits from professional coordination backup Caseloads shall not exceed: 1. 20 individuals who meet high intensity level of need or 2. 40 individuals who meet medium intensity level of need or 3. 60 individuals who meet low intensity level of need or 4. A mixed case load with weighting equal to the above ratios Most staff caseloads will include individuals with a mix of intensity levels and needs. In order to monitor compliance with the above limits for mixed case loads, staff will be required to average a minimum of two hours per month in required case management activities (case management engagement, assessment, service/supports planning and monitoring, care coordination with service providers) per active individual as averaged across each staff person's caseload. CSBs shall use the average amount of hours in required case management services provided per individual served to determine compliance with the above caseload limits. Compliance shall be monitored by the agency quarterly with each case manager's caseload averaging a minimum of two hours per individual per month. CSBs shall be able to demonstrate compliance with the caseload limits during a utilization review through, at a minimum, caseload reports per staff member.
MHCM Service Authorization and Utilization Review	
Service Authorization	Providers must submit a registration to the individual's MCO or FFS service authorization contractor within one business day of admission. The start date of the registration shall be changed to the date of submission if submitted after one business day. If the individual qualifies for case management through a different population definition ('at risk', SED, or SMI) a new registration is required. Providers may contact the FFS service authorization contractor or the MCO directly for more information.
Documentation and Utilization Review	Refer to Chapter IV and VI of this manual for documentation and utilization review requirements that apply to all providers of Mental Health Services.

	In addition: 1. There must be an ISP from each provider rendering services to the individual. 2. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the ISP. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

MHCM Billing Requirements

1. A billing unit is one calendar month.

2. Billing can be submitted for case management only for months in which a case management required activity related to the ISP occurs. These activities must be documented in the clinical record. The provider shall bill for the specific date of a face-to-face visit or a specific date that a case management activity related to the ISP was provided. Providers are NOT to span the month for Case Management services.

3. Reimbursement shall be provided only for "active" individuals on a caseload, as defined in the staff caseload requirements section above.

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

5. In accordance to 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

6. Services rendered during the same month as the admission to the IMD is reimbursable for individuals ages 22 - 64 as long as the service was rendered prior to the date of the admission.

7. Two conditions must be met to bill for Case Management services for individuals that are in an acute care psychiatric units or who are in institutions and who do not meet the exclusions noted above. The services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management services provided to the individual are limited to one month of service, 30 calendar days prior to discharge from the facility. Case management for hospitalized individuals may

be billed for no more than two non-consecutive pre-discharge periods in 12 months.

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

9. Case Management services are intended to be an individualized client-specific activity between the case manager and the individual. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was individual-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure the individual has proceeded correctly.

10. Providers must follow the requirements for the provision of telemedicine described in the “Telehealth Services Supplement” including the use of the GT modifier for units billed for services provided through telemedicine. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.