
PROGRAM IMPLEMENTATION GUIDE

Community Psychiatric Support and Treatment (CPST) —Youth, School Setting

A practical guide for providers on standing up and running a compliant CPST – Youth, School Setting program — school partnerships, staffing, service delivery, crisis response, supervision, caseloads, and billing.

Virginia Department of Medical Assistance Services (DMAS)

Aligned to CPST – Youth, School Setting Draft Policy Appendix (08.31.2026 v2)

About This Guide

This guide translates the draft CPST – Youth, School Setting Provider Policy Appendix within the Mental Health Services Manual into an operational roadmap. It is written for agency leadership, clinical directors, supervisors, and program managers who are building a new CPST – School Setting program. It walks through how to establish school division partnerships, hire and train the team, deliver services inside a school without disrupting instruction, align with IEPs and 504 plans, respond to crises during and outside the instructional day, keep services going across the school calendar, set caseloads, provide supervision, and bill correctly.

How to use it

This guide is operational, not regulatory. Where it summarizes a requirement, the CPST – Youth, School Setting Appendix and its Attachment 1 remain the controlling source. Section references throughout (“§”) point back to the appendix.

Two tiers, one population. CPST – School Setting serves youth under 21 at Tier 1 or Tier 2. Requirements that differ by tier are flagged as they arise.

What is different from CPST – Community. The school is the primary service location, and the program runs on a Memorandum of Understanding (MOU) with each school division. Look for the school-specific sections on MOUs (2.2), IEP/504 alignment (5), tiered crisis response (6), and school calendar continuity (9.2).

“Shall” means required. Language marked as a requirement reflects an appendix “shall.” Recommendations are labeled as such.

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1. What CPST – School Setting Is

Community Psychiatric Support and Treatment (CPST) – School Setting is a **team-based, trauma-informed service for youth, delivered primarily in the school**. It combines assessment, psychotherapy, care coordination, and crisis and functional supports, grounded in safety, trustworthiness, collaboration, and cultural humility. Services are delivered in partnership with the youth, their family, and the school, and are driven by the youth's Individual Service Plan (ISP), aligned with their Individualized Education Program (IEP) or Section 504 plan where one exists (§2).

The school is the primary service location. Services may also be delivered in the home when the ISP identifies home-based goals that directly improve the youth's functioning at school. The long-term aim is **optimal school integration with minimal ongoing professional intervention**. Families and caregivers are expected to take an active role in treatment.

Alongside the school — not instead of it

CPST – School Setting is an intensive, individually authorized clinical intervention for youth whose needs exceed what universal and targeted school supports can address. It does not replace the division's multi-tiered system of supports, its student services staff, or a youth's IEP or 504 plan. Providers **shall** coordinate with school-based supports to avoid duplication and document in the ISP how CPST differs from what the school is separately providing (§2.2).

1.1 Tier 1 vs. Tier 2

	CPST Tier 1	CPST Tier 2
Team	LMHP, plus optionally an additional LMHP, LMHP-type, QMHP, or QMHP-T	All Tier 1 roles, and may add a Behavioral Health Technician (BHT) for rehabilitation skills practice only
Face-to-face contact	Youth interacts regularly with one or two team members	Youth interacts regularly with two team members, and may interact with three
Level of Need	CANS Lifetime LON 2 or 3; moderate impairment	CANS Lifetime LON 4, 5, or 6; significant impairment; SED, Early SMI, or SMI
Typical intensity	Averages 2–3 hours per week	Averages 5–8 hours per week (about 20–32 hours per month, by LON)
Distinct component	Assessment, treatment planning, restorative life skills, care coordination, crisis support, and psychotherapy if needed	Adds Rehabilitation Skills Practice (in person, one-to-one, practiced in vivo in the school)

	CPST Tier 1	CPST Tier 2
Caregiver commitment	Average of at least 30 minutes per week	Average of at least 1 hour per week

Collaborative Behavioral Health Service

CPST is delivered by a team of two or more professional and paraprofessional staff under § 54.1-3500. Every team member serving a youth or family must communicate and collaborate to meet supervision, oversight, and documentation requirements. The LMHP leads assessment, ISP development and oversees direct service delivery (§2, §2.1).

1.2 What services must focus on

The appendix requires school-setting CPST to focus on key developmental needs and protective factors (§2.2).

Independent coping strategies and self-care	Executive functioning (planning, organization, impulse control)	Problem-solving for life challenges
Prosocial peer relationships	Meaningful participation in the school community	Restoring positive family/caregiver relationships
Positive relationships with trusted adults at school	Concrete life skills (communication, stress management, decision-making)	

Service goals center on restoring the youth to their best developmental trajectory and on the functional skills needed to sustain relationships with peers, school staff, and family; build connectedness and belonging at school; improve attendance and reduce behavior that leads to lost class time or discipline; and strengthen the family's capacity to support success at school and in the community.

2. Standing Up the Program

Before a single unit is billed, the agency needs its licensure, DMAS enrollment, Cardinal Care Managed Care Organization (CCMCO) contracting, accreditation pathway, and — unique to this service — a signed MOU with each school division where it will work. Work these steps in parallel where possible; several have clocks that start on your DMAS enrollment effective date.

2.1 Licensure, enrollment sequence and CCMCO contracting

- 1. Obtain the correct DBHDS license.** 03-021 (MH Non-Center-Based CPST for Children and Adolescents). If you will serve youth ages 18 to under 21, you also need 03-020 (MH Non-Center-Based CPST for Adults). Licenses must be active and in good standing (conditional, annual, or triennial) (§7.1).

- 2. Enroll with DMAS.** Provider type 156 (Behavioral Health Services) or 456 (Behavioral Health Clinic and Services); specialty **924 (CPST – School Setting)**; taxonomy 251S00000X; Type 2 organizational NPI tied to the 03-021 license (and to the 03-020 license, if applicable) (§7.2).
- 3. Submit required enrollment attachments.** The DBHDS license(s), and evidence you have initiated accreditation or are accredited.
- 4. Submit CCMCO contracting applications.** Apply to each CCMCO.
- 5. Execute a school division MOU** for every division (or VCPE-recognized private school) where you will deliver services — see 2.2.
- 6. Complete accreditation within 18 months** of the specialty's effective date in the DMAS Provider Enrollment System and submit accreditation updates within 30 calendar days of any change (§7.3).
- 7. List staff on the CPST Directory.** Submit each CPST staff member's qualifications to the Center for Evidence-Based Partnerships (CEP-VA) CPST Directory and keep it current (§7.5).

Keep these clocks visible

5 business days to notify the MCO and each affected family when an MOU lapses or a youth transfers outside MOU coverage.

30 calendar days to submit accreditation updates, and MOU amendments when a school is added or removed.

18 months to complete accreditation and for LMHP/LMHP-types to earn the MAP credential.

12 months for all staff to complete required skills-training curricula. *[Verify against Attachment 1 — not in the portion of the draft reviewed]*

2.2 School division partnerships and the MOU

The MOU is the operating agreement that makes school-based delivery possible. Providers **shall** maintain a current MOU with each Virginia public school division, or with each private school recognized by the Virginia Council for Private Education (VCPE), where services are delivered (§7.4).

- 1. Renew annually.** The MOU is reviewed and signed by both parties every year.
- 2. List every school.** A public-division MOU names each school (and its address) where services are delivered and is amended within **30 calendar days** of adding or removing a school.
- 3. Reference your crisis consultation policy.** Each MOU must reference the provider's crisis consultation policies, so school personnel know how and when CPST consultation is available during the instructional day (§4.5).

At a minimum, every MOU must address the following (§7.4):

MOU element	What to settle with the division
Space	Private, confidential space adequate for clinical services, and a backup process when it is unavailable
Scheduling	A protocol that minimizes lost instructional time and does not routinely pull a youth from the same class period
Staff clearance	Compliance with division background check, fingerprinting, visitor identification, and building access requirements
Information exchange	Terms for exchanging information between provider and division, including consent
School functioning data	How and how often the division provides the indicators required at §3.1.3 (see 5.4)
Crisis coordination	Division threat assessment and emergency procedures, the role of CPST staff in an instructional-day crisis, and the notification sequence
Mandated reporting	Who reports, and how coordinated reporting works when both provider and school staff hold the obligation
Points of contact	A division-designated school liaison for each school and a corresponding provider point of contact
Treatment planning	The division's commitment to make school personnel reasonably available to participate in treatment planning
Disputes	A dispute resolution process
Termination	A notice period of at least 60 calendar days and both parties' obligations to support continuity of care during it

If an MOU lapses

Notify the MCO and the parent or legally authorized representative of **each affected youth within 5 business days**. Continue services in the home or other community settings during the transition (see 9.2). A youth **shall not** be discharged solely because an MOU lapsed, was terminated, or was not renewed (§7.4).

Recommended: calendar MOU renewal dates at least 90 days out so a lapse never reaches families.

2.3 Policies you must have in place

The appendix requires the agency to maintain written policies and procedures across several areas. Build these before go-live:

- 1. EBP identification** — which evidence-based protocols, principles, practices, and policies you incorporate, and how staff are trained in each (§3).
- 2. Crisis consultation & 24/7 availability** — how an experienced LMHP (1+ year with SMI/SED) is reachable on call at all hours; how in-school staff reach that LMHP immediately with a response **within 15 minutes** during the instructional day and

within 30 minutes at all other times; and how the on-call LMHP and any after-hours line can see the crisis mitigation plan in real time (§4.5, §5.3.2).

3. In-person support arrangement — how the Clinical Director’s in-person support is arranged within a clinically appropriate timeframe, including travel to a youth’s location when needed (§4.2).

4. Service delivery and staff caseloads — established and maintained by the Clinical Director (or a designated administrator) (§1).

5. Caseload protection and outside-employment disclosure — how staff are protected from high caseloads and required to disclose other Medicaid-billed employment.

6. Recommended: School operations procedures — MOU renewal tracking, school calendar continuity planning, school transfers, information-exchange and consent workflows, and coordinated mandated reporting.

3. Staffing the Team

CPST is built on a tiered workforce. Understanding who can do what and who oversees whom, is the foundation for scheduling, supervision, and billing. In a school program, every team member also has to be cleared to work in the building under the division’s MOU.

3.1 Roles at a glance

Role	Who / credential	Core responsibilities
CPST Clinical Director	Full-time LMHP with a current, active, unrestricted Virginia (DHP) license	Overall clinical and programmatic oversight; accountable for quality, integrity, and compliance; may also serve as LMHP Clinical Supervisor and carry a caseload if it does not compromise oversight
LMHP Clinical Supervisor	LMHP (fully licensed to practice independently)	Recommends, oversees, and supervises services; authorizes ISPs; leads IEP/504 team collaboration; provides or delegates clinical supervision
LMHP-type	LMHP-R, LMHP-RP, or LMHP-S (resident/supervisee)	Assessment, treatment planning, psychotherapy; assessments require LMHP review and co-signature
QMHP / QMHP-T	Qualified Mental Health Professional (incl. trainee)	Restorative life skills, care coordination, crisis support; may assist with assessment and treatment-planning information gathering
BHT	Behavioral Health Technician (Tier 2 only)	Rehabilitation Skills Practice component only

One Clinical Director rule

A CPST Clinical Director cannot serve as Clinical Director for more than one DBHDS-licensed agency. Within the same licensed agency, one director may oversee both a youth and an adult CPST program. An LMHP titled “Clinical Supervisor” who performs all Clinical Director duties meets the requirement regardless of title. Through 06/30/2029, DMAS allows the Director and LMHP Clinical Supervisors to hold LMHP-type status with 50% or fewer supervision hours remaining, and honors specific DBHDS variances (§1, §4.1–4.2).

3.2 Who can deliver each service component

Match staffing to the component. This table also determines who bills which code/modifier combination (see Section 11).

Service component	Qualified staff	Delivery notes
Assessment (incl. CANS Lifetime)	LMHP, LMHP-type (CANS-certified)	One-to-one; in person at home, school, or a family-chosen location; LMHP-type requires LMHP co-signature; CANS-certified QMHP/QMHP-T may assist
Treatment Planning / ISP	LMHP, LMHP-type	Face-to-face with youth, family, and natural supports; school personnel invited; QMHP/QMHP-T may assist with information gathering
Psychotherapy	LMHP, LMHP-type	Individual or group; telemedicine if clinically appropriate
Restorative Life Skills Training	LMHP, LMHP-type, QMHP, QMHP-T	Focused on functioning in the school day; individual or group; at least half of units in person
Care Coordination	LMHP, LMHP-type, QMHP, QMHP-T	One-to-one; includes ongoing coordination with the school team and IEP/504 alignment
Crisis Support	LMHP, LMHP-type, QMHP, QMHP-T	One-to-one; 24/7/365; response tiered by time of day (Section 6)
Rehabilitation Skills Practice (Tier 2)	LMHP, LMHP-type, QMHP, QMHP-T, BHT	In person, one-to-one only; practiced in vivo in classrooms, hallways, cafeteria, and transitions

3.3 Required training by credential

All staff complete a foundational curriculum plus role-specific youth training, accessed through the DBHDS Learning Management System, with documentation flowing to CEP-VA at VCU (Attachment 1, §1).

Credential	Foundational	Role-specific (Youth)
LMHP / LMHP-type	Foundational Skills Curriculum (FSC)	MAP Credentialed Therapist; CANS Lifetime certification for anyone completing assessments
QMHP / QMHP-T	Foundational Skills Curriculum (FSC)	CPST Intermediate Skills (IS); CANS Lifetime certification if assisting with assessments
BHT	DBHDS BHT Academy	CPST Intermediate Skills (IS)

MAP credential (Youth programs)

Every youth-serving agency must have at least one LMHP who is a MAP Credentialed Therapist. All LMHP/LMHP-types who provide or supervise youth CPST must be MAP-credentialed or actively working toward it, with **18 months** from enrollment or hire to complete the PracticeWise Direct Services Curriculum, six months of consultation, and the Therapist Portfolio review.

Recommended school onboarding: division background check and fingerprinting cleared before first school visit; orientation to each school's bell schedule, visitor procedures, emergency and threat-assessment protocols, and the MOU's mandated-reporting process; introductions to each school liaison.

4. Delivering Service in the School Setting

4.1 Where services happen

- 1. School first.** Covered components are provided primarily in the school setting — a public school or a VCPE-recognized private school (§1, §5).
- 2. Home when it serves school goals.** Services may be delivered at home when the ISP identifies home-based goals directly tied to school functioning (§2).
- 3. Office cap.** Services in the provider's DBHDS-licensed office may not exceed **three (3) hours per week (Sun–Sat) per youth** and must be for the youth's benefit (§9.3).
- 4. No segregated settings.** Services are not provided in segregated, disability-specific, or institutional settings unless temporarily necessary for acute safety concerns (§9.3).
- 5. Tie every location to a goal.** The service location is documented in the ISP and linked to a specific goal or objective (§5.2.1(G)).

4.2 Scheduling around instruction

The MOU must commit the provider to a scheduling protocol that **minimizes lost instructional time and does not routinely pull a youth from the same class period** (§7.4). Because loss of instructional time is also a tracked outcome (see 5.4), scheduling is a clinical issue as well as a courtesy to the school.

- 1. Recommended:** rotate session times across periods and days; avoid core-content blocks and assessments flagged by the teacher.

2. Recommended: use naturally occurring settings — arrival, transitions, lunch, recess, and dismissal — for rehabilitation skills practice and in-vivo coaching, where skills actually need to work.

3. Recommended: confirm the private space in advance each week and keep a documented backup space per the MOU.

4.3 Individual (one-to-one) vs. group

Most components are delivered one-to-one. Two may be delivered in groups when clinically appropriate and approved by the LMHP Clinical Supervisor (§9.3).

Component	One-to-one required?	Group ratios & rules
Assessment / CANS Lifetime	Yes	Group not permitted
Treatment Planning / ISP	Yes	Group not permitted
Care Coordination	Yes	Group not permitted
Crisis Support	Yes	Group not permitted
Rehabilitation Skills Practice (Tier 2)	Yes	Group not permitted
Restorative Life Skills Training	Individual or group	Group ≤ 1 staff : 6 youth
Psychotherapy	Individual or group	Group ≤ 1 LMHP/LMHP-type : 8 youth per §6.1

The in-person / individual minimums that trip people up

Restorative Life Skills: at least half of units per authorization must be in person; telemedicine may not exceed half of the units billed per week, and the rationale is documented in the ISP and progress note.

Tier 2 Restorative Life Skills: at least half of units per authorization must be delivered individually (one team member per youth); the remainder may be group.

Rehabilitation Skills Practice: 100% in person, one-to-one — never telehealth, never group, and never without the youth present.

4.4 Telehealth boundaries

1. Restorative Life Skills: telemedicine allowed if clinically appropriate, in consultation with the LMHP Clinical Supervisor and with the youth's documented agreement; not more than half of weekly units.

2. Psychotherapy: telemedicine allowed when clinically appropriate, in consultation with the LMHP Clinical Supervisor and the youth.

3. Crisis Support: telehealth or in person, as clinically justified and documented; in-person response available when the plan or situation requires it.

4. Rehabilitation Skills Practice and Assessment/CANS: in person only.

4.5 Caregiver participation

Admission requires an identified caregiver or legally authorized representative who is available and willing to participate — an adult with legal custody or primary caregiving responsibility who engages in family and caregiver psychotherapy and service activities. The caregiver commits to an average of **at least 30 minutes per week (Tier 1) or one hour per week (Tier 2)** of covered components (§8.1–8.2). As identified in the ISP, services may occur with the family or caregiver without the youth present, except Rehabilitation Skills Practice (§9.3).

When no caregiver can participate

A youth may still be admitted when the LMHP documents all of the following: the circumstances preventing caregiver participation (e.g., foster or congregate care, housing instability, unaccompanied status, incarceration, work schedule); the engagement efforts made and their outcome; an alternative adult support and their agreed role (e.g., kinship caregiver outside the home, foster parent, local DSS worker, CASA, or designated school staff member); and a continued-outreach plan reviewed at every 90-day ISP review.

The MCO **may not deny** authorization solely because no caregiver is participating when this documentation is present (§8.1(7)).

4.6 What is not billable in a school

Being in the room is not a service

Treatment must be the active delivery of an intervention identified on the ISP. **Passive observation of a youth without an intervention is not billable** — a real risk in classroom settings, so train staff to document the intervention delivered, not the time present (§9.1).

Also not reimbursable: calls to schedule, confirm, or cancel; paperwork and documentation (and requiring the youth to be present to complete it); team meetings held only among provider staff without the youth or family; staff research on the youth's behalf; and summer camps, after-school programs, or other group programming billed as rehabilitation (individually authorized services during breaks remain allowed).

5. Working With the School Team

The appendix builds structured collaboration with the school into the ISP, the review cycle, and care coordination. These requirements are the heart of what makes CPST – School Setting different from community-based CPST.

5.1 Aligning the ISP with an IEP or 504 plan

Where a youth has a current IEP or Section 504 plan, the ISP **shall** (§5.2.1(J)):

1. Identify each IEP/504 goal related to behavioral, emotional, or social functioning.

2. State for each such goal whether it is addressed by the IEP/504 plan, by CPST, or by both.
3. For any goal addressed by both, document how CPST differs in scope, intensity, or method from the school-delivered service.
4. Name the school personnel responsible for school-delivered components and the mechanism for ongoing coordination.

Situation	What the LMHP must do
Youth has an IEP or 504 plan	Attend at least one IEP or 504 team meeting per service authorization period — or, if not practicable, submit written clinical input and document both the submission and why attendance was not practicable (§5.2.1(K))
Youth has no IEP or 504 plan, but impairment may affect educational performance	With parental consent, communicate that observation to the school team in writing. The provider does not initiate or conduct special education evaluations — that remains the local education agency's role (§5.2.1(L))

5.2 Bringing school personnel into treatment planning

The provider **shall** invite designated school personnel to participate in ISP development and each review, and document every invitation, who was invited, whether they participated, and, if they did not, how school input was obtained instead. School non-participation is **not** grounds for denying admission, denying authorization, or discharge, provided reasonable efforts and alternative input are documented (§5.2.2).

5.3 Avoiding duplication with FAPE

CPST cannot bill for what the school must provide

CPST – School Setting **shall not** be billed for any service the local education agency must provide at no cost as a free appropriate public education (FAPE) under IDEA, including counseling or other related services on the IEP (§9.2(8)).

Where an IEP related service overlaps with a CPST component, the ISP must identify the overlap, which entity is responsible, and the clinical rationale for any CPST intervention in the same domain. Document this at admission and review it at every 90-day ISP review and every authorization renewal. CPST can still be delivered when the youth's clinical need exceeds the scope, intensity, or duration of the IEP service — as long as the incremental need is documented.

5.4 School functioning indicators

In addition to the CANS Lifetime, document these indicators **at admission and at each 90-day ISP review** (§3.1.3):

Indicator	What to record
Attendance	Attendance rate for the preceding reporting period, including unexcused absences and tardies

Indicator	What to record
Discipline	Number of disciplinary referrals and days of in-school and out-of-school suspension
Instructional time lost	Estimated instructional time lost to behavioral health–related removal from class
Placement	Any change in educational placement or setting

Indicators come from school division records under the MOU's information-exchange procedure. When school data are unavailable, document why and record the indicator from caregiver and youth report, labeled as such. These indicators also feed step-down decisions (see 10.3).

6. Crisis Support in the School Setting

Crisis support is available **24 hours a day, 7 days a week, 365 days a year** — it is not limited to the instructional day. What changes by time of day is how, and how fast, the provider responds (§5.3, §5.3.3).

Crisis: internal first

CPST providers prioritize internal crisis support and prevention before escalating to external resources and establish the CPST provider as the youth's primary crisis contact. Youth and families are encouraged to contact the provider (or 988) before 911 when it is safe to do so — but nothing limits the right to call 911 or 988 directly at any time, and that decision is never discouraged. A youth's independent use of a crisis resource is not a provider referral and does not count against the provider.

6.1 Tiered response by time of day

	During the instructional day	Evenings, weekends, breaks, and out of session
First response	The CPST team member in the building initiates internal crisis support under the crisis mitigation plan and attempts de-escalation before external resources — unless acuity precludes it or school officials direct otherwise	Provider-delivered internal crisis support by telephone or telemedicine under the crisis mitigation plan
On-call LMHP	Immediate, direct access for any team member (including QMHP, QMHP-T, BHT); LMHP responds within 15 minutes	Reachable by telephone; responds within 30 minutes

	During the instructional day	Evenings, weekends, breaks, and out of session
In-person arm	Qualified CPST staff present in the building	Mobile Crisis Response, the Regional Crisis Hub, or 988 may be designated in the plan when CPST staff cannot respond in person in time — the provider stays engaged and resumes services
Governing procedures	School division emergency, behavioral threat assessment, and student safety procedures; nothing limits school officials' authority	Crisis mitigation plan and §5.3.2 procedures

Never leave a youth without a response

Tiering adjusts how the provider responds; it never reduces the hours crisis support is available. Where Mobile Crisis Response or a Regional Crisis Hub is not reliably available in the youth's area, the crisis mitigation plan must name an alternative in-person resource, and the provider documents the arrangement (§5.3.3(C)). Designating an external after-hours responder is coordination of modality — it is not a substitute for the crisis mitigation plan itself.

6.2 The school-ready crisis mitigation plan

The crisis mitigation plan is completed and signed by all team members and the youth or legal representative **within 30 calendar days of admission** and updated regularly (§5.3.1). For school-setting youth it must also:

1. Spell out the response **during** the instructional day and the response **outside** it.
2. Identify school-specific triggers, settings, and times of day associated with escalation.
3. Record the youth's preferred de-escalation strategies and safe locations in the building.
4. Name the designated school personnel who will be informed of the plan and their agreed role.
5. Lay out the instructional-day response sequence — who is contacted, in what order, and when CPST staff are engaged.
6. State when and how the parent or legally authorized representative is contacted.
7. Address high-risk periods, including transitions into and out of school breaks, and the youth's capacity to self-initiate contact with 988.

Share the plan with school personnel under the MOU's information-exchange and consent terms and review it with them **at least annually and after any instructional-day crisis**. The plan must be consistent with, and never conflict with, the division's

emergency, behavioral threat assessment, and student safety procedures (§5.3.1(E)–(F)).

6.3 When external escalation is appropriate

Internal crisis support is attempted first except when an acute condition is present: immediate physical danger requiring 911; active suicidal or homicidal ideation with plan and means where a safe, timely in-person CPST response cannot be initiated; a need for immediate medical assessment; or a youth in an unknown location who cannot be reached (§5.3.2(A)). When the provider does refer to an external crisis resource, it must:

1. Stay actively engaged, coordinate with responders, and send the current ISP and crisis mitigation plan at the time of referral.
2. Contact the youth's MCO.
3. Document interventions attempted (or the acute condition that precluded them), time, location, interventions provided, and continuity steps.
4. Follow up as soon as practicable to debrief, update the plan, and reinforce self-directed crisis response.

The CPST provider and its affiliates may not provide Mobile Crisis Response, 23-Hour Crisis Stabilization, or Residential Crisis Stabilization to youth receiving CPST (CSBs licensed for 23-hour or residential crisis stabilization excepted) (§9.2(2)).

7. Caseloads

Caseload limits protect quality and staff sustainability. The appendix points to Attachment 1, Section 3 for staff caseloads and LMHP supervision of cases. The figures below mirror the CPST – Community requirements.

7.1 Weighted staff caseload (primary-component staff)

For staff providing Restorative Life Skills Training, Care Coordination, and/or Crisis Support, the **weighted caseload shall not exceed 20**. Blended Tier 1 / Tier 2 caseloads are recommended.

Weighted caseload formula

Weighted caseload = (Tier 2 youth × 2.5) + (Tier 1 youth) — must not exceed 20

Example: 4 Tier 2 youth (4 × 2.5 = 10) + 10 Tier 1 youth = 20. At capacity.

Recommended for school programs: group caseloads by building where possible to cut travel between schools and keep staff present when crises occur.

Compliance is measured as a **6-month rolling monthly average** from a formal caseload log kept for each staff member.

7.2 Non-licensed staff unit cap

750 units / month

Non-licensed staff (LMHP-types, QMHP, QMHP-T, BHT) may bill no more than 750 CPST units per calendar month **across all agencies where they are employed**, assessed on a rolling 6-month average and subject to audit — which is why outside-employment disclosure is a required policy.

7.3 LMHP oversight (supervision of cases) caps

Oversight scenario	Max cases / month
Oversight primarily of fully-licensed LMHPs / LMHP-types doing assessment, treatment planning, psychotherapy	120
Mixed team (LMHP-types + paraprofessionals) — Director sets cap by documented composition	Up to 100
Oversight primarily of QMHPs / QMHP-Ts / BHTs (LMHP directly provides assessment & treatment planning)	75

The Clinical Director determines how many cases can be managed with appropriate attention to quality and safety — the numbers above are ceilings, not targets.

8. Supervision & Team Meetings

Supervision in CPST is relationship-based, work-focused education and oversight delivered on a required monthly cadence that scales with credential and workload (Attachment 1, §2). The figures below mirror CPST – Community.

8.1 The three functions of supervision

- 1. Educational / Clinical:** teaching therapeutic skills and building self-awareness and clinical judgment.
- 2. Regulatory Compliance:** translating policy into practice standards, documentation, licenses, certifications, and continuing education. May be handled by a separate QA/compliance role if documented.
- 3. Supportive:** helping staff manage the emotional demands of the work — especially important for staff working alone inside a school building.

8.2 Minimum supervision by credential

Credential & workload	Frequency	Min. individual + group / month	Min. individual, group + related activities / month
LMHP, full-time	Monthly	1 hour	1 hour
LMHP-type, QMHP, QMHP-T, BHT — full-time, or part-time with 10+ cases	Weekly	2 hours (≥ 1 hr individual)	4 hours

Credential & workload	Frequency	Min. individual + group / month	Min. individual, group + related activities / month
LMHP-type, QMHP, QMHP-T, BHT — part-time with < 10 cases	Weekly	1 hour	2 hours

Where a DHP licensing board requires more supervision (e.g., for residents/supervisees), the higher standard governs. Board-required supervision counts toward CPST requirements only if provided by an LMHP employed by or under contract with the CPST agency.

8.3 What counts as supervision time

Supervision-related activities that may count toward the monthly totals include:

Individual supervision sessions	Group supervision	Case consultation
Clinical documentation review	Clinical case oversight (collaborative BH)	Rehabilitative skills practice planning
Direct observation	Co-treatment sessions	Performance evaluation
Training and education	Crisis intervention oversight	Ethical & legal guidance
Professional development planning		

Team meetings and collaborative oversight

Because CPST is a collaborative behavioral health service, the team must actively communicate. Two activities structure this: **clinical case oversight** — two-way communication and collaborative treatment planning between the staff doing assessment/treatment-planning/psychotherapy and those doing skills, care coordination, crisis, and rehab-skills-practice; and **rehabilitative skills practice planning** — collaborative activity planning with the Tier 2 rehab-skills staff. Build recurring team meetings that produce this documented, two-way collaboration.

8.4 Oversight and team collaboration

1.90-day LMHP face-to-face. The LMHP or LMHP-type responsible for assessment, treatment planning, and psychotherapy sees each youth face-to-face at least every 90 calendar days for an ISP review, a functional reassessment, or a psychotherapy session, documented in a progress note (§4.3).

2.Delegation keeps accountability. An LMHP/LMHP-type may delegate information gathering and documentation to a QMHP or QMHP-T but remains responsible for the accuracy and quality of all assessments, diagnoses, and ISPs (§4.4).

3. Documented two-way collaboration. Build recurring team meetings for clinical case oversight and rehabilitative skills practice planning. Note that team meetings among provider staff alone are not billable (§9.1).

4. Documentation. All supervision and supervision-related activities are documented and available on request; supervision under 12VAC35-105 is in addition to these requirements.

9. The Clinical Operating Rhythm

Once staffed and trained, the program runs on recurring clinical obligations — plus a second set of obligations driven by the school calendar. Build both into scheduling and EHR workflows to prevent authorization and audit problems.

9.1 Clinical cadence

Cadence	Obligation
Before authorization	CANS Lifetime completed ≤ 30 days before the preservice request (or a prior CANS ≤ 12 months old reviewed and attested by the admitting LMHP); youth assessed and referred for any qualifying standalone EBP
Within 1 business day of admission	Preservice service authorization request submitted
At admission	School functioning indicators baselined; IEP/504 alignment and FAPE overlap documented; caregiver (or alternative adult support) documented
Within 30 days of admission	Crisis mitigation plan completed and signed by all team members and the youth/representative, including school-specific elements
Every 90 days (minimum)	LMHP/LMHP-type face-to-face; formal ISP review face-to-face with school personnel invited; school functioning indicators; FAPE overlap review; caregiver outreach plan review where applicable
Each authorization period	LMHP attends ≥ 1 IEP/504 meeting or submits written input; FAPE overlap reviewed at renewal
After 180 days without significant progress	Provider and MCO develop an alternative ISP
Annually	CANS Lifetime reassessment (every 365 days until discharge); crisis mitigation plan reviewed with school personnel; MOU re-signed
At 18 months at the same Level of Need	Reassess and refer to clinically appropriate standalone EBPs; notify MCO; update ISP with transition plan; authorization period drops to 3 months
24/7/365	Crisis support accessible; experienced LMHP on call (≤ 15 min instructional day / ≤ 30 min otherwise)

9.2 School calendar and transition events

Event	Obligation
≥ 15 days before summer recess or any break > 10 instructional days	LMHP documents a written continuity plan in the ISP: frequency, duration, and location of services; components and goals; risks of lost routine and mitigations; and the plan to resume school-based delivery (§9.4)
During breaks and closures	Authorization stays in effect; enrollment may not be ended solely because school is out; services continue at home or in the community on school-functioning goals
After any instructional-day crisis	Follow up with the youth; review the crisis mitigation plan with school personnel
Transfer within the same division	Verify MOU coverage; convene an ISP review within 10 business days
Transfer to another division or uncovered school	Notify MCO within 5 business days; execute a new MOU or coordinate transfer to a provider that holds one; home/community services up to 60 days; no discharge solely due to transfer
MOU lapse or termination	Notify MCO and each family within 5 business days; continue services at home/community; no discharge solely due to lapse

10. Billing Essentials

CPST is billed in 15-minute units against the base code H0036 with component- and population-specific modifiers. The right combination depends on the service component, and the staff credential.

10.1 Core billing rules

- 1. Bill active intervention only.** Time must reflect delivery of an ISP intervention; passive observation in a classroom is not billable (§9.1).
- 2. Never bill FAPE services.** Do not bill for counseling or related services the school must provide under the IEP (§9.2(8)).
- 3. Bill only face-to-face time**, with telehealth exceptions for Care Coordination and Crisis Support; travel between schools, homes, and the office is never billable.
- 4. Rate unit is 15 minutes** for every component.
- 5. Simultaneous billing is limited** to Assessment and Treatment Planning by an LMHP/LMHP-type and a QMHP when clinically needed and documented.
- 6. Extra psychotherapy units:** where an authorization includes the additional 16 units/month for psychotherapy, those units may be billed only for the psychotherapy component.

11. Implementation Checklist

A consolidated readiness checklist for launching or realigning a CPST – School Setting program.

Licensure & enrollment

- 1.DBHDS 03-021 license obtained (plus 03-020 if serving ages 18 to under 21), active and in good standing
- 2.DMAS enrollment complete (type 156/456; specialty 924; taxonomy 251S00000X; Type 2 org NPI)
- 3.Accreditation initiated; full accreditation on track within 18 months
- 4.CCMCO contracting applications submitted
- 5.Staff qualifications submitted to the CEP-VA CPST Directory and kept current

School partnerships

- 1.MOU signed with each division or VCPE-recognized private school, listing every school served
- 2.All MOU elements addressed: space, scheduling, clearances, information exchange, indicator data, crisis coordination, mandated reporting, liaisons, treatment-planning participation, disputes, 60-day termination notice
- 3.Crisis consultation policy referenced in each MOU
- 4.MOU renewal dates and 30-day amendment triggers tracked; lapse-notification workflow ready

Staffing & training

- 1.Full-time LMHP Clinical Director designated
- 2.LMHP Clinical Supervisor(s) identified; oversight caps mapped to team composition
- 3.At least one MAP Credentialed Therapist; MAP pathway underway for all LMHP/LMHP-types
- 4.FSC / IS / BHT Academy enrollment underway; completion clock tracked
- 5.Assessors CANS Lifetime–certified
- 6.Division background checks, fingerprinting, and building access cleared for every school-based staff member

Operations & policy

- 1.Required policies drafted: EBP identification, 24/7 crisis consultation with 15/30-minute response standards, in-person support arrangement, service delivery and caseloads, caseload protection, outside-employment disclosure
- 2.Caseload logs established; weighted-caseload and 750-unit trackers built with 6-month rolling averages
- 3.Supervision schedule set to credential-based minimums; documentation workflow in place

4. Recurring team meetings scheduled to produce documented collaborative case oversight
5. School calendar continuity planning scheduled at least 15 days before summer and long breaks

Clinical workflow & EHR

1. ISP template includes IEP/504 goal crosswalk, FAPE overlap determination, service locations tied to goals, and school-personnel invitation log
2. School functioning indicator fields built for admission and each 90-day review
3. Crisis mitigation plan template includes instructional-day and after-hours responses and all school-specific elements
4. Cadence built into EHR: 30-day crisis plan, 90-day face-to-face/ISP review, per-authorization IEP/504 participation, 365-day CANS, 18-month EBP re-evaluation

Billing

1. Billing system configured with the §12.2 code/modifier combinations
2. Staff trained that passive observation, travel, and FAPE services are not billable
3. Simultaneous-billing rule configured and documented

This guide summarizes operational requirements from the draft CPST – Youth, School Setting Provider Policy Appendix (08.31.2026 v2) for provider implementation. It does not supersede the appendix, the Mental Health Services Manual, or DBHDS licensing regulations (12VAC35-105). Verify all specifics against the current published appendix and MCO requirements before go-live.