



United Behavioral Health

## Supplemental Clinical Criteria: Virginia Medicaid

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### INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*<sup>1</sup> defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*<sup>2</sup> may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®<sup>3</sup>. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required,

<sup>1</sup> **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

<sup>2</sup> **Clinical Criteria**

**(Level of Care Utilization System-LOCUS)** Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.

**(Child and Adolescent Service Intensity Instrument-CASII)** -Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

**(Early Childhood Service Intensity Instrument-ECSII)** - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.

**(ASAM Criteria)** Criteria used to make medical necessity determinations for substance-related disorder benefits.

<sup>3</sup> Optum is a brand used by United Behavioral Health and its affiliates.

or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

#### EVIDENCE-BASED PRACTICE CRITERIA

In addition to the applicable Clinical Criteria, for all services, treatments and levels of care, services are delivered according to evidence-based practices consistent with the applicable definition of Medical Necessity and the following:

- Services are:
  - Provided under an individualized plan of treatment or diagnostic plan developed in conjunction with providers of appropriate disciplines on the basis of a thorough evaluation of the member's strengths and disabilities;
  - Supervised and evaluated by the most appropriate physician or provider;
  - For the purpose of diagnosis or services are reasonably expected to improve the member's condition:
    - It is not necessary that a course of therapy have as its goal restoration of the member to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some members. For many other members, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement.
    - "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the member's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
- The individualized written plan includes the type, amount frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals.
- For continued service, the member continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice.
- Discharge is indicated when stability can be maintained without further treatment or with less intensive treatment.
  - Discharge planning includes linkages with community resources, supports, and providers in order to promote a member's return to a higher level of functioning in the least restrictive environment.
  - A discharge plan and a summary with recommendations for appropriate services concerning follow-up or aftercare have been developed as well as a summary of the member's condition upon discharge.

## MENTAL HEALTH: BEHAVIORAL THERAPY SERVICES

**BEHAVIORAL THERAPY SERVICES** are systematic interventions provided by licensed practitioners within their scope of practice to individuals younger than 21 years of age in the individual's home. Behavioral therapy includes, but is not limited to, Applied Behavior Analysis (ABA).

Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure that the individual's family is trained to effectively manage the individual's behavior in the home using behavior modification strategies.

### Admission Criteria

- The enrollee is under 21 years of age and enrolled in Medicaid/FAMIS Plus or FAMIS Fee-for-Service.
- The enrollee has a medical need for behavioral therapy. The need for behavioral therapy has been identified through the enrollee's physician, nurse practitioner, or physician assistance with knowledge of the enrollee's developmental history and current status as medically necessary to correct or ameliorate significant impairments in major life activities that have resulted from developmental, behavioral, or mental disabilities.
- The enrollee is medically stable to benefit from treatment at this level of care.
- The enrollee has a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that is relevant to the need for behavioral therapy or has a provisional psychiatric diagnosis as developed by a Licensed Mental Health Professional (LMHP) when no definitive diagnosis has been made.
- The enrollee meets at least 2 of the following criteria on a continuing or intermittent basis:
  - Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language.
  - Severe impairment in social interaction/social reasoning/social reciprocity/and interpersonal relatedness.
  - Frequent intense behavioral outbursts that are self-injurious or aggressive towards others.
  - Disruptive obsessive, repetitive, or ritualized behaviors.
  - Difficulty with sensory integration.
- The enrollee has a level of impairment which requires treatment that cannot be provided by another Department of Medical Assistance Services (DMAS) program or a lower level of care/service and requires behavioral interventions and the expertise of a LMHP, Licensed Behavior Analyst (LBA), or Licensed Assistant Behavior Analyst (LABA). The provider documents that less intensive treatment modalities have been ruled out (and why), or have been tried but have not been successful in effectively modifying the target behavior.
- Behavioral Therapy is expected to increase appropriate social-communicative interactions and pivotal responses within a social framework, increase adaptive functioning and produce beneficial changes in pivotal responses that result in more widespread behavioral changes across a number of other non-targeted behaviors.
- The enrollee is willing to participate in services.
- Family and caregivers lack the skills needed to effectively manage the enrollee's behaviors in the home environment. Training is necessary to educate the family and caregivers concerning the enrollee's diagnosis and to reach effective behavioral management techniques. At least one family member or caregiver must be able to participate in services to effectively support the enrollee being served. The family or caregiver must agree to participate in services, receive behavioral management training, and implement behavioral strategies to maintain the enrollee's progress during and after treatment.
- Services are medically necessary.
- None of the following conditions exist:
  - The enrollee has attained behavioral control and only requires services such as social skills enhancement.
  - The enrollee is eligible to receive Community Mental Health Rehabilitation Services (CMHRS).

## Continuing Stay Criteria

- The enrollee's primary care provider or a physician nurse practitioner or physician assistant familiar with the enrollee's development history and current status has provided an updated order or letter of recommendation.
- Continuation of services must include the following information:
  - Any change in the enrollee's diagnosis.
  - A summary of recommended therapy goals.
    - Based on the needs of the enrollee and family/caregiver, it may be appropriate to request a service authorization extension at a reduced number of hours to assist the enrollee and family to successfully transition from a higher intensity of Behavioral Therapy services to a lower level of service.
  - A description of how the current therapy protocol is impacting the enrollee's clinical progress.
  - Objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values and specific references to each goal and objective in the individual service plan (ISP).
  - Overview of family involvement during service period with regards to the individual's ISP to include: who has been involved; progress made; and continuing needs of family goals/training to include reasons the individual and parent/caregiver need continued clinically directed Behavioral Therapy.
  - A summary of progress towards generalization of adaptive functioning in multiple settings to include assessing for maintenance of the skills acquired and updating the ISP as needed to test for generalization of skills in multiple environments.
  - A description of any services gaps (no greater than 30 calendar days) and how the lapse in service affected treatment planning and progress, service coordination and family learning and family/caregiver involvement in the application of behavior modification practices.
  - The reason the enrollee needs continued clinically directed behavioral therapy.
  - The reason the enrollee's continued therapy cannot be managed in a lower level of care.
- There is a Service Coordination Summary that contains the following information:
  - A description of all service coordination and/or referral activities that were scheduled to be implemented by the caregivers and provider within the previously authorized time period.
  - A discussion of how the service coordination served to facilitate treatment plan outcomes based on the assessed needs of the enrollee and the desired service outcomes of the caregivers.
  - A description of how the referrals to medical services (such as Speech-Language Pathology services, Occupational Therapy, Physical Therapy, Neurological services and Psychiatric services) have impacted the overall progress and generalization of skills gained from behavioral therapy services.
- There is a Generalization Summary that contains the following information:
  - Progress regarding specific parent/caregiver involvement goals and objectives including a description of the methods used to measure progress within each goal area.
  - Progress toward achieving educational goals with other care providers (Medicaid Home and Community Based Waiver funded attendants, relatives, etc.) who routinely come in contact with the enrollee.
  - The generalization of adaptive functioning in multiple settings.
  - Progress toward the anticipated date of discharge from services including any plan to gradually reduce services and consultative action.
  - Justification of the ongoing need to have a clinician involved with the parent/caregiver to provide behavioral therapy and why services cannot be provided at a lower level of care.

## Discharge Criteria

- Any of the following conditions are met:

- No meaningful or measurable improvement has been documented in the individual's behavior(s) despite receiving services according to the treatment plan; there is reasonable expectation that the family and/or caregiver are adequately trained and able to manage the enrollee's behavior; and termination of the current level of services would not result in further deterioration or the recurrence of the signs and symptoms that necessitated treatment.
- Treatment is making the symptoms persistently worse or the enrollee is not medically stable for behavioral therapy to be effective.
- The enrollee has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate.
- The enrollee demonstrates an inability to maintain long-term gains from the proposed plan of treatment.
- The family and/or caregiver refuses or is unable to participate meaningfully in the behavioral plan.

### **Service Delivery**

- The following are clinical best practices for Applied Behavior Analysis.
  - **Evaluation & Treatment Planning**
    - Once a diagnosis has been established:
      - A standardized functional assessment is used to maximize the effectiveness and efficiency of behavioral support interventions. The assessment may incorporate information such as interviews with caregivers, structured rating scales, direct observation data, and attention to coexisting medical conditions.
      - Targets include areas such as the following:
        - Communication skills
        - Language skills
        - Social interaction skills
        - Restricted, repetitive patterns of behavior, interests, or activities
        - Self-injurious, violent, destructive or other maladaptive behavior
      - A credentialed provider with ABA expertise is identified to provide treatment. Examples include:
        - A Master- or Doctoral-level provider that is a Board Certified Behavior Analyst (BCBA)
        - A licensed behavioral health clinician who has attested to having sufficient expertise and has been credentialed to provide ABA services
        - A Board Certified Assistant Behavior Analyst (BCaBA) or non-licensed individual under the direct supervision of a BCBA or licensed behavioral health clinician who takes responsibility for the member's care that does either of the following:
          - Assist in the initial or concurrent assessment of the member's deficits or adaptive behaviors
          - Implement a treatment plan that has been developed by a BCBA or licensed behavioral health clinician
        - Paraprofessional interventions must be directly supervised with the child present at least 1 hour per month, up to 8 hours per month, not to exceed 1 hour for every 10 hours of direct care provided
      - Outcome-oriented interventions targeting specific baseline behaviors are identified in a treatment plan describing the frequency, intensity, duration and progress that will be continuously updated.
        - Treatment planning a minimum of 1 hour per month up to 8 hours per month (not to exceed 1 hour for every 10 hours of direct service).

- The treatment plan must address how the parents/guardians will be trained in management skills that can be generalized to the home.
      - Parent/guardian training is an expectation. In the rare circumstance that parent/guardian is unable the documentation must reflect the reason and identify an alternate plan to provide management skills in the home.
      - The treatment goals and objectives must be comprehensive and clearly stated.
    - The treatment plan is in sync with the child's Individual Family Service Plan (IFSP) / Individualized Education Plan (IEP).
  - All components of the child's care are tracked and updated throughout the duration of services.
- ABA intervention must include the following elements:
  - Mitigate the core features of ASD
  - Target specific deficits related to imitation, attention, motivation, compliance and initiation of interaction, and the specific behaviors that are to be incrementally taught and positively reinforced
  - Tie to objective and quantifiable treatment goals that have projected timeframes for completion
  - Include the child's parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home
  - Train family members and other caregivers to manage problem behavior and interact with the child in a therapeutic manner
  - As indicated, include psychotherapy (e.g., cognitive behavioral therapy) for higher functioning children to treat conditions such as anxiety and anger management
  - Have an appropriate level of intensity and duration driven by factors such as:
    - Treatment goals
    - Changes in the targeted behavior(s)/response to treatment
    - The demonstration and maintenance of management skills by the parents and caregivers;
    - Whether specific issues are being treated in a less intensive group format (e.g., social skills groups)
    - The child's ability to participate in ABA given attendance at school, daycare or other treatment settings
    - The impact of co-occurring behavioral or medical conditions on skill attainment
- Treatment methodologies utilized as part of intensive behavior therapies should be considered established by the National Autism Centers Standards Projects.
- Parent/Caregiver support is expected to be a component of the ABA program, as they will need to provide additional hours of behavioral interventions. Parents or caregivers must be involved and engaged in the training and follow through on treatment recommendations beyond that provided by licensed or certified practitioners. Parent support groups are considered not medically necessary.
- Services are intensive and may be provided daily, but ordinarily will not exceed 8 hours per day or 40 hours per week inclusive of other interventions. These hours of service also take into account other non-behavioral services such as school, speech, and occupational therapies, generally covered by other entities.
- If applicable, documentation of communication and coordination with other service providers and agencies, (i.e. day care, preschool, school, early intervention services providers) and/or other allied health care providers (i.e. occupational therapy, speech therapy, physical therapy and any other

applicable providers) to reduce the likelihood of unnecessary duplication of services. Documentation should include the following:

- Types of therapy provided
- Number of therapies per week
- Behaviors/deficits targeted
- Progress related to the treatment/services being provided
- Measureable criteria for completing treatment with projected plan for continued care after discharge from ABA therapy
- Total number of days per week and hours per day of direct services to child and parents or caregivers to include duration and location of requested ABA therapy
- Dates of service requested
- Licensure, certification and credentials of the professionals providing ABA services to the child
- Evidence that parents and/or caregivers have remained engaged in the treatment plan, following all appropriate treatment recommendations
  - o Detailed description of interventions with the parent(s) or caregiver(s), including:
    - Parental or caregiver education, training, coaching and support
    - Overall parent or caregiver goals including a brief summary of progress. As part of the summary of progress the information should also include percentage of planned sessions attended
    - Plan for transitioning ABA interventions identified for the child to the parents or caregivers
- With each medical necessity review for continued ABA treatment, an updated treatment plan and progress reports will be required for review, including all of the following documentation:
  - There is a reasonable expectation on the part of the treating clinician that the child's behavior and skill deficits will continue to improve to a clinically meaningful extent, in at least two settings (home, school, community) with ABA services
  - Therapy is not making the symptoms or behaviors persistently worse
  - Progress is assessed and documented for each targeted symptom and behavior, including progress toward defined goals, and including the same modes of measurement that were utilized for baseline measurements of specific symptoms and behaviors.
  - The treatment plan and progress report should reflect improvement from baseline in skill deficits and problematic behaviors using validated assessments of adaptive functioning.
  - When there has been inadequate progress with targeted symptoms or behaviors, or no demonstrable progress within a six month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for inadequate progress or not meeting the goals, and treatment interventions should be modified or changed in order to attempt to achieve adequate progress. Documentation of such an assessment and subsequent treatment plan change(s) must include:
    - o Increased time and/or frequency working on targets
    - o Change in treatment techniques
    - o Increased parent/caregiver training
    - o Identification and resolution of barriers to treatment effectiveness
    - o Any newly identified co-existing disorder (e.g., anxiety, psychotic disorder, mood disorder)
    - o Goals reconsidered (e.g., modified or removed)
- When goals have been achieved, either new goals should be identified that are based on targeted symptoms and behaviors that are preventing the child from

adequately participating in age-appropriate home, school or community activities, or that are presenting a safety risk to self, others, or property; or, the treatment plan should be revised to include a transition to less intensive interventions.

- Treatment methodologies utilized as part of intensive behavior therapies should be considered established by the National Autism Centers Standards Projects.
- ABA providers are required to have a separate record for each member that contains the following documentation:
  - Comprehensive assessment establishing the autism diagnosis
  - All necessary demographic information
  - Complete developmental history and educational assessment
  - Functional behavioral assessment including assessment of targeted risk behaviors
  - Behavioral/medical health treatment history including but not limited to:
    - o known conditions
    - o dates and providers of previous treatment
    - o current treating clinicians
    - o current therapeutic interventions and responses
- Individualized treatment plan and all revisions to the treatment plan, including objective and measurable goals, as well as parent training
- Daily progress notes including:
  - place of service
  - start and stop time
  - who rendered the service
  - the specific service (e.g., parenting training, supervision, direct service)
  - who attended the session
  - interventions that occurred during the session
  - barriers to progress
  - response to interventions
- All documentation must be legible
- All documentation related to coordination of care
- All documentation related to supervision of paraprofessionals
- If applicable, a copy of the child's Individualized Education Plan (IEP)
- If applicable, progress notes related to Early Intervention Plan or Pre-school/Special Education Program or allied health services
- Certification and credentials of the professionals providing the ABA therapy

## MENTAL HEALTH: CRISIS INTERVENTION SERVICES

**Crisis intervention** provides immediate mental health care in the home or community and be available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. Crisis intervention activities include assessment, short-term counseling designed to stabilize the individual and care coordination. Crisis intervention services may include office visits, Temporary Detention Order preadmission screenings or telephone contacts. Crisis intervention objectives are to prevent the exacerbation of a condition; prevent injury to the individual or others; and provide treatment in the least restrictive setting.

### Admission Criteria

The Comprehensive Needs Assessment will document the individual's behavior and describe how the individual meets criteria for this service. Assessment time is allowed to document the medical necessity and assess the level of services needed. There must be documentation of an immediate mental health service need with the objectives of preventing exacerbation of a condition, preventing injury to the individual and others, and providing treatment in the context of the least restrictive

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

- Individuals must **meet both Criteria A and B** to qualify for services:
  - A. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.
  - B. Individuals **must meet two** of the following criteria at the time of admission to the service:
    - Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness or isolation from social supports;
    - Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
    - Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or
    - Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

### **Service Delivery**

- An LMHP, LMHP-S, LMHP-R, LMHP-RP shall conduct a Comprehensive Needs Assessment as defined earlier in the chapter. An assessment completed by a Certified Pre-Screener who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S may be used in place of the Comprehensive Needs Assessment as long as all 15 required elements of the Comprehensive Needs Assessment are included. Assessments completed by Certified Pre-Screeners must be signed off by an LMHP, LMHP-S, LMHP-R or LMHP-RP within one business day.
- Crisis intervention shall be provided only by an LMHP, LMHP-S, LMHP-R, LMHP-RP, or a Certified Pre-Screener.
- During Emergency Custody Order (ECO) related Crisis Intervention services CSB's may use the Virginia Preadmission Screening Report to document the required elements of the Comprehensive Needs Assessment.
- An ISP shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on the ISP shall not be required for the service to be provided on an emergency basis.
- For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised by the fourth face-to-face contact to reflect the short-term counseling goals.
- Services may include office visits, home visits, pre-admission screenings, telephone contacts or other client-related activities for the prevention of institutionalization.
- Note: Pre-admission screenings related to an ECO or Temporary Detention Order (TDO) are covered as crisis intervention only when the service is provided by a CSB or BHA as required by law and the encounter meets the crisis intervention service requirements.
- The use of crisis intervention is allowed to certify necessity for an admission of an individual below the age of 21 to a freestanding inpatient psychiatric facility if the certification occurs as a result of an admission to the crisis intervention service, federal regulations require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met (refer to the DMAS Residential Treatment Services Manual for clarification on independent team certifications).
- Services shall be provided for short-term crisis counseling contacts occurring within a 30 calendar day period from the time of the first face-to-face crisis contact. Services are based on medical necessity, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.
- Crisis intervention services may be provided to eligible individuals outside of the clinic

and reimbursed, provided the provision of out-of-clinic services is clinically/programmatically appropriate based on the needs identified in the Comprehensive Needs Assessment. Travel by staff to provide out-of-clinic services shall not be reimbursable.

- Crisis intervention may involve contacts with the family or significant others with or without the individual present.
- If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.
- Client-related activities provided in association with a face-to-face contact are reimbursable.
- Provision of short-term clinical care and counseling designed to stabilize the individual or family unit.
- Providing access to further immediate assessment and follow-up services.
- Service provider care coordination to include linking the individual and family with ongoing care to prevent future crises.
- A unit of service is 15 minutes of Crisis Intervention.
- Services are based on medical necessity.

## MENTAL HEALTH: CRISIS STABILIZATION SERVICES

**Crisis Stabilization** services provide intensive short term mental health care to nonhospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature. The goal is to address and stabilize the acute mental health needs at the earliest possible time with ongoing services, avert hospitalization or re-hospitalization; provide a high assurance of safety and security in the least restrictive environment, and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

### Admission Criteria

The Comprehensive Needs Assessment must document the need for crisis stabilization services. To qualify for this service, individuals must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization.

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

### Service Delivery

- An LMHP, LMHP-S, LMHP-R or LMHP-RP shall conduct a face-to-face Comprehensive Needs Assessment as defined earlier in this chapter. An assessment completed by a Certified Pre-Screener who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S may be used in place of the Comprehensive Needs Assessment as long as all 15 required elements of the Comprehensive Needs Assessment are included. If the assessment is completed by the Certified Pre-Screener it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within one business day.
- The program shall provide to individuals, as appropriate, psychiatric assessment

including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

- The ISP as described in the ISP Requirements section of this chapter must be developed or revised within three calendar days of admission to this service.
- Counseling, as appropriate, shall be provided by a LMHP, LMHP-S, LMHP-R or LMHPRP. Service provider care coordination.
- Service authorization is based on medical necessity. Daily service provision is limited to the times when the individual meets the clinical necessity and service definition requirements.
  - Psychiatric Evaluation in Crisis Stabilization Services:
    - DMAS recommends that an individual eligible for crisis stabilization services receive a psychiatric/medical evaluation within 72 hours of admission to the service. The purpose of a psychiatric/medical evaluation during initiation of crisis stabilization services is to address medical and pharmacological interventions that may help to support the individual with managing their acute symptoms in the least restrictive environment. The evaluation may be conducted by a physician, nurse practitioner or physician assistant acting within the scope of their practice in accordance with the applicable Virginia Health Regulatory Board. The evaluation does not have to be performed by the Crisis Stabilization provider and may be coordinated with a private provider. DMAS does not require the evaluation to be billed nor does the provider have to be enrolled as a Medicaid provider, including an ordering, prescribing or referring (ORP) practitioner.
    - A face-to-face evaluation is recommended, however, if coordinated with an outpatient provider, the evaluation may be conducted through telemedicine as allowed in physician and outpatient psychiatric services. See the DMAS Physician Manual and Psychiatric Service Manual for additional details. Telemedicine is not allowed for services billed under Crisis Stabilization.
    - Crisis Stabilization providers do not need to discharge individuals if they are not seen by a psychiatrist, nurse practitioner or physician assistant within 72 hours of service admission. Providers should document attempts and any barriers to coordinating a psychiatric/medical evaluation for the individual, or the reasons why it would not be in the individual's best interest to meet with a psychiatrist, nurse practitioner or physician assistant during this treatment period.

## Limitations

- Service may be provided in any of the following settings, but shall not be limited to: (1) the home of an individual who lives with family or another primary caregiver; (2) the home of an individual who lives independently; or (3) community based programs licensed by DBHDS to provide crisis stabilization or emergency services which are not institutions for mental disease (IMDs).
- A billing unit is one hour.
- Room and board, custodial care, and general supervision are not components of this service.
- The services must be provided consistent with the ISP in order to receive Medicaid reimbursement.
- Outpatient psychiatric services are not billable at the same time crisis stabilization services are provided with the exception of office visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.
- Crisis Stabilization services are not reimbursable for members residing in Residential Treatment Settings. Please view the Residential Treatment Services Provider Manual for requirements of crisis services within the program.

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

### Exclusions

- Individuals may not receive Crisis Stabilization when they meet the exclusion criteria below:
  - Individuals with medical conditions which require hospital care;
  - Individuals with a primary diagnosis of substance use disorder;
  - Individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to self or others.

## MENTAL HEALTH: DAY TREATMENT/PARTIAL HOSPITALIZATION

**Day treatment/partial hospitalization** services will be interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. Day treatment/partial hospitalization services will be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week to groups of individuals in a nonresidential setting. Day treatment/partial hospitalization services consist of diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for individuals with serious mental health disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment but do not require psychiatric inpatient treatment.

### Admission and Continuing Stay Criteria

The Comprehensive Needs Assessment will document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

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

### Service Delivery

- Prior to the start of services a Comprehensive Needs Assessment will be conducted by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. ISPs shall be required during the entire duration of services and be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.

- For continued stays of more than 90 calendar days, each service authorization requires that the individual receive an updated face-to-face assessment conducted by a LMHP, LMHP-R, LMHP-S, or LMHP-RP to document continued medical necessity and to define treatment goals that would be included in the ISP for continued services. The results of this assessment may be requested by DMAS or its contractor to receive approval of reimbursement for continued services. This assessment must be completed no later than 90 calendar days from the start of services.
- An ISP and the ISP Requirements will be fully developed within 30 calendar days of service initiation.
- At a minimum, services are provided by QPPMH's under the supervision of a QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP.
- Supervision by the QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP is demonstrated by a review of progress notes, the individual's progress toward achieving ISP goals and objectives and recommendations for change based on the individual's status. Supervision must occur monthly. Documentation that supervision occurred must be in the individual's clinical record and signed by the QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP. Individual, group, or a combination of individual and group supervision is acceptable. The program must operate a minimum of two continuous hours in a 24-hour period. Providers must meet DBHDS regulations (12VAC 35-105-590) staff requirements related to supervision.
- Individual and/or group counseling provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
- Service provider care coordination.
- Service units are service authorized based on medical necessity.

#### **Discharge Criteria**

- Individuals are ready for discharge from this service when other less intensive services may achieve stabilization. Services will not be at this level of care if the following applies:
  - The individual is no longer in an acute psychiatric state and at risk of psychiatric hospitalization and;
  - The individual's level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

### **MENTAL HEALTH: INTENSIVE COMMUNITY TREATMENT SERVICES (ICT)**

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

#### **Admission Criteria**

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

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

### Continuing Stay Criteria

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

### Service Delivery

- Prior to admission, an appropriate service specific provider intake shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria.
- Service-specific provider intakes shall be required at the onset of services and Individual Service Plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement.
- Psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting will be provided to individuals who are best served in the community.
- ICT may be billed if the individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.
- An ISP must be fully developed by the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or QMHP-A and approved by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP within 30 days of the initiation of services.
- ICT may be provided based on an initial service specific provider intake. Service authorization is based on medical necessity.
- Continuation of service may be reauthorized at 26-week intervals based on written service specific provider re-assessment and certification of need by a LMHP.
- ICT services may only be rendered by a qualified team.
- Service Coordination is provided to ensure there is no duplication in services or billing and to ensure continuity of care.
- The purpose of ICT Service Coordination is to ensure that the individual receives all needed services and supports; that these resources are well-coordinated and integrated; and that they are provided in the most effective and efficient manner possible.
- ICT Service Coordination includes assisting the individual to access and appropriately utilize needed services and supports; assisting them to overcome barriers to being able to maximize the use of these resources; actively collaborating with all internal and external service providers; coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer's life); assessing the effectiveness of these services/supports; preventing duplication of services or the provision of unneeded interventions; and revising the service plan as clinically indicated.

## MENTAL HEALTH: THERAPEUTIC DAY TREATMENT

**THERAPEUTIC DAY TREATMENT** provides medically necessary, individualized, and structured therapeutic interventions to children/adolescents with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement to school day or year. The supporting diagnosis must be made by an LMHP practicing within the scope of his or her license. This service includes clinical evaluation, psychiatric medication education and management, interventions to build daily living skills or enhance

social skills, and individual, group, and family counseling and contacts provided in a structured setting. The service must be provided for two or more hours per day.

### Admission Criteria

- To qualify for Therapeutic Day Treatment reimbursement individuals must meet all including the Diagnostic, Clinical Necessity, and Level of Care criteria.
  - Diagnostic Criteria: The diagnosis must be the primary clinical issue addressed with the service targeted for treatment. The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.
  - Clinical Necessity Criteria: Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals shall meet at least two of the following:
    - Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization<sup>i</sup> or out-of-home placement<sup>ii</sup> because of conflicts with family or community.
    - Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.
    - Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.
  - Level of Care Criteria: Therapeutic day treatment is appropriate for children and adolescents who meet at least one of the following:
    - The individual must require year-round treatment in order to sustain behavior or emotional gains.
    - The individual's behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:
      - TDT programming during the school day; or
      - TDT programming to supplement the school day or school year.
    - The individual would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning.
    - The individual must (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.
    - The individual is placed or pending placement in a preschool enrichment and/or early intervention program but the individual's emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted in these programs without TDT services.
- Individuals receiving TDT must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the individual's functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

### Discharge Criteria

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

## Service Delivery

- Prior to admission, an appropriate service-specific provider intake shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Service-specific provider intakes shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, new intake/admission documentation shall be prepared and a new service authorization shall be required.
- The service-specific provider intake contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
- An Individual Service Plan (ISP) shall be fully completed, signed, and dated by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or QMHP-E and by the individual or the parent/guardian within 30 days of initiation of services.
- The ISP shall be a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the clinical assessment. The ISP contains his treatment or training needs, his goals and measurable objectives to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. The individual shall be included in the development of the ISP and the ISP shall be signed by the individual. If the individual is a child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a child or an adult who lacks legal capacity, is unable or unwilling to sign the ISP.
- Services must be therapeutic in nature and align with the member's ISP.
- The ISP, including the individualized discharge plan contained in the ISP, should be reviewed every 3 months at a minimum, but as frequently as medically necessary.
- The ISP must be updated between school and summer programs based on the activities being provided.
- The provider will be asked to explain what care coordination has taken place to prepare for discharge and step down to lower levels of care with every request for services.

### SUBSTANCE-RELATED DISORDERS: ALL LEVELS OF CARE

Please refer to the ASAM Criteria.

### WRAPAROUND SERVICE: INTENSIVE IN-HOME (IIH) SERVICES FOR CHILDREN AND ADOLESCENTS

**INTENSIVE IN-HOME (IIH) SERVICES FOR CHILDREN AND ADOLESCENTS** are time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual.

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

### Admission Criteria

- To qualify for Intensive In-Home reimbursement individuals must meet all of the criteria including Diagnostic, At Risk, Family Involvement and Level of Care.
  - Diagnostic Criteria
    - Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities.
    - The diagnosis must be the primary clinical issue addressed by services.
    - The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.
  - At Risk Criteria
    - The impairments experienced by the member are to such a degree that they meet the criteria for being at risk of out of home placement as defined in the below section.
    - Meet two of the following:
      - Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.
      - Exhibit such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary resulting in being at risk for out of home placement.
      - Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior resulting in being at risk for out of home placement.
    - At Risk of Hospitalization
      - Means one or more of the following:
        - Within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted; **REFER TO EMERGENCY SERVICES FOR ASSESSMENT IF NECESSARY;**
        - The parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;
        - A representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP who is neither an employee of or consultant to the IHH services or therapeutic day treatment (TDT) provider, has recommended an out of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;
        - The individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days;
        - The treatment team or family assessment planning team (FAPT) recommends IHH services or TDT for an individual currently who is either:
          - Transitioning (within the last 30 days) out of residential treatment services,
          - Transitioning (within the last 30 days) out of therapeutic group home services,

- Transitioning (within the last 30 days) out of acute psychiatric hospitalization, or
  - Transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.
- At Risk of Out of Home Placement
  - Means placement in one or more of the following:
    - A therapeutic group home;
    - Regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services;
    - Treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care;
    - Psychiatric residential treatment facility;
    - Emergency shelter for the individual only due either to his mental health or behavior or both;
    - Psychiatric hospitalization; or
    - Juvenile justice system or incarceration.
- Level of Care Criteria:
  - Meet one of the following:
    - These services shall be provided in this level of care when the clinical needs of the individual put him at risk for out-of-home placement, as these terms are defined in this section:
    - When services that are far more intensive than outpatient clinic care are required to stabilize the individual in the family situation, or
    - When the individual's residence as the setting for services is more likely to be successful than a clinic.
- Family Involvement Criteria:
  - Both of the following criteria are met:
    - At least one parent/legal guardian or responsible adult with whom the individual is living must be willing to participate in the intensive in-home services with the goal of keeping the individual with the family.
    - In the instance of this service, a responsible adult shall be an adult who lives in the same household with the child and is responsible for engaging in therapy and service-related activities to benefit the individual.

### **Discharge Criteria**

- The individual is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms.
- The level of functioning has improved with respect to the goals outlined in the Individual Service Plan (ISP) and the individual can reasonably be expected to maintain these gains at a lower level of treatment.
- The child is no longer in the home.
- There is no parent or responsible adult actively participating in the service.
- Discharges shall also be warranted when the service documentation does not demonstrate that services meet the IIH service definition or when the services progress meets the "failed services" definition.
  - "Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues. Discharge is required when the individual has achieved maximal benefit from this level of care and their level of functioning has not improved despite the length of time in treatment and interventions attempted.

## Service Delivery

- Prior to admission, an appropriate service-specific provider intake shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria.
- Service-specific provider intakes shall be required at the onset of services and Individual Service Plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the service provider, the provider shall discharge the individual. If the individual continues to need services, then a new intake/admission shall be documented and a new service authorization shall be required.
- An individual service plan shall be fully completed, signed, and dated by either a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and individual's parent/guardian within 30 days of initiation of services.
- It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. The ISP shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual.
  - Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per individual/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive services.
  - Emergency assistance shall be available to the family, and delivered, as needed, by the IHH service provider 24 hours per day, seven days a week.
  - All interventions and the settings of the intervention shall be defined in the ISP.
  - Services shall be directed toward the treatment of the eligible individual and delivered primarily in the family's residence with the individual present.
  - As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP.

## WRAPAROUND SERVICE: MENTAL HEALTH CASE MANAGEMENT

**Mental health case management** is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the assessment, the ISP, and the progress notes.

## Population Definitions

The following definitions are referred to in the discussion of the appropriate populations for Mental Health Case Management services.

- **Serious Mental Illness**

Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are

seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

a. Diagnosis

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

b. Level of Disability

- There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:
  - 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.
  - Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
  - Has difficulty establishing or maintaining a personal social support system.
  - Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
  - Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.

c. Duration of Illness

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

Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM, or the child must exhibit all of the following:

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

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

• **At Risk of Serious Emotional Disturbance**

Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:

- The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or
- 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
- 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.).

### **Admission Criteria**

- The Medicaid eligible individual will meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance:
  - There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent.
  - The individual must require case management as documented on the ISP, which is developed by a qualified mental health case manager and based on an appropriate assessment and supporting documentation.
  - To receive case management services, the individual must be an “active client,” which means that the individual has an ISP in effect which requires regular direct or client-related contacts and communication or activity with the client, family, service providers, significant others, and others, including a minimum of one face-to-face contact every 90 calendar days.

### **Service Delivery**

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such). 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 LMHP, LMHP-R, LMHP-RP or LMHP-S. If completed by a qualified case management 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 rules for case management services. The assessment serves as the basis for the ISP.
- The ISP must document the need for case management and be fully completed within 30 calendar days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review. The ISP shall be updated at least annually.
- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded.
- Linking the individual to needed services and supports specified in the ISP.
- Provide services in accordance with the ISP.
- Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;
- Coordinating services and service planning with other agencies and providers involved with the individual.
- Enhancing 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.
- Making collateral contacts, which are non-therapy contacts, with significant others to promote implementation of the service plan and community adjustment. Following up and monitoring to assess ongoing progress and ensuring services are delivered.

- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.
- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.
- Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of CMHRS services, specifically mental health case management.
- A face-to-face contact must be made at least once every 90 calendar day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the member's status.
- Case Management services are intended to be an individualized client-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was consumer-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.
- Monitoring and Re-Evaluation of the Service Need by the Case Manager:
  - The case manager will continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. At a minimum, the case manager will review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.
  - This quarterly re-evaluation is documented in the case manager's file. The case manager will have monthly activity regarding the individual and a face-to-face contact with the individual at least once every 90 calendar days.
  - The case manager will revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers change. When such a change occurs, the case manager will involve the individual in the discussion of the need for the change.

#### WRAPAROUND SERVICE: MENTAL HEALTH SKILL BUILDING SERVICES (MHSS)

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

## Admission Criteria

- Individuals qualifying for Mental Health Skill-building Services must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.
- Services are provided to individuals who require individualized goal-directed training to achieve or maintain stability and independence in the community.
- Individuals age 21 and over shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:
  - The individual shall have one of the following as a primary mental health diagnosis:
    - Schizophrenia or other psychotic disorder as set out in the DSM-5,
    - Major Depressive Disorder;
    - Recurrent Bipolar I or Bipolar II;
    - Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) the individual requires individualized training in order to achieve or maintain independent living in the community.
- The individual shall require individualized goal directed training in order to acquire or maintain self-regulation of basic living skills such, as symptom management; adherence to psychiatric and physical health and medication treatment plans; appropriate use of social skills and personal support system; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.
- The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or non-residential crisis stabilization, (iii) ICT or Program of Assertive Community Treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.
- The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the service specific provider intake date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service.
- Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.
- Individuals 18-20 years shall meet all of the above medical necessity criteria in order to be eligible to receive mental health skill building services and the following:
  - The individual shall not be in a supervised setting. If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition.
- Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance use disorder. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Mental Health Skill-building Services as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The

impact of the substance abuse condition on the mental health condition must be documented in the service specific provider intake, the ISP, and the progress notes.

## Service Delivery

- A service specific provider intake shall be required at the onset of services. The service specific provider intake must be conducted face-to-face by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The service specific provider intake shall document the individual's behavior and describe how the individual meets criteria for this service. The service specific provider intake may be completed no more than 30 days prior to the initiation of services and must indicate that service needs can best be met through mental health skill-building services. The LMHP, LMHP-R, LMHP-RP, LMHP-S performing the intake shall document the primary mental health diagnosis on the intake form.
- Service specific provider intakes shall be repeated upon any lapse in services of more than 30 calendar days. Services of any individual that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service in the individual's medical record.
- Service authorization is not required to bill for the face-to-face service specific provider intake.
- A review of Mental Health Skill Building Services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individual who have received at least 6 months of Mental Health Skill Building Services to determine the continued need for this service.
- The LMHP, LMHP-R, LMHP-S or LMHP-RP must then document the need for the continuation of services by indicating that the individual is continuing to meet eligibility requirements and is making progress towards Individual Service Plan (ISP) goals. Clinically it may be helpful for the LMHP, LMHP-R, LMHP-S or LMHP-RP to complete a new service specific provider intake to review clinical progress and assess the medical necessity of continuing MHSS. However, DMAS regulations do not specifically require the provider to complete a service specific provider intake every six months when providing MHSS.
- Providers may bill for service hours or bill for the service specific provider intake to complete the six month MHSS review requirement. The service specific provider intake must be updated annually.
- The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall complete, sign and date the ISP within 30 days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP.
- The total time billed for the week shall not exceed the frequency established in the individual's ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall include the dated signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of service. If the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.
- Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in the manner in which he may participate with the process, modify as appropriate, and update the ISP. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record no later than 15 calendar days from the date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.
- The ISP must be rewritten annually.
- The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.
- Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

- If the provider knows of or has reason to know of the individual's non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the QPPMH, the supervising LMHP, LMHPR, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any non-adherence to the prescribed medication regimen. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-adherence concerns. The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:
  - Name and title of caller;
  - Name and title of professional who was called;
  - Name of organization that the prescribing professional works for;
  - Date and time of call;
  - Reason for care coordination call;
  - Description of medication regimen issue or issues to be discussed; and
  - Resolution of medication regimen issue or issues that were discussed.
- Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill building services medical record. The provider shall document evidence of the individual's prior psychiatric services history, as required above under the medical necessity requirements, by contacting the prior provider or providers of such health care services after obtaining written consent from the individual.
- Family member statements shall not suffice to meet this requirement.
- The provider shall document the following minimum elements:
  - Name and title of caller;
  - Name and title of professional who was called;
  - Name of organization that the professional works for;
  - Date and time of call;
  - Specific placement provided;
  - Type of treatment previously provided;
  - Name of treatment provider; and
  - Dates of previous treatment.
- Providers may use their own records to validate prior history, however they must clearly document in the MHSS note where in the electronic record substantiating information (ex: doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found. If an individual sees a psychiatrist outside of the agency and the medication area of the record is documented to reflect the psychiatric history and prescribed medications, then in that section of the record each of the required elements in the regulation including: the worker who checked the record, what record was viewed and the person who wrote the note that was viewed, the name of the organization that the record belongs to, the date and time the record was reviewed, the specific placement provided, the type of treatment previously provided, the name of the treatment provider, and the dates of the previous treatment must be provided. A MHSS note directing the reader to refer to another section of the individual's medical record with the same provider agency will be accepted as meeting the requirement. Again, it must clearly document in the MHSS note where in the electronic record substantiating information can be found.
- The provider shall document evidence of the psychiatric medication history, as required by above under the medical necessity requirements by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy after obtaining written consent from the individual.
- Prescription lists or medical records, including discharge summaries, obtained from the pharmacy or current or previous prescribing provider of health care services that contain:
  - Name of prescribing physician;
  - Name of medication with dosage and frequency; and
  - Date of prescription shall be sufficient to meet this criteria.
- Family member statements shall not suffice to meet this requirement.
- The MHSS regulations outline specific documentation requirements in order to satisfy the criteria for validating medication history. Examples include either photocopies of the prescription information from the bottle or contacting the prior provider. Providers may use their own records to validate medication history (doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date), however

they must clearly document in the MHSS note where in the electronic record substantiating information can be found.

- In the absence of such documentation, the current provider shall document all contacts (i.e. telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements:
  - Name and title of the caller;
  - Name and title of prior professional who was called;
  - Name of organization that the professional works for;
  - Date and time of call;
  - Specific prescription confirmed;
  - Name of prescribing physician;
  - Name of medication; and
  - Date of prescription.
- Only direct face-to-face contacts and services to an individual shall be reimbursable.
- Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.
- Any services provided to individuals that are strictly vocational in nature shall not be billable. However, support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.
- Room and board, custodial care, and general supervision are not components of this service and are NOT eligible for Medicaid reimbursement.
- Provider qualifications. The enrolled provider of mental health skill-building services shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHPS, QMHP-A, QMHP-C, QMHP-E or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the MHSS record.
- MHSS must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.
- If MHSS is provided in a Therapeutic Group Home or assisted living facility the ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

#### WRAPAROUND SERVIC: MENTAL HEALTH PEER SUPPORT SERVICES AND FAMILY SUPPORT PARTNERS

**Peer Support Services** for adults are person centered, strength-based, and recovery oriented rehabilitative service for members 21 years or older provided by a PRS successful in the recovery process with lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders who is trained to offer support and assistance in helping others in recovery to reduce the disabling effects of a mental health or substance use disorder or cooccurring mental health and substance use disorder that is the focus of support. Services assist the member develop and maintain a path to recovery, resiliency, and wellness. Specific peer support service activities shall emphasize the acquisition, development, and enhancement of recovery, resiliency, and wellness. Services are designed to promote empowerment, self-determination, understanding, and coping skills through mentoring and service coordination supports, as well as to assist members in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

**Family Support Partners** are Peer Recovery Support Services and is a strength-based memberized team-based service provided to the caregiver of Medicaid-eligible youth under age 21, with a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver must be directed exclusively toward the

benefit of the Medicaid-eligible youth. Services are expected to improve outcomes for youth with complex needs who are involved with multiple systems and increase the youth and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar a mental health or substance use disorder or co-occurring mental health and substance use disorder, or (ii) an adult with personal experience with a family member with a similar a mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. The PRS shall perform the service within the scope of their knowledge, lived-experience, and education.

#### **Admission Criteria Mental Health Peer Support Services**

- Members 21 years or older qualifying for MH Peer Support Services will meet the following requirements:
  - Have a documented mental health disorder diagnosis;
  - Require recovery oriented services for the acquisition of skills needed to engage in and maintain recovery; the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and increasing responsibilities, wellness potential, and shared accountability for the member's own recovery; and
  - Demonstrate moderate to severe functional impairment because of the diagnosis that interferes with or limits performance (relative to the person's ethnic or cultural environment) in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his or her illness, living more independently).

#### **Admission Criteria Mental Health Family Support Services**

- Caregivers of youth under age 21 who qualify to receive MH Family Support Partners will (i) have a youth with a mental health disorder, who requires recovery oriented services, and (ii) meets two or more of the following:
  - Member and his caregiver need peer-based recovery oriented services for the maintenance of wellness and the acquisition of skills needed to support the youth;
  - Member and his caregiver need assistance to develop self-advocacy skills to assist the youth in achieving self-management of the youth's health status;
  - Member and his caregiver need assistance and support to prepare the youth for a successful work/school experience;
  - Member and his caregiver need assistance to help the youth and caregiver assume responsibility for recovery.

Note: Members 18-20 years old who meet the medical necessity criteria stated above for MH Peer Support Services, who would benefit from receiving peer supports directly, and who choose to receive MH Peer Support Services directly instead of through MH Family Support Partners shall be permitted to receive MH Peer Support Services by an appropriate PRS.

#### **Continuing Stay Criteria**

To qualify for continued services for Peer Support Services and Family Support Partners medical necessity service criteria shall continue to be met, progress notes shall document the status of progress relative to the goals identified in the Recovery Resiliency and Wellness Plan, and the member continues to require the monthly minimum contact requirements.

#### **Discharge Criteria**

- Discharge criteria for both Peer Support Services and Family Support Partners will occur when one or more of the following is met:
  - Goals of the Recovery Resiliency and Wellness Plan have been substantially met; or
  - The individual or as applicable for youth under 21, the caregiver, request discharge; or
  - The member or as applicable for youth under 21, the caregiver, fail to make the monthly minimum contact requirements or the member or caregiver, as applicable, discontinues

participation in services.

## **Service Delivery**

- Service delivery is based on the member's identified needs, established medical necessity criteria, consistent with the assessment of the practitioner who recommended services, and goals identified in the member Recovery Resiliency and Wellness Plan. The level of services provided and total time billed by the enrolled/credentialed provider for the week shall not exceed the frequency established in the Recovery, Resiliency, and Wellness Plan. As determined by the goal(s) identified in the Recovery, Resiliency and Wellness Plan, services may be rendered in the provider's office or in the community, or both. Peer Support Services and Family Support Partners shall be rendered on a member basis or in a group. Services shall be delivered in compliance with the following minimum contact requirements:
  - Billing will occur only for services provided with the member present. Telephone time is supplemental rather than replacement of face-to-face contact and is limited to 25% or less of total time per recipient per calendar year. Justification for services rendered with the member via telephone shall be documented. Any telephone time rendered over the 25% limit will be subject to retraction.
  - Contact will be made with the member receiving Peer Support Services or Family Support Partners a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact, subject to the 25% limitation described above, depending on the member's support needs and documented preferences.
  - In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month, not to exceed two units. After two consecutive months of unsuccessful attempts to make face-to-face contact, discharge shall occur.
  - Peer Support Services or Family Support Partners may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space. Services shall not be delivered at the time within the same space of another service. Peer Support Services shall be an ancillary service and shall not impede, interrupt, or interfere with the provision of the primary service setting.
- Specific strategies and activities will be rendered and fully align with the Recovery, Resiliency, and Wellness Plan. Strategies and activities shall include at a minimum:
  - Person centered, strength based planning to promote the development of self-advocacy skills;
  - Empowering the member to take a proactive role in the development and updating of their Recovery, Resiliency, and Wellness Plan;
  - Crisis support; and
  - Assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the Recovery Resiliency and Wellness Plan so that the member:
    - Remains in the least restrictive setting;
    - Achieves their goals and objectives identified in the Recovery Resiliency and Wellness Plan;
    - Self-advocates for quality physical and behavioral health services; and
    - Has access to strength-based behavioral health services, social services, educational services and other supports and resources.

## **Limitations**

- An approved service authorization or registration submitted by the enrolled/credentialed provider shall be required prior to service delivery in order for reimbursement to occur. To obtain service

authorization, all providers' information supplied to the DMAS or its contractor shall be fully substantiated throughout the member's record.

- A unit of service shall be defined as 15 minutes. Peer Support Services and Family Support Partners shall be limited to four hours per day (up to 16 units per calendar day) and nine hundred (900) hours per calendar year. Service delivery limits may be exceeded based upon documented medical necessity and service authorization approval.
- Service shall be initiated within 30 calendar days of the completed assessment and shall be valid for no longer, than 30 calendar days. If the time has exceeded 30 calendar days without service initiation, another assessment for services shall be required.
- Peer Support Services and Family Support Partners rendered in a group setting shall have a ratio of no more than 10 members to one PRS and progress notes shall be included in each Medicaid member's record to support billing.
- General support groups which are made available to the public to promote education and global advocacy do not qualify as Peer Support Services or Family Support Partners.
- Non-covered activities include:
  - Transportation;
  - Record keeping or documentation activities (including but not limited to progress notes, tracking hours and billing and other administrative paperwork);
  - Services performed by volunteers;
  - Household tasks such as chores and grocery shopping;
  - On the job training;
  - Case management;
  - Meals and breaks;
  - Outreach to potential clients; and
  - Room and board.
- Members with the following conditions are excluded from Peer Support Services and Family Support Partners unless there is clearly documented evidence and diagnosis of a substance use disorder or mental health disorder overlaying the diagnosis:
  - A developmental disability including:
    - intellectual disabilities,
    - organic mental disorder including dementia or Alzheimer's,
    - Or
    - traumatic brain injury.

## WRAPAROUND SERVICE: PSYCHOSOCIAL REHABILITATION

**Psychosocial Rehabilitation** is a program of two or more consecutive hours per day provided to groups of individuals in a community, nonresidential setting who require a reduction of impairments due to a mental illness and restoration to the best possible functional level in order to maintain community tenure. This service provides a consistent structured environment for conducting targeted exercises and coaching to restore an individual's ability to manage mental illness. This service provides education to teach the individual about mental illness, substance use, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a consistent program structure and environment.

### Admission Criteria

The Comprehensive Needs Assessment will document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

- Individuals must **meet both Criteria A and B** to qualify for services:
  - A. Individuals must meet two of the following criteria on a continuing or intermittent basis:
    - Experience difficulty in establishing or maintaining normal interpersonal

- relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness or isolation from social supports;
  - o Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
  - o Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary;
  - Or
  - o Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. "Cognitive" is defined as the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.
- B. The individual must meet one of the following criteria:
- o Have experienced long-term or repeated psychiatric hospitalizations; or
  - o Experience difficulty in activities of daily living and interpersonal skills; or
  - o Have a limited or non-existent support system; or
  - o Be unable to function in the community without intensive intervention; or
  - o Require long-term services to be maintained in the community.

### **Service Delivery**

- Prior to the start of services, a Comprehensive Needs Assessment will be conducted by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. ISPs shall be required during the entire duration of services and be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessments or ISPs shall be denied reimbursement.
- An ISP shall be completed as described in the ISP Requirements section of this chapter within 30 calendar days of service initiation.
- Psychosocial rehabilitation services may be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, QMHP-C, LMHP, LMHP-S, LMHP-R, or LMHP-RP.
- Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-S, LMHP-R, or LMHP-RP to support that the individual continues to meet the medical necessity criteria. The LMHP, LMHP-R, LMHP-RP or LMHP-S shall determine and document the continued need for the service as described in the Comprehensive Needs Assessment section of this chapter. This review may be requested by DMAS or its contractor to receive approval of reimbursement for continued services.
- Social skills training, community resource development, and peer support among fellow members, which are oriented toward empowerment, recovery and competency.
  - o Psychoeducational activities to teach the individual about mental illness and appropriate medication to avoid complications and relapse;
  - o Provide opportunities to learn and use independent living skills, and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.
- Service provider care coordination.
- Service Units are based on medical necessity.
- The program shall operate a minimum of two continuous hours in a 24-hour period.
  - o Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the individual's understanding or ability to access community resources and this is an identified need in the assessment and ISP.

## Exclusions

- The following services are specifically excluded from payment for psychosocial rehabilitation services:
  - Vocational services;
  - Prevocational services;
  - Supported employment services.

## REFERENCES

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Virginia Administrative Code, Title 12, Agency 30, Chapter 50, Section 130 - Skilled Nursing Facility Services, EPSDT, School Health Services and Family Planning.

Virginia Administrative Code, Title 12, Agency 30, Chapter 50, Section 226 – Community Mental Health Services.

Virginia Administrative Code, Title 12, Agency 30, Chapter 130, Section 600 – Definitions.

## REVISION HISTORY

Date	Action/Description
08/31/2017	<ul style="list-style-type: none"> <li>• Version 1 – Behavioral Therapy Services Under EPSDT</li> </ul>
04/11/2018	<ul style="list-style-type: none"> <li>• Version 2 – Added:               <ul style="list-style-type: none"> <li>○ Day Treatment/Partial Hospitalization</li> <li>○ Mental Health Case Management</li> <li>○ Psychosocial Rehabilitation</li> <li>○ Therapeutic Day Treatment</li> </ul> </li> </ul>
05/09/2018	<ul style="list-style-type: none"> <li>• Version 3 – Added:               <ul style="list-style-type: none"> <li>○ Crisis Intervention Services</li> <li>○ Crisis Stabilization Services</li> <li>○ Intensive Community Treatment Services</li> <li>○ Intensive In-Home (IIH) Services for Children and Adolescents</li> <li>○ Mental Health Skills Building</li> <li>○ Peer Support Services and Family Support Partners</li> </ul> </li> <li>• Consolidated all guidelines into one document on the new guideline template.</li> </ul>
07/12/2019	<ul style="list-style-type: none"> <li>• Version 4               <ul style="list-style-type: none"> <li>○ Added National LOCG language to sections: Common Criteria- Admission; Best Practices-Evaluation and Treatment planning</li> <li>○ Updated per state specific language to sections: Behavioral Therapy Services- Continuation of Services; Crisis Stabilization Services- Admission Criteria; Day Treatment/Partial Hospitalization-Continuing Stay Criteria</li> </ul> </li> </ul>

Date	Action/Description
	<ul style="list-style-type: none"> <li>○ Per state specific updates, removed language references to "At-Risk of Physical Injury" form</li> <li>○ Updated references</li> </ul>
January 31, 2020	<ul style="list-style-type: none"> <li>● Version 5: Added Evidence-Based Practice Criteria section, updated references, removed LOCUS/CASI/ECSII language for mental health and wraparound services.</li> </ul>

<sup>i</sup> At Risk of Hospitalization means one or more of the following:

- Within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted;
- The parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;
- (iii)A representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of or consultant to the IIH services or therapeutic day treatment (TDT) provider, has recommended an out of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; The individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days;
- The treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:
  - Transitioning (within the last 30 days) out of residential treatment services,
  - Transitioning (within the last 30 days) out of therapeutic group home services,
  - Transitioning (within the last 30 days) out of acute psychiatric hospitalization, or
  - Transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.

<sup>ii</sup> Out of Home Placement means placement in one or more of the following:

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