CHAPTER IV

COVERED SERVICES AND LIMITATIONS
CHAPTER IV
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Exhibits 84
MEDALLION II
Medicaid members receive primary and acute care through Medicaid contracted managed care organizations (MCO), also known as the Medallion II Program. For MCO enrollees, assessment and evaluation, and outpatient psychiatric and substance abuse therapy services (individual, family, and group) are handled through the enrollee’s MCO.

MCOs may have different service authorization criteria and reimbursement rates, however MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the enrollee’s MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Mental health providers must contact the member’s MCO directly for information regarding the contractual, coverage, and reimbursement guidelines for services provided through the MCO. MCO contact information is available on the DMAS website at http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf.

The following psychiatric and substance abuse services are carved-out of the MCO contract and are covered through fee-for-service, including for MCO enrollees, in accordance with DMAS fee-for-service established coverage criteria and guidelines. The MCO is responsible to cover transportation for carved-out services.

Coverage Through DMAS for Medallion II MCO Enrollees (Medicaid, FAMIS Plus and FAMIS MOMS)

Intensive In-home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health and Substance Abuse Crisis Intervention
Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance, and for Adults with Serious Mental Illness
Mental Health Day Treatment/Partial Hospitalization Services for Adults
Psychosocial Rehabilitation
Mental Health and Substance Abuse Crisis Intervention
Intensive Community Treatment
Crisis Stabilization
Mental Health Support
Substance Abuse Intensive Outpatient Treatment
Substance Abuse Day Treatment
Opioid Treatment
Residential Substance Abuse Treatment for Pregnant and Post Partum Women
Substance Abuse Day Treatment for Pregnant and Post Partum Women
Substance Abuse Case Management
Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)
Coverage Through DMAS For FAMIS MCO Enrollees*

Intensive In-Home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Crisis Intervention
Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance.

Note—No other CMHRS other than those listed above are covered by DMAS For FAMIS MCO Enrollees*

Medicaid managed care organizations will be receiving data on the community mental health rehabilitative services utilized by their members. Providers of community mental health rehabilitative services may be contacted by the managed care organizations to discuss the care of these individuals.

COVERED SERVICES AND LIMITATIONS

Introduction

The mental health services described below are covered under the Medicaid Program. Providers of services must meet the qualifications described under “Provider Participation Requirements” in Chapter II of this manual. Criteria for all clinical service providers must be met.

A “Licensed mental health professional” (LMHP) refers to a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, a psychiatric clinical nurse specialist or a psychiatric nurse practitioner.

A person who has completed their graduate degree and is under the direct personal supervision of a person licensed under Virginia law, who is working towards licensure, and who is in compliance with the appropriate Virginia licensing board may perform the functions of the LMHP for purposes of Medicaid reimbursement. The Board of Health Professions refers to masters prepared individuals in Counseling and Psychology as
“Resident”. The Board of Health Professions refers to masters prepared individuals in social work as “Supervisee”. For purposes of Medicaid reimbursement, these persons shall use LMHP-E after their signatures to indicate this status.

Qualified Mental Health professionals (QMHPs), Paraprofessionals, and Qualified Substance Abuse Professionals (QSAPs) criteria must be met.

All these qualifications are listed in Chapter II of this manual.

Services must be provided in conjunction with a current service specific provider assessment of the member’s specific needs and in accordance with the Individualized Service Plan (ISP) developed for that individual. A physical examination is recommended as a component of the assessment for all Community Mental Health Rehabilitative Services.

Community Mental Health Rehabilitative Services require a Individualized Service Plan (ISP) completed by the service specific provider, which is a comprehensive and regularly updated document specific to the member being treated containing but not necessarily limited to their treatment or training needs, 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 service specific provider shall include the member in the development of the ISP. To the extent that the member’s condition requires assistance for participation, assistance shall be provided. The ISP shall be updated as the needs and progress of the member changes.

Under the Medicaid Program, mental health clinic services are also covered. The recognized providers of these services, a description of the services, billing procedures, and other items are included in the Mental Health Clinic Provider Manual issued by the Department of Medical Assistance Services (DMAS).

Medicaid members who are receiving Community Mental Health Rehabilitative Services may receive other Medicaid-covered services for which they qualify unless specifically prohibited as described for each service. Please note the program service matrix in the exhibits of this chapter that provides guidance regarding the provision of concurrent or overlapping services.

Transportation of the member to medical appointments must be authorized by and billed to the Medicaid transportation broker or the member’s assigned MCO and not included as part of the service.

**Independent Clinical Assessment for Children’s Rehabilitative Services**

Effective July 18, 2011, the Department of Medical Assistance Services (DMAS) will require an independent clinical assessment as a part of the service authorization process for Medicaid and FAMIS children’s community mental health rehabilitative services (CMHRS). This includes children and youth up to age 21 enrolled in Medicaid and FAMIS fee for service or managed care programs. DMAS will contract with local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) (herein referred to as the “independent assessor”) to conduct the independent clinical assessment. The affected children’s community-based mental health rehabilitative services are Intensive In-Home
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(IIH), Therapeutic Day Treatment (TDT), and Mental Health Support Services (MHSS) for individuals up to the age of 21. Each child or youth must have at least one independent clinical assessment either prior to the initiation of the affected services mentioned above or for individuals already receiving services, the independent clinical assessment will be required as part of the first service re-authorization process. Children and youth who are being discharged from residential treatment (DMAS Levels A, B, or C) do not need an independent clinical assessment to access IIH, TDT, or MHSS. They are required to have an independent clinical assessment as part of any subsequent service reauthorization.

An independent clinical assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for one of the affected CMHRS services for dates of service beginning on or after July 18th, 2011. New services are defined as CMHRS services for which the individual does not have a current service authorization in effect as of July 17, 2011. Independent assessors shall meet the DMAS definition of a licensed mental health professional including persons who have registered with the appropriate licensing board and are working toward licensure.

Effective September 1, 2011, a completed independent clinical assessment will be required for those individuals up to the age of 21 who are currently receiving services and whose service re-authorization is due for dates of service on or after September 1, 2011 for IIH, TDT, and MHSS. CSBs/BHAs will conduct independent clinical assessments on and after August 1, 2011 for service re-authorizations with dates of service continuing on and after September 1, 2011.

For children and youth currently receiving Intensive In-Home, Therapeutic Day Treatment, or Mental Health Support Services (under 21) and for whom a re-authorization is desired, an independent clinical assessment must be conducted within thirty (30) days of the current service authorization expiration date. The provider of services shall inform the parent/legal guardian in writing at least 30 days prior to the current service authorization expiration date that an independent clinical assessment is needed. To facilitate the process, providers should encourage parents/legal guardians to call for an appointment as early as possible. The independent clinical assessment must be completed and submitted to KePRO by the independent assessor prior to the service provider submitting the service re-authorization request to KePRO, or the request will be administratively rejected. A copy of the independent clinical assessment must be in the service provider’s client’s file.

Levels A and B Residential Services will follow these same requirements effective in November 2011. Providers will be notified 30 days in advance when this requirement is implemented. Please note that Mental Health Support Services and Levels A & B Residential Services are not a covered benefit for MCO FAMIS enrollees.

The Independent Clinical Assessment Process

1. A parent or legal guardian of a child or youth who is believed to be in need of one of the affected community-based mental health rehabilitative services must contact the local CSB/BHA to request an independent clinical assessment. If a service provider receives a request to provide one of the affected services, the service provider must refer the parent/legal guardian to the local CSB/BHA first to obtain the independent clinical assessment. The independent clinical assessment must be completed prior to service initiation. (Please see the behavioral health section of the DMAS website www.dmas.virginia.gov, for a list of CSB/BHA contact information.)
If the child or youth is in immediate need of treatment, the independent assessor will make a referral to appropriate, currently reimbursed Medicaid emergency services in accordance with 12 VAC 30-50-226 and may also contact the child or youth’s MCO to alert the MCO of the child’s needs.

2. Once the CSB/BHA is contacted by the parent or legal guardian, the independent clinical assessment appointment will be offered within five (5) business days of a request for IIH Services and within ten (10) business days of a request for TDT and MHSS. The appointment may be scheduled beyond the respective time frame at the documented request of the parent or legal guardian. CSBs/BHAs will attempt to accommodate working schedules of parents and legal guardians. Medicaid transportation may be used to transport the child or youth and parent/legal guardian to the independent clinical assessment appointment.

3. The independent assessor will conduct the independent clinical assessment with the child or youth and the parent or legal guardian using a standardized format and make a recommendation for the most appropriate, medically necessary services, if indicated. Only the parent or legal guardian and child or youth will be permitted in the room during the independent clinical assessment. Recommendations may include community mental health rehabilitative services, psychiatric, or outpatient mental health services.

4. The independent clinical assessor will inform the parent or legal guardian about the recommended service options and their freedom of choice of providers. The family or legal guardian will be asked if they have a service provider in mind for the recommended service(s). If a service provider has been identified, the independent assessor will note the choice of service provider on the Choice form. In addition, the independent assessor will ask the parent or legal guardian to sign a release of information if the parent agrees to share clinical assessment information with the chosen service provider(s). If a service provider has not been identified, the independent assessor will provide the parent or legal guardian with a provider list generated by DMAS. For outpatient mental health services, the independent assessor will provide the parent or legal guardian with a provider list generated by the child or youth’s MCO or the parent or guardian can contact the primary care physician.

5. The independent assessor will electronically submit the independent clinical assessment summary data within one (1) business day of completing the assessment into the service authorization contractor web portal service authorization system. The service authorization contractor will process the independent clinical assessment and will batch this information into the MMIS. The independent clinical assessment will be effective for a 30 day period. The independent assessor will complete assessment documentation within three (3) business days.

6. If a community mental health services has been recommended, the parent or legal guardian will choose and contact a service provider. Prior to the initiation of treatment, the CMHRS service provider must request a copy of the findings of the independent clinical assessment. If the parent or legal guardian consents to the release of information, the independent assessor will mail, fax or send a copy of the independent clinical assessment to the service provider within five (5) business days of the request. The service provider (supported by the independent assessment) will then conduct a service specific provider
assessment for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Support Services (H0032, U8) and develop an initial service plan.

7. If the selected service provider concurs that the child meets criteria for the service recommended by the independent assessor, the selected service provider will submit a service authorization request to the service authorization contractor. A copy of the independent clinical assessment must be in the service provider’s client’s file. The service provider’s service specific provider assessment for IIH (H0031), Therapeutic Day Treatment (H0032, U7) or Mental Health Support Services (H0032, U8) must not occur prior to the mental health independent clinical service specific provider assessment.

8. If a service provider identifies the need for additional services not included in the independent clinical assessment that is clinically indicated due to a significant change in the child’s life that occurred after the independent clinical assessment, the service provider must contact the independent assessor and request a modification within thirty (30) days of the completion of the independent clinical assessment. If the independent clinical assessment is greater than thirty (30) days old, another independent clinical assessment must be obtained prior to the initiation of a new CMHRS service. Examples of a significant change include hospitalization; school suspension or expulsion; death of a significant other; or hospitalization or incarceration of a parent/legal guardian.

Service Authorization is required for the following services:

- Intensive In-Home (H2012)
- Community Residential Treatment, Level A (H2022 HW (CSA) H2022 HK (non CSA))
- Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) H2020 HK (non-CSA)
- Therapeutic Day Treatment for children up to age 21 (H0035)
- Day Treatment / Partial Hospitalization for adults 21 years of age and older (H0035)
- Intensive Community Treatment (H0039)
- Psychosocial Rehabilitation (H2017)
- Mental Health Support Services (H0046)
- Mental Health Case Management (H0023)

The Service Authorization process is described in Appendix C of this manual.

COMMUNITY MENTAL HEALTH SERVICES

The following mental health services are covered under the Medicaid Program. Carefully read the criteria, service definitions, and maximum service limits in the discussion of each service.

Service limitations are counted from the first date-of-service billed. The fiscal year period for the start up of this process will be July 1 through June 30.
Services are delivered to specific populations based on the mental health needs of each individual.

For those services not requiring service authorization the provider of choice may bill for an assessment even if the member is found ineligible for the service, as long as clear documentation of this activity is provided and the service specific provider assessment time duration is recorded and all service specific provider service specific provider assessment requirements (listed in Chapter IV) are met.

For services that require service authorization, the service specific provider assessment to determine specific medically necessity interventions may be billed using the designated service specific provider assessment procedure code and modifier (if needed). If there is a lapse in service for more than 30 consecutive days the reason for the lapse and the rationale for the continued need for the service must be documented. The ISP must be reviewed and updated to determine if there are changes, and signed by the client and/or family. If the assessor feels a more comprehensive service specific provider assessment is needed and there are additional service specific provider assessments available for the fiscal year, they may choose to complete a comprehensive service specific provider assessment and bill the appropriate service specific provider assessment code that corresponds to the service/treatment. Follow your agency’s policies regarding discharge procedures. Please refer to Chapter V of this manual for service specific provider assessment billing codes and instructions.

For all community mental health rehabilitative services that allow concurrent provision of case management, the service provider must collaborate with the case manager and primary care physician and provide notification of the provision of services. In addition, the provider must send monthly updates to the case manager. A discharge summary must be sent to the case manager within 30 days of the service discontinuation date. Case management can be provided through one of the following: Intensive In-Home services, Treatment Foster Care Case Management, mental health or intellectual disability/mental retardation case management from a Community Service Board (CSB) or Behavioral Health Authority (BHA), or case management for clients with developmental disabilities who are eligible for or receiving services through the Individual and Family Developmental Disabilities Support Waiver. Only one type of case management can be provided at a time.

Providers of all community mental health and substance abuse services are required to adhere to DMAS marketing requirements. Please see Appendix D for details on these requirements.

**SERVICE CRITERIA AND DEFINITIONS - EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) FOR INDIVIDUALS UNDER THE AGE OF 21**

**Intensive In-Home Services (IIH) for Children and Adolescents (H2012)**

**Service Definition**

IIH services for Children/Adolescents under age 21 are intensive, time-limited interventions provided typically but not solely in the residence of a child who is at risk of
being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to documented clinical needs of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g. counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response.

Home is defined as the family residence and includes a child living with natural parents, relatives, or a legal guardian, or the family residence of the child’s permanent or temporary foster care or pre-adoption placement. Children receiving Treatment Foster Care Case Management are not eligible for IIH services.

**Eligibility Criteria**

Effective July 18, 2011, an Independent Clinical Assessment that must be conducted by the CSB/BHA prior to the authorization of new service requests for IIH services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

Effective September 1, 2011, a completed Independent Clinical Assessment will be required for those individuals up to the age of 21 who are currently receiving services. CSBs/BHAs will conduct independent clinical assessments on and after August 1, 2011 for service re-authorizations with dates of service continuing on and after September 1, 2011.

Members of Intensive In-Home (IIH) Services 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 client’s functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Individuals must demonstrate a clinical necessity arising from a severe condition due to 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:

1. 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; and/or

2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; and/or

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example is at risk for acting out in such a fashion that will cause harm to themselves or others.

Services shall be used when there is a risk of out-of-home placement, due to the clinical needs of the child, and either:
1. Services that are far more intensive than outpatient clinic care are required to stabilize the child in the family situation; or
2. The child’s residence, as the setting for services, is more likely to be successful than a clinic.

With respect to both 1 and 2, the IIH service specific provider assessment must describe how services in the child’s residence are more likely to be successful than an outpatient clinic.

**“Out-Of-Home” Defined:**

An out-of-home placement (at risk of) is defined as one or more of the following:

- Level A or Level B group home
- Regular foster home (if currently residing with biological family and due to behavior problems is at risk of move to DSS custody)
- Treatment foster care placement (if currently residing with biological family or a regular foster family and due to behavior problems is at risk of removal to higher level of care) (IIH services would be provided to the child and the biological family or the foster family)
- Level C residential facility
- Emergency shelter (for child only, due to MH/behavioral problems),
- Psychiatric hospitalization
- Juvenile justice/incarceration placement (detention, corrections)

**At-Risk is defined as one or more of the following:**

- The youth currently has escalating behaviors that have put them or others at immediate risk of physical injury.
- The parent or legal guardian is unable to manage the mental, behavioral or emotional problems in the home and is actively seeking alternate out of home placement (within the past 2-4 weeks [it needs to be a current problem, not a threat of removal from the home that the parent has made in the past and not acted on]).
- List failed services within the past 30 days from one of the following:
  - Crisis Intervention
  - Crisis Stabilization
  - Outpatient Psychotherapy
  - Outpatient Substance Abuse Services
  - Mental Health Support (recommended age 18 or older)
- Recommendation for IIH by treatment team/FAP T team for a member currently in one of the following:
  - RTC Level C (transition)
  - Group Home Level A or B (transition)
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- Acute Psychiatric Hospitalization (transition)
- Foster Home (transition, or foster parent is unwilling to continue)
- MH case management
- Crisis Intervention
- Crisis Stabilization
- Outpatient Psychotherapy
- Outpatient Substance Abuse Services

The child and at least one parent or responsible adult with whom the child is living must be willing to participate in in-home services, with the goal of keeping the child with the family. Services must be directed toward the treatment of the eligible child.

Services may also be used to facilitate treatment after the transition to home from an out-of-home placement when services more intensive than outpatient clinic care are required for the transition to be successful. Upon discharge from Level A, B or C residential care facility the Independent Clinical Assessment will not be required for the first 30 days post discharge. The Independent Clinical Assessment will be required when service reauthorization for IIH is medically necessary.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment is allowed within IIH 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 treatment plan and the progress notes.

Required Activities:

- The provider must maintain a copy of the entire Independent Clinical Assessment in each member’s file. After the Independent Clinical Assessment and prior to admission a face-to-face service specific provider assessment must be conducted and documented. A LMHP or a LMHP-E must perform this service specific provider assessment to determine all necessary IIH services. If a LMHP-E performs the service specific provider assessment, the service specific provider assessment must be reviewed and signed by the LMHP within one business day of conducting the service specific provider assessment to collaboratively determine the client’s diagnosis. The service specific provider assessment must be conducted in the beneficiary’s home unless there is a documented safety or privacy issue. The service specific provider assessment must be conducted annually for youth that remain in service greater than 12 months.

- The service specific provider assessment must indicate the specifics of how the child meets the service eligibility criteria, is at risk an out of home placement related to their behavioral health issues, and that service needs can best be met through intensive in-home services. The IIH service specific provider assessment must list treatments that have been tried or explored within the last 30 days. The service specific provider assessment (H0031) must include the items specified by DMAS.
Service specific provider assessment Elements for DMAS Reimbursed Intensive In-Home Service:

All thirteen elements must be addressed in the provider specific assessment or payment will be retracted.

1. Presenting Issue(s)/Reason for Referral: Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms. Identify precipitating events/stressors, relevant history.) If child is at risk of out of home placement, state specific reason.

2. Mental Health History/Hospitalizations: Give details of mental health history and any mental health related hospitalizations and diagnoses, including the types of interventions that have been provided to the member. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past.

3. Medical Profile: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. As needed, an Individualized Fall Risk assessment: Does client have any physical conditions or other impairments that put her/him at risk for falling for children 10 years or younger, the risk should be greater than that of other children the same age.

4. Developmental History: Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. Educational/Vocational Status: School, grade, special ed. /IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships.

6. Current Living Situation and Family History and Relationships: Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning list all family members.

7. Legal Status: Indicate client's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

8. Drug and Alcohol Profile: Substance use / abuse of client / family members. Type of Substance, Frequency/Duration

9. Resources and Strengths: Verbalize member's strengths. Extracurricular activities, church, extended family
10. Mental Status Profile

11. Diagnosis: Diagnosis- Includes DSM-IV Code & Description—Diagnosis must be made by an LMHP.


13. Recommended Treatment Goals with time frames.

- An ISP must be completed by the QMHP within 30 days of the initiation of services and must document the need for services. The ISP will demonstrate the need for a minimum of three hours a week of IIH Service. If the minimum three hours is not provided, there must be documentation of a valid reason. IIH services below the three-hour-per-week minimum may be covered when services are being tapered off prior to discharge. However, variations in the pattern of service delivery must be consistent with the frequency of services specified for the goals and objectives of the service plan. Service plans must incorporate a discharge plan, which identifies transition from intensive in-home to less intensive or non-home-based services. The duration of weeks with fewer than 3 hours of services due to planned discharge may occur within the last 2 weeks of IIH treatment. The ISP plans must be cosigned by the member and/or parent/guardian participating in treatment.

- Services include: crisis treatment, individual and family counseling, communication skills counseling (to assist the child and parents in practicing appropriate problem-solving, anger management, interpersonal interaction, etc.), case management activities, coordination with other required services, and 24-hour emergency response.

- Services must be delivered in the child’s home with the child present. If it is determined that the content of the session is inappropriate for the child to be present, this must be documented. Documentation must reflect the necessity of providing services related to the child’s issues, without the child present.

- In some circumstances, such as lack of privacy or unsafe conditions, services may be provided in the community instead of the home, if this is supported by the service specific provider assessment and the ISP.

- Direct clinical services must be provided by a QMHP, QMHP eligible, LMHP or a LMHP-E.

- “Licensed mental health professional (LMHP)” refers to a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, a psychiatric clinical nurse specialist and a psychiatric nurse practitioner. If psychotherapy is to be billed by the LMHP, the therapist must comply with the outpatient psychotherapy criteria outlined in Chapters II, IV, V, and VI of the Psychiatric Services Provider Manual.
LMHP-E refers to an individual who has completed his or her graduate degree from an accredited program and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards licensure in the State of Virginia and be supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.

A LMHP or a LMHP-E must provide clinical supervision at regular intervals. The full-time work schedule is 32 hours or more per week. Full time LMHP or the LMHP-E can supervise up to 10 staff; Half-time staff whose work schedule 16 to 31.9 hours per week can supervise up to five (5) supervisees. If a supervisor works less than half time, the supervision limit is two (2) counselors.

The LMHP or LMHP-E must provide clinical supervision weekly, with individual face to face supervision occurring at least every other week. Group supervision may occur on the other weeks. If the supervisor is on leave for one episode that is more than two weeks, a substitute supervisor must provide clinical supervision.

The clinical supervisor (LMHP or a LMHP-E) must be available for consultation as needed, 24/7.

Supervision for clinical staff must be documented by the LMHP or a LMHP-E providing the supervision activity. A supervision log or note must be placed in the client’s file documenting that supervision was provided. A more detailed note written by the supervisor summarizing the meeting and noting any recommendations must be maintained in a separate file.

A QMHP can only provide administrative supervision. The LMHP or a LMHP-E must provide clinical supervision.

Because Intensive In-Home Services are EPSDT services, a referral should be made to the child’s health care provider for a well child or EPSDT screening.

The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

Limitations

Intensive In-Home Services (H2012) requires service authorization before any services (beyond the service specific provider assessment) are reimbursed. The provider’s clinical service specific provider assessment will continue to be allowed to be billed without service authorization.

For full time equivalent staff the caseload cannot exceed five clients. If a member is transitioning out of Intensive In-Home Services, the caseload may be 1:6 for up to 30 days. A team approach may be utilized consistent with FTE ratio above.
Since case management services are an integral and inseparable part of IIH services, any and all types of case management services cannot be billed separately for periods of time when IIH services are being reimbursed. Coordination must occur for all services that the child receives. Only one type of case management can be provided at a time.

- Equine therapy is not a reimbursable service.
- Couples therapy that does not directly relate to the youth’s behavioral health issues is not reimbursable.
- Tutoring or assisting with academic instruction is not a reimbursable service.
- Observational sessions greater than one hour conducted in the school environment during the school day will not be reimbursable. These sessions must have a specific clinical rationale and be requested by school staff related to the youth’s behavioral health problems.
- Telephone calls must be limited and may not take the place of Face to Face therapeutic interventions.
- Service is not appropriate for a family while the child is not living in the home or for families being kept together until an out-of-home placement for the child can be arranged.
- Staff travel time is excluded.
- Provider transportation is not reimbursable.
- Activities outside the home, such as trips to the library, restaurants, museums, health clubs, shopping centers, and the like, are not considered a part of the scope of services. There must be a clinical rationale documented for any activity provided outside the home. Services may be provided in the community instead of the home if this is supported by the service specific provider assessment and the ISP.
- IIH may not be billed prior to discharge from any Level A, Level B, or Level C residential service.
- Outpatient therapy may occur simultaneously as long as services are not duplicated and there is coordination with the treating therapist.
- Providers must comply with DBHDS licensing requirements.

**Service Units and Maximum Service Limitations**

- The service limit for provider service specific provider assessments is 2 per provider per member per fiscal year. This allows each provider to bill 2 service specific provider assessments for each individual from July 1 – June 30 of every year.
The service specific provider assessment code (H0031) must be billed before the service treatment (H2012) will pay in the Medicaid Management of Information System (MMIS) claims system. For new client’s the provider’s service specific provider assessment must not occur prior to the Independent Clinical Assessment or there will be post payment retractions (Note Chapter V for service specific provider assessment billing instructions).

The unit of service for IIH service is one hour.

For reimbursement of this service, a minimum of 3 hours per week of therapeutic intervention must be medically necessary for the individual, with a maximum of 10 hours per week. In exceptional circumstances only, and with appropriate supporting documentation that describes medical necessity, providers may bill for up to 15 hours per week. The service authorization vendor will authorize up to a maximum of 50 hours per calendar month.

The information provided for service authorization must corroborated and be validated in the clinical record. An approved Service Authorization is required for any units of service (H2012) to be paid. The process for requesting service authorization is detailed in Appendix C of this manual.

A maximum of 26 weeks of Intensive In-Home Services may be authorized annually with coverage under the State Plan Option service. The MMIS claims payment system will stop payment for State Plan Option Services when claims exceed the 26 week service limit allowed in the regulations. If the member is in need of services beyond the State Plan Option Service limit of 26 weeks, providers must request the service extension through the PA vendor under Early and Periodic Screening Diagnosis and Testing (EPSDT). The MMIS system starts counting the State Plan Option Service limit on July 1st of every year. Once the 26 weeks are used, providers may request extended services under EPSDT through June 30th of each year. The IIH Service limits under State Plan Option will renew each July 1st to 26 weeks per member.

A week is defined as Sunday through Saturday.

The annual treatment year for all members is defined as the period July 1 through the following June 30.

Discharge Criteria

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if the following applies:

   a. The child is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms; and

   b. The level of functioning has improved with respect to the goals outlined in the ISP, and the child can reasonably be expected to maintain these gains at a lower
level of treatment.

**Therapeutic Day Treatment (TDT) for Children and Adolescents (H0035)**

**Service Definition**

Covered services are a combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in programs of two or more hours per day with groups of children and adolescents (up to the age of 21 as a EPSDT service).

**Eligibility Criteria**

Effective July 18, 2011, an Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for TDT services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.

Effective September 1, 2011, a completed Independent Clinical Assessment will be required for those individuals up to the age of 21 who are currently receiving services. CSBs/BHAs will conduct independent clinical assessments on and after August 1, 2011 for service re-authorizations with dates of service continuing on and after September 1, 2011.

Recipients of 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 member’s functioning. It is unlikely that individuals with severe cognitive and developmental delays/impairments would clinically benefit and meet the service eligibility criteria.

Children and adolescents must demonstrate a clinical necessity for the service arising from a condition due to a **mental, behavioral, or emotional illness** that results in significant functional impairments in major life activities. A psychiatric diagnosis (DSM-IV, Axis I) is required. This determination of significant disability should be based upon consideration of the social functioning of most children who are the same age. The disability must have become more disabling over time (within the past 30 days) and must require **significant** intervention through services that are supportive, intensive, and offered over a period of time in order to provide therapeutic intervention. Individuals must meet **at least two** of the following on a continuing or intermittent basis (within the past 6 months) and the support for this must be clearly documented in the medical record with child-specific examples:

1. 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 (see definition below) because of conflicts with family or community.

2. Exhibit such inappropriate behavior that recent repeated interventions by the mental health, social services, educational system, or judicial system are necessary. *For example, crisis intervention services have been provided, outside intervention for truancy has been made, or there have been repeated in school
and out of school suspensions that must be addressed as a part of the TDT Individual Service Plan.

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example the youth exhibits acting out in such a fashion that will cause harm to themselves or others.

An out-of-home placement (at risk of) is defined as one or more of the following:

- Level A or Level B group home;
- Regular foster home (if currently residing with biological family and due to behavior problems is at risk of move to DSS custody);
- Treatment foster care placement (if currently residing with biological family or a regular foster family and due to behavior problems is at risk of move to higher level of care);
- Level C residential facility;
- Emergency shelter (for child only, due to MH/behavioral problems); or
- Psychiatric hospitalization, juvenile justice/incarceration placement (detention, corrections).

In addition to meeting two of the three criteria listed above, children and adolescents must meet one of the following that must be supported by child-specific documentation in the medical record:

1. Have deficits in social skills, peer relations, or dealing with authority; are hyperactive; have poor impulse control; or are experiencing a diagnosed behavioral issue. The deficits or problem behaviors must be documented in the medical record and must be to the level that they significantly impact the child’s abilities to participate in activities of daily living compared to most children who are the same age.

2. Would otherwise be placed on homebound instruction because of severe emotional or behavioral problems, or both, that interfere with learning. The medical record must contain documentation from the school that supports this criterion.

3. Require year-round (9-12 months) treatment in order to sustain behavioral or emotional gains. The medical record must document the need for year-round treatment and any periods when service has been decreased and behavioral or emotional gains have been lost.

4. Behavioral and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without this programming during the school day or as a supplement to the school day or school year. The medical record must document the type of classroom programming that is unable to meet the child’s needs, and why the needs are not able to be met and how the problem behaviors are exhibited.
5. Children in preschool enrichment and early intervention programs when the child’s emotional or behavioral problems, or both, are so severe that he/she cannot function in these programs without therapeutic day treatment services. *The medical record must clearly document the severity of the problems and how they impact participation in the preschool or intervention programs.*

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed 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 treatment plan and the progress notes.

**Required Activities:**

- The provider must maintain a copy of the entire Independent Clinical Assessment in each member’s file. Prior to admission, a face-to-face service specific provider assessment must be conducted and documented. A LMHP or a LMHP-E must perform a service specific provider assessment to determine all necessary TDT services. If a license-eligible professional performs the service specific provider assessment, the service specific provider assessment must be reviewed with the LMHP within 24 hours of conducting the service specific provider assessment to collaboratively determine the client’s diagnosis. The service specific provider assessment (H0032, U7) must include the following elements specified by DMAS. All thirteen elements must be addressed in the service specific provider assessment or payment will be retracted.

1. **Presenting Issue(s)/Reason for Referral:** Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms. Identify precipitating events/stressors, relevant history.) If child is at risk of out of home placement, state specific reason.

2. **Mental Health History/Hospitalizations:** Give details of mental health history and any mental health related hospitalizations and diagnoses, including List the types of interventions that have been provided to the member. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past.

3. **Medical Profile:** Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. Individualized Fall Risk assessment: Does client have any physical conditions or other impairments that put her/him at risk for falling For children 10 years or younger, the risk should be greater than that of other children the same age.

4. **Developmental History:** Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. **Educational/Vocational Status:** School, grade, special ed./IEP status, grades,
behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships

6. **Current Living Situation and Family History and Relationships:** Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning list all family members.

7. **Legal Status:** Indicate client's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations

8. **Drug and Alcohol Profile:** Substance use / abuse of client / family members. Type of Substance, Frequency/Duration

9. **Resources and Strengths:** Verbalize member’s strengths. Extracurricular activities, church, extended family

10. **Mental Status Profile.**

11. **Diagnosis:** Diagnosis- Includes DSM-IV Code & Description.

12. **Professional Service specific provider assessment Summary/ Clinical Formulation:** Documentation of needed services.

13. **Recommended Treatment Goals:**

   • Service authorization is not required to bill for the face-to-face service specific provider assessment. (Note Chapter V for service specific provider assessment code and billing instructions).

   • The provider’s service specific provider assessment must be reviewed and updated at least annually.

   • As needed, referrals to the member’s primary care provider for Early and Periodic, Screening, Diagnosis, and Treatment screening examinations are to be made and documented in the medical record. The results of the screening exams should be included in the medical record.

   • A comprehensive ISP indicating all entities participating in treatment must be completed by a QMHP documenting the need for services within 30 days of service initiation. Services must be provided in accordance with the ISP. The ISP must be cosigned by the member or legal guardian.

   • Medicaid will only reimburse for allowed service activities. Time not actively involved in providing services directed by the ISP is not allowed. This means indirect services (time not spent working with the child or on behalf of the child) are not allowed to be billed for Medicaid reimbursement.

   • Allowed Reimbursable Activities:
Completing diagnostic evaluations, assessing treatment needs;
Consultation with teachers and others involved in the child/adolescent’s treatment and observation in the classroom;
Planning and implementing individualized pro-social skills curriculums and interventions; e.g., problem-solving, anger management, community responsibility, increased impulse control, appropriate peer relations, etc.,
Monitoring progress in demonstrating the acquisition of pro-social skills (anger management, problem-solving skills, identification and appropriate verbalization of feelings, conflict resolution, etc.);
Implementing cognitive-behavioral programming;
Planning and implementing individualized behavior modification programs and monitoring progress through collaboration with school personnel, family, and others involved in the child/adolescent’s treatment; (Family contacts, either in person or by telephone, occurs at least once per week.
Responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day;
Providing individual, group, and family counseling based on specific treatment objectives;
Collaborating with all other community practitioners providing services to the child/adolescent, including scheduling appointments and meetings, and
If the child or adolescent is on medication, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the child/adolescent and parent/guardian and documented. Response to medication and education, as well as compliance must also be documented.

Activities that are not allowed / reimbursed:
Inactive time or time spent waiting to respond to a behavioral situation;
Transportation; and
Time spent in documentation of client and family contacts, collateral contacts, and clinical interventions

The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

A daily log of services provided is documented. The student’s response to the interventions must be included in the daily log. A minimum of a weekly summary must include a description of the child or adolescent’s behavior, the staff interventions, and the response to the interventions. The summary must support the time billed and must be filed in the chart within 1 week of service provision. The weekly summary must include a description of all intensive behavioral health provided to support the number of units billed for the specific date of service.

Limitations

The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., before school, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group counseling/therapy and psychoeducational activities.
• At a minimum, services are provided by a QMHP or QMHP eligible staff.

• The caseload for the direct service provider is a maximum of six (6) children per day.

• Therapeutic group activities, such as counseling, psychotherapy, and psycho-education are limited to no more than 10 individuals.

• If an individual receiving Day Treatment for Children and Adolescents is also receiving case management services the provider must collaborate with the case manager and pediatrician by notifying the case manager and the pediatrician of the provision of Day Treatment for Children and Adolescents. Monthly updates on the individual’s progress are sent to the case manager. A discharge summary must be sent to the case manager when the service is discontinued.

• Services must not duplicate those services provided by the school.

**Service Units and Maximum Service Limitations**

• There is a maximum of 780 units that are allowed based on medical necessity per fiscal year.

  One unit = 2 to 2.99 hours  
  Two units = 3 to 4.99 hours  
  Three units = 5 plus hours  
  No more than three units can be billed per day.

• Claims must be billed with an HA modifier. (Please note the special billing instructions included in Chapter V of this manual).

• A maximum of 780 units of TDT can authorized annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

• Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement.

• Staff travel time is excluded.

**Discharge Criteria**

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if the following applies:

   a. The child does not demonstrate meeting the eligibility criteria and;

   b. The level of functioning has improved with respect to the goals outlined in the
ISP, and the child can reasonably be expected to maintain these gains at a lower level of treatment.

Community-Based Residential Services for Children and Adolescents Under 21 (Level A)  
**H2022 HW (CSA), H2022 HK (non CSA)**

**Service Definition**

Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This residential service will provide structure for daily activities, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals as identified in the treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Service authorization is required for Medicaid reimbursement. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.

**Eligibility Criteria**

Individuals qualifying for this service must demonstrate medical 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 in the home, school, at work, or in the community. The service must reasonably be expected to improve the child’s condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when all of the following are met:

A) The member is medically stable, but needs intervention to comply with mental health treatment; and

B) The member’s needs cannot be met with a less intense service; and

C) An assessment which demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment tool (CANVasS) must be completed by the locality for Comprehensive Services Act (CSA) children/adolescents and must be current to within 30 days of placement. For non-CSA children, a service specific provider assessment must be made by the independent referring clinician noting at least two moderate impairments within the past 30 days. A moderate impairment is evidenced by, but not limited to:

   (1) Frequent conflict in the family setting such as credible threats of physical harm. Frequent is defined as more than expected for the child’s age and developmental level.
(2) Frequent inability to accept age-appropriate direction and supervision from caretakers, family members, at school, or in the home or community.

(3) Severely limited involvement in social support, which means significant avoidance of appropriate social interaction, deterioration of existing relationships, or refusal to participate in therapeutic interventions.

(4) Impaired ability to form a trusting relationship with at least one caretaker in the home, school, or community.

(5) Limited ability to consider the effect of one’s inappropriate conduct on others and interactions consistently involving conflict, which may include impulsive or abusive behaviors.

If a child or adolescent has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Community-Based Residential Treatment 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 treatment plan and the progress notes.

A CSA child is defined as one who receives any CSA funding, including payments only for educational expenses. A non-CSA child receives no CSA funding or is an adoption subsidy case.

**Independent Team Certification**

For CSA children, the Family Assessment and Planning Team’s (FAPT) identification of the need for the service and the Community Policy and Management Team’s (CPMT) authorization for payment will constitute certification by an independent team. Coordination with the child or adolescent’s primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) provider should occur.

For CSA children only, the placing agent must give the provider the name of the locality fiscally responsible for the child. The provider will be submitting this information to the service authorization contractor.

For non-CSA children, the authorizing independent team shall consist of the child or adolescent’s PCP and a LMHP not affiliated with the residential provider. If the child or adolescent is away from home, as in another level of residential treatment, and cannot access the PCP, another physician who has knowledge of the child/adolescent may complete the certification.

A Medicaid-reimbursed admission to a community residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the member;
2. Proper treatment of the member’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3. The services can reasonably be expected to improve the member’s condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed and signed and dated by the screener and the physician prior to the start of services (see “Exhibits” section at the end of this chapter for a sample of the form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent certifying team, prior to admission, that:

1) Includes a licensed physician who:
   (i) Has competence in diagnosis and treatment of pediatric mental illness; and
   (ii) Has knowledge of the member’s mental health history and current situation.

B. For a member who applies for Medicaid while an inpatient in the facility or program, the certification must:

1) Be made by the team responsible for the CIPOC;
2) Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and
3) Includes the dated signatures of a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

**Continued Stay Criteria for Level A**

Service authorization through the service authorization contractor for continued stay is required. A qualified mental health provider must re-assess the medical necessity for service after six consecutive months. The re-assessment must also be signed by a licensed mental health provider. The licensed mental health provider for the re-assessment and continued service authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that assesses and recommends continuation of the service must be in the client’s record.

1. For continued treatment beyond the initial six month authorization, the current (within 30 days) Comprehensive Individual Plan of Care (CIPOC) update of progress related to the goals and objectives must document the need for the continuation of the service.
2. For re-authorization to occur, either the desired outcome or level of functioning has not been restored or improved, in the time frame outlined in the child’s CIPOC or the child continues to be at risk for relapse based on history or the tenuous nature of the functional gains, and use of less intensive services will not achieve stabilization. InterQual Criteria must be met as well as any one of the following must apply:

A) The child has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.

B) The child is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.

C) The child is not making progress, and the CIPOC has been modified to identify more effective interventions.

D) There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of residential treatment.

Discharge Criteria

1. Medicaid reimbursement is not available when other less intensive services may achieve stabilization. Reimbursement shall not be made for this level of care if any of the following applies:

   a. The level of functioning has improved with respect to the goals outlined in the CIPOC and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

   b. The child no longer benefits from service as evidenced by absence of progress toward CIPOC goals for a period of 60 days.

   c. InterQual® Behavioral Health criteria and Community Based Treatment criteria is no longer met.

Documentation

- For CSA cases, the Virginia Child and Adolescent Needs and Strengths (CANVaS) will be used for assessment required prior to admission.

- For non-CSA cases, the service specific provider assessment by the EPSDT physician and independent LMHP must include the elements specified by DMAS.

1. **Presenting Issue(s)/Reason for Referral:** Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms. Identify precipitating events/stressors, relevant history. If child is at risk of out of home placement, state specific reason.

2 **Mental Health History/Hospitalizations:** Give details of mental health history and any
mental health related hospitalizations and diagnoses, including list the types of interventions that have been provided to the member. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past.

3. **Medical Profile:** Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. Individualized Fall Risk assessment: Does client have any physical conditions or other impairments that put her/him at risk for falling. For children 10 years or younger, the risk should be greater than that of other children the same age.

4. **Developmental History:** Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. **Educational/Vocational Status:** School, grade, special ed./IEP status, grades, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships.

6. Current **Living Situation and Family History and Relationships:** Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning list all family members.

7. **Legal Status:** Indicate client's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations.

8. **Drug and Alcohol Profile:** Substance use / abuse of client / family members. Type of Substance, Frequency/Duration

9. **Resources and Strengths:** Verbalize member’s strengths. Extracurricular activities, church, extended family

10. **Mental Status Profile.**

11. **Diagnosis:** Diagnosis- Includes DSM-IV Code & Description.

12. **Professional Service specific provider assessment Summary/ Clinical Formulation:** Documentation of the needed services.

13. **Recommended Treatment Goals.**

   - The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission.
   - The Initial Plan of Care (IPOC) must be completed upon admission by the QMHP and must be signed and dated by the program director. (See the “Exhibits” section
The IPOC must include:
1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the child;
3. Treatment objectives with short-term and long-term goals;
4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.

A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the QMHP within 30 days of authorization for Medicaid reimbursement. (See the “Exhibits” section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

The CIPOC must:
1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child’s situation and must reflect the need for residential psychiatric care;
2. Be based on input from school, home, other healthcare providers, the child, and family (or legal guardian);
3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;
5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child’s family, school, and community;
6. The CIPOC must be reviewed and signed by a QMHP every 30 days. The review must include:
   • The response to services provided; and
• Recommended changes in the plan as indicated by the child’s overall response to the ISP interventions; and

• Determinations regarding whether the services being provided continue to be required; and

• Updates must include the dated signatures of the QMHP service provider.

Required Activities:

• There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues, indicated in the member’s IPOC and the CIPOC.

• Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. The child must participate in seven (7) psycho-educational activities per week. Program activities must be documented at the time the service is rendered and must include the dated signatures of qualified staff rendering the service.

• In addition to the residential services, the child must receive at least weekly, individual psychotherapy that is provided by a LMHP. Family psychotherapy may also be provided if there is continued family involvement. Therapy sessions are limited to no more than three (3) sessions in a seven-day period, including individual, family, and group psychotherapy. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized (see the Psychiatric Services Provider Manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and documentation criteria.) If the weekly psychotherapy is missed due to the member’s illness or refusal, justification must be in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up a missed session.

• The facility/group home must coordinate services with other providers.

• The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of this community mental health rehabilitative service.

• If an individual receiving Community-Based Services for Children and Adolescents under 21 (Level A) is also receiving case management services the provider must collaborate with the case manager by notifying the case manager of the provision of Level A services and send monthly updates on the individual’s progress. A discharge summary must be sent when the service is discontinued.

• The staff ratio must be at least 1 to 6 during the day and at least 1 to 10 while the children/adolescents are scheduled to be asleep. To assist in assuring client safety,
the agency must provide adequate supervision of residents at all times, including off campus activities.

**Therapeutic Passes**

Therapeutic passes are permitted if the goals of the pass are part of the master treatment plan. The goals of a particular visit must be documented prior to granting the pass. When the child or adolescent returns from the pass, the response to the pass must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. The function of the pass is to assess the member’s ability to function outside the structured environment and to function appropriately within the family and community.

A. Overnight passes may occur only after the completion and documentation of successful day passes and as a part of the discharge plan. Outcomes of the therapeutic leave must be documented. No more than 24 days of therapeutic leave annually are allowed. Days of leave are counted from the date of admission to Medicaid covered services at the A and B levels. Overnight passes from Level C Residential Treatment Services are not included in the allowance for Levels A and B. (Please refer to the Psychiatric Services Provider Manual for Level C Residential Treatment.) If a child/adolescent has successfully completed day passes at a higher level of care in the previous placement the child/adolescent may be granted overnight passes prior to the completion of day passes at the new program if therapeutically indicated. Provision of active therapeutic services while on overnight passes is required to bill for days away from the facility.

B. If a child requires acute, inpatient medical treatment (non-psychiatric), is on runaway status, or goes to detention for more than 10 days, for Medicaid purposes, the authorization will need to be end-dated and addressed as a discharge. Any subsequent residential treatment would be considered a new admission. If a child requires acute psychiatric admission, any subsequent residential treatment would also be considered a new admission.

- None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a DMAS residential authorization.

**Limitations**

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.
DMAS does not pay for programs/facilities that only provide independent living services.

**Service Units and Maximum Service Limitations**

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included.

Service authorization is required for payment of all residential services billed to Medicaid. Please note that the service authorization process is described in Appendix C of this manual.

The fiscal years will be run from July 1 through June 30.

**Therapeutic Behavioral Services (Level B) – H2020 HW (CSA) H2020 HK (non-CSA)**

**Service Definition**

Therapeutic Behavioral Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and activities, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or the academic educational needs of the members. Service authorization is required for Medicaid reimbursement. See Appendix C for service authorization information.

**Eligibility Criteria**

Individuals qualifying for this service must demonstrate medical 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 in the home, school, at work, or in the community. The service must reasonably be expected to improve the child’s condition or prevent regression so that the services will no longer be needed.

The individual is eligible for this service when all of the following are met:

A. The member is medically stable, but needs intervention to comply with mental health treatment; AND

B. The individual’s needs cannot be met with a less intense service; AND

C. An assessment demonstrates at least two areas of moderate impairment in major life activities. A moderate impairment is defined as a major or persistent disruption in major life activities. The state uniform assessment (CANVaS) tool must be completed by the locality for Comprehensive Services Act (CSA) children/adolescents and must be current
to within 30 days of placement. For non-CSA children, a service specific provider
assessment must be made by the EPSDT physician and an independent LMHP noting at
least two moderate impairments within the past 30 days. A moderate impairment is
evidenced by, but not limited to:

1. Frequent conflict in the family setting; for example, credible threats of physical
   harm. Frequent is defined as more than expected for the child’s age and
developmental level.

2. Frequent inability to accept age-appropriate direction and supervision from
caretakers, family members, at school, or in the home or community.

3. Severely limited involvement in social support; which means significant
   avoidance of appropriate social interaction, deterioration of existing
   relationships, or refusal to participate in therapeutic interventions.

4. Impaired ability to form a trusting relationship with at least one caretaker in the
   home, school, or community.

5. Limited ability to consider the effect of one’s inappropriate conduct on others
   and/or interactions consistently involving conflict, which may include impulsive
   or abusive behaviors.

If a child or adolescent has co-occurring mental health and substance abuse disorders,
integrated treatment for both disorders is allowed within Community-Based Residential
Treatment 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 primary mental health condition must be documented in the treatment plan and the
progress notes.

**Independent Team Certification**

For CSA children, the Family and Planning Team’s (FAPT) identification of the need for
the service and the Community Policy and Management Team’s (CPMT) authorization for
payment will constitute certification by an independent team. Coordination with the child
or adolescent’s primary care physician (PCP) or Early, Periodic, Screening, Diagnosis, and
Treatment (EPSDT) provider should occur.

For CSA children only, the placing agent must give the provider the name of the locality
fiscally responsible for the child. The provider will be submitting this information to the
service authorization contractor.

For non-CSA children, the authorizing independent team shall consist of the child or
adolescent’s PCP and a LMHP not affiliated with the residential provider. If the child or
adolescent is away from home, as in another level of residential treatment, and cannot
access the PCP, another physician who has knowledge of the child/adolescent may
complete the certification.

A Medicaid-reimbursed admission to a community residential treatment facility can only
occur if the independent team can certify that:
1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the member;
2. Proper treatment of the member’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the member’s condition or prevent further regression so that the services will no longer be needed.

The certification of need for admission must be completed, signed, and dated by the screener and the physician prior to the start of services (see “Exhibits” section at the end of this chapter for a sample of this form).

At least one member of the independent certifying team must have pediatric mental health expertise.

A. For an individual who is already a Medicaid member when he/she is admitted to a facility or program, certification must be made by an independent team prior to admission that:
   1. Includes a licensed physician who:
      i.) Has competence in diagnosis and treatment of pediatric mental illness; and
      ii.) Has knowledge of the member’s mental health history and current situation.
   2. Signs and dates the certification. Signatures must include the physician and the team. For CSA children, the majority of the FAPT (requires 3 members) and a physician must sign and date the certification. For non-CSA children, the LMHP and a physician must sign and date the certification.

B. For a member who applies for Medicaid while an inpatient in the facility or program, the certification must:
   1. Be made by the team responsible for the Comprehensive Plan of Care (CIPOC);
   2. Cover any period of time before the application for Medicaid eligibility for which claims for reimbursement by Medicaid are made; and
   3. Be signed and dated by a physician and the team.

The date of Independent Team Certification is based on the date of the latest required signature. All signatures must be dated.

**Continued Stay Criteria for Level B**
Service authorization through the SA contractor for continued stay is required. A qualified mental health provider must re-assess for medical necessity for service after six months. The re-assessment must also be signed by a licensed mental health provider (LMHP). The
LMHP for the re-assessment and continued service authorization may be an independent practitioner or may be affiliated with the residential program. For CSA children, documentation from the CPMT that assesses and recommends continuation of the service must also be in the client’s record.

1. For continued treatment beyond the initial six month authorization a current CIPOC and a current (within 30 days) progress update related to the goals and objectives on the CIPOC must document the need for the continuation of the service.

2. For authorization to occur past the initial six months, either the desired outcome or level of functioning has not been restored or improved in the time frame outlined in the child’s ISP, or the child continues to be at risk for relapse based on recent history or the tenuous nature of the functional gains and use of less intensive services will not achieve stabilization. InterQual® criteria must be met as well as any one of the following:

A. The child has achieved initial CIPOC goals but additional goals are indicated that cannot be met at a lower level of care.

B. The child is making satisfactory progress toward meeting goals but has not attained CIPOC goals, and the goals cannot be addressed at a lower level of care.

C. The child is not making progress, and the CIPOC has been modified to identify more effective interventions.

D. There are current indications that the child requires this level of treatment to maintain level of functioning as evidenced by failure to achieve goals identified for therapeutic visits or stays in a non-treatment residential setting or in a lower level of care.

**Discharge Criteria**

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

1. Reimbursement shall not be made for this level of care if any of the following applies:

   a. The level of functioning has improved with respect to the goals outlined in the ISP, and the child can reasonably be expected to maintain these gains at a lower level of treatment; or

   b. The child no longer benefits from service as evidenced by absence of progress toward service plan goals for a period of 60 days.

   c. InterQual® Behavioral Health Criteria, and Residential and Community-Based Treatment criteria is no longer met.

**Documentation**

- For CSA cases, the Virginia Child and Adolescent Needs and Strengths (CANVaS) will
be used for assessment required prior to admission.

- For non-CSA cases, a service specific provider assessment by the EPSDT physician and independent LMHP must include the following elements specified by DMAS.

1. **Presenting Issue(s)/Reason for Referral**: Chief Complaint. Indicate duration, frequency and severity of behavioral symptoms. Identify precipitating events/stressors, relevant history.) If child is at risk of out of home placement, state specific reason.

2. **Mental Health History/Hospitalizations**: Give details of mental health history and any mental health related hospitalizations and diagnoses, including List the types of interventions that have been provided to the member. Include the date of the interventions and the name of the provider. List family members and the dates and the types of treatment that family members either are currently receiving or have received in the past.

3. **Medical Profile**: Significant past and present medical problems/illnesses/injuries/known allergies; current physical complaints/medications. Individualized Fall Risk assessment: Does client have any physical conditions or other impairments that put her/him at risk for falling For children 10 years or younger, the risk should be greater than that of other children the same age.

4. **Developmental History**: Describe client as an infant & toddler: child's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and parents ability to provide these; parents feelings/thoughts about child as an infant and toddler. Was the client significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?

5. **Educational/Vocational Status**: School, grade, special ed./IEP status, grades, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, peer relationships.

6. **Current Living Situation and Family History and Relationships**: Daily routine & structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting client and family's functioning list all family members.

7. **Legal Status**: Indicate client's criminal justice status. Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations.

8. **Drug and Alcohol Profile**: Substance use / abuse of client / family members. Type of Substance, Frequency/Duration.

9. **Resources and Strengths**: Verbalize member’s strengths. Extracurricular activities, church, extended family.

10. **Mental Status Profile**.

11. **Diagnosis**: Diagnosis- Includes DSM-IV Code & Description.
12. **Professional Service specific provider assessment Summary/ Clinical Formulation:**
Document the need for services.

13. **Recommended Treatment Goals.**

   - The Independent Team Certificate of Need or CON, which is a demonstration of the need for the service, is required prior to admission.

   - The Initial Plan of Care (IPOC) must be completed upon admission (within 24 hours) by the LMHP and must be signed and dated. (See the “Exhibits” section at the end of this chapter for a sample form. The sample form is not required to be used as shown but must, at a minimum, include all the elements of the sample).

   - The IPOC must include:
     1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

     2. A description of the functional level of the child;

     3. Treatment objectives with short-term and long-term goals;

     4. A listing of any medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient;

     5. Plans for continuing care, including review and modification to the plan of care; and

     6. Plans for discharge.

   - There must be provision of individualized and intensive supervision and structure of daily living designed to minimize the occurrence of behaviors related to functional deficits as identified in the initial plan of care (IPOC);

   - A fully developed Comprehensive Individual Service Plan (CIPOC) must be completed by the LMHP within 30 days of admission;

   The CIPOC must:

   1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the child’s situation and must reflect the need for residential psychiatric care;

   2. Be based on input from school, home, other healthcare providers, the child, and family (or legal guardian);

   3. State treatment objectives that include measurable short-term and long-term goals and objectives, with target dates for achievement;
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives related to the diagnosis;

5. Describe comprehensive discharge plans with related community services to ensure continuity of care upon discharge with the child’s family, school, and community; and

6. The CIPOC must be reviewed signed by the LMHP every 30 days. The review must include:
   - The response to services provided;
   - Recommended changes in the plan as indicated by the child’s overall response to the ISP interventions;
   - Determinations regarding whether the services being provided continue to be required; and
   - Updates must be signed and dated by the LMHP service provider.

**Required Therapeutic Activities**

- There must be daily documentation of the provision of individualized supervision and structure designed to minimize the occurrence of behavioral issues, indicated in the member’s IPOC and the CIPOC.

- Daily documentation of services provided must clearly reflect behaviors, activities, and treatment methodologies that indicate attention to and movement toward stated goals and objectives in the CIPOC.

- Psycho-educational programming, which is part of the residential program, must include, but is not limited to, development or maintenance of daily living skills, anger management, social skills, family living skills, communication skills, and stress management. The child must participate in seven (7) psycho-educational activities per week. Program sessions must be documented at the time the service is rendered and must be signed and dated by the qualified staff rendering the service.

- In addition to the residential services, the child must receive at least weekly, individual psychotherapy that is provided by a LMHP. Family psychotherapy may also to be provided if there is continued family involvement. If provided by a Medicaid-enrolled provider, the psychotherapy services may be billed separately as outpatient psychiatric services and must be prior authorized in addition to the authorization for the residential services. (See *Psychiatric Services* provider manual, Appendix C and Chapter IV, for details on outpatient service authorization procedures and criteria) If the weekly psychotherapy is missed due to the member’s illness or refusal written justification must be in the clinical record. More than two (2) missed sessions per quarter will be considered excessive. Reasonable attempts should be made to make up missed sessions. Individuals receiving Therapeutic Behavioral Services (Level B) must also receive group psychotherapy that is provided as part of the program. If provided by a Medicaid-
enrolled LMHP, group psychotherapy may be billed separately and must be prior
authorized in addition to the authorization for the residential services (See
Psychiatric Services provider manual, Chapter IV and Appendix C, for details on
outpatient requirements and pre-authorization procedures).

- The facility/group home must coordinate services with other providers.
- The service provider must notify or document the attempts to notify the primary
care provider or pediatrician of the member’s receipt of this community mental
health rehabilitative service.
- If an individual receiving Day Therapeutic Behavioral Services for Children and
Adolescents under 21 (Level B) is also receiving case management services the
provider must collaborate with the case manager by notifying the case manager of
the provision of Level B services and send monthly updates on the individual’s
progress. A discharge summary must be sent when the service is discontinued.
- The staff ratio must be at least 1 staff to 4 children during the day and at least 1
staff to 8 children while the children/adolescents are scheduled to be asleep. To
assist in assuring client safety, the agency must provide adequate supervision of
residents at all times, including off campus activities.

Therapeutic Passes
Therapeutic passes are permitted if the goals of the pass are part of the master treatment
plan. The goals of a particular visit must be documented prior to granting the pass. When
the child or adolescent returns from the pass, the response to the pass must be documented.
Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an
overnight pass. The function of the pass is to assess the member’s ability to function
outside the structured environment and to function appropriately within the family and
community.

A. Overnight passes may occur only after the completion and documentation of successful
day passes and as a part of the discharge plan. Outcomes of the therapeutic leave must be
documented. No more than 24 days of therapeutic leave annually are allowed. Days of
leave are counted from the date of admission to Medicaid covered services at the A and B
levels. Overnight passes from Level C Residential Treatment Services are not included in
the allowance for Levels A and B. (Please refer to the Psychiatric Services Provider
Manual for Level C Residential Treatment.) If a child/adolescent has successfully
completed day passes at a higher level of care in the previous placement the
child/adolescent may be granted overnight passes prior to the completion of day passes at
the new program if therapeutically indicated. Provision of active therapeutic services while
on overnight passes is required to bill for days away from the facility.

B. If a child requires acute, inpatient medical treatment (non-psychiatric), is on runaway
status, or goes to detention for more than 10 days, for Medicaid purposes, the authorization
will need to be end-dated and addressed as a discharge. Any subsequent residential
treatment would be considered a new admission. If a child requires acute psychiatric
admission, any subsequent residential treatment would also be considered a new admission.

C. None of the days away from the residential facility for acute medical, acute psychiatric,
runaway, or detention are billable under a DMAS residential authorization.

**Limitations**

DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all treatment beds located within the program/facility and on any adjoining or nearby campus or site. Treatment beds are all beds in the facility regardless of whether or not the services are billed to Medicaid.

If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart), the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

Programs/facilities that only provide independent living services are not reimbursed.

The caseload of the clinical director must not exceed a total of 16 clients including all sites for which the clinical director is responsible.

**Service Units and Maximum Service Limitations**

The service is limited to one unit daily. The rate includes payment for therapeutic services rendered to the child. Room and board costs are not included in the rate. Service authorization is required for payment of all residential services. The service authorization process is described in Appendix C of this manual.

The fiscal years will be run from July 1 through June 30.

**Day Treatment/Partial Hospitalization (H0035 HB)**

**Service Definition**

Day treatment/partial hospitalization services available to adults shall be time limited 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 are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting.

**Eligibility Criteria**

In order for adults to receive Medicaid-reimbursed Day Treatment/Partial Hospitalization Services, individuals 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. Individuals must meet at least two of the following on a continuing or intermittent basis:
1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.

2. Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

3. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Day Treatment/Partial Hospitalization 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.

**Required Activities**

- Major diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for adults with serious mental disorders that require coordinated, intensive, comprehensive, and multi-disciplinary treatment but do not require inpatient treatment. Psycho-education refers to education on mental health topics to improve the member’s behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A LMHP must perform a face-to-face evaluation/diagnostic service specific provider assessment and approve the services prior to initiation of treatment. Service authorization is not required to bill for the face-to-face service specific provider assessment. (Note Chapter V for service specific provider assessment code and billing instructions).

- An ISP must be completed by a QMHP or a LMHP within 30 days of service initiation. The ISP must be cosigned by the member.

- Services must be provided in accordance with the ISP.

- Progress notes for Day Treatment/Partial Hospitalization Services are completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the arrival and departure time of each client to and from the program, the amount of service delivered, and a staff’s signature and credentials, and a date.
At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP. (This will include current experienced staff who do not meet the criteria.)

Supervision by the QMHP or LMHP is demonstrated by a review of progress notes, the member’s progress toward achieving ISP goals and objectives and recommendations for change based on the member’s status. Supervision must occur monthly. Documentation that supervision occurred must be in the member’s clinical record and signed by the QMHP or LMHP. Individual, group, or a combination of individual and group supervision conducted by the QMHP or LMHP with paraprofessionals is acceptable.

Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the member’s progress towards achieving ISP goals and objectives, and recommendations for change based on the member’s status. Supervision must occur and be documented in the clinical record monthly.

The program must operate a minimum of two continuous hours in a 24-hour period.

A LMHP must perform a face-to-face evaluation and re-approve services that are provided longer than 90 continuous days. This evaluation must be completed no later than 90 days from the start of services.

If case management is being provided, there must be coordination with the case management agency.

The service provider must notify or document the attempts to notify the primary care provider of the member’s receipt of community mental health rehabilitative services.

**Limitations**

**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:

a. The individual is no longer in an acute psychiatric state and at risk of psychiatric hospitalization and;

b. 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.
• Staff travel time is excluded.

Service Units and Maximum Service Limitations

• One unit= 2-3.99 hours/day
• Two units= 4-6.99 hours/day
• Three units= 7+ hours/day

A maximum of 780 units of Partial Hospital / Day Treatment is allowable annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement.

Psychosocial Rehabilitation (H2017)

Service Definition

Psychosocial rehabilitation services are programs of two or more consecutive hours per day provided to groups of adults in a non-residential setting.

Eligibility Criteria

Individuals 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. Individuals must meet at least two of the following on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.

2. Require help in basic living skills, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

3. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

4. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

To receive Psychosocial Rehabilitative services, the individual must meet one of the criteria listed below. The individual must:

1. Have experienced long-term or repeated psychiatric hospitalizations; or
2. Lack daily living skills and interpersonal skills; or
3. Have a limited or non-existent support system; or
4. Be unable to function in the community without intensive intervention; or
5. Require long-term services to be maintained in the community.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Psychosocial rehabilitation 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 assessment, the ISP, and the progress notes.

Required Activities:

- Prior to treatment, there must be a face-to-face service specific provider assessment by the QMHP and approved by the LMHP within 30 days which clearly documents the need for services. Service authorization is not required to bill for the face-to-face service specific provider assessment. (Note Chapter V for the service specific provider assessment code and billing instructions).
- Within 30 days of service initiation, the ISP must be completed by a QMHP and must clearly document the need for the services. The ISP must be cosigned by the member.
- Every three months, the LMHP or the QMHP must review, modify as appropriate, and update the ISP.
- Services that continue for more than six months must be reviewed by an LMHP. The LMHP must document the need for continued services. The ISP must be rewritten at least annually.
- Perform education to teach the patient about mental illness and appropriate medication to avoid complications and relapse, 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.
- Services must be provided in accordance with the ISP.
- Progress notes for psychosocial rehabilitation services are completed at least monthly. Notes must specifically describe the specific service that was provided. Notes must correlate with time billed.
- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP.
- Supervision is demonstrated by the QMHP by a review of the member’s progress towards achieving ISP goals and objectives and recommendations for
change based on the member’s status. Supervision (this may be a group supervisory meeting with all paraprofessionals and a discussion of multiple members) must occur and be documented in the clinical record monthly.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional (this may be a group supervisory meeting with all paraprofessionals and a discussion of multiple members), and a review of the member’s progress towards achieving ISP goals, and objectives and recommendations for change based on the member’s status. Supervision must occur and be documented in the clinical record monthly.

- The program must operate a minimum of two continuous hours in a 24-hour period.

- If case management is being provided, there must be coordination with the case management agency.

- The service provider must notify the primary care provider of the member’s receipt of community mental health rehabilitative services.

**Service Units and Maximum Service Limitations**

- One unit = 2 to 3.99 hours per day
- Two units = 4 to 6.99 hours per day
- Three units = 7 + hours per day.

- Time for field trips (off-site activities) is allowed if the goal is to provide an opportunity for supervised practice of socialization skills or therapeutic activities that are designed to increase the member’s understanding or ability to access community services.

- Staff travel time is excluded.

- Vocational services are not reimbursable.

- A maximum of 936 units of Psychosocial Rehabilitation is allowable annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

- The service authorization process is described in Appendix C of this manual.

**Crisis Intervention (H0036)**

**Service Definition**
Crisis intervention services are mental health care, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute mental health dysfunction requiring immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the member or others; and
- To provide treatment in the least restrictive setting.

**Eligibility Criteria**

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

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Crisis Intervention 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 assessment, the treatment plan, (please see below for ISP requirements), and the progress notes.

**Required Activities**

- A Certified BHA Pre-screener or QMHP must complete and document a face-to-face service specific provider assessment of the crisis situation upon request; provide short-term counseling to stabilize the individual or family unit; provide access to further immediate service specific provider assessment and follow-up; and link the individual and family with ongoing care to prevent future crises. If the service specific provider assessment is performed by the QMHP, it must be reviewed and approved by a LMHP or Certified Pre-screener within 72 hours.

- Services may be provided to eligible individuals outside of the clinic and billed if it is clinically or programmatically appropriate, or both.

- There must be documentation of immediate mental health care 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.

- 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 must be done by the BHA or, for children and adolescents under 21, by an independent team. Both the team and the independent team must meet federal regulations for an independent team.

**NOTE:** Medicaid cannot be billed for crisis intervention services for a member under Emergency Custody Orders (ECOs) or Temporary Detention Orders (TDOs). Services may be billed up to the time an order for TDO or ECO is received. If the ECO ends...
without a TDO being called, services rendered after the ECO ends may be reimbursed. Documentation of TDOs and ECOs must clearly delineate the separation of time. Refer to the Hospital Provider Manual, Appendix B, for further information.

- Staff travel time is excluded from billable time.
- Crisis intervention services may involve the member’s family or significant others.
- An ISP is not required for newly admitted members. Inclusion of the service on the existing ISP is not required for the service to be provided to an active member on an emergency basis.
- An ISP prepared by a Certified Pre-screener or QMHP by the fourth face-to-face contact must be developed or revised to reflect treatment goals and interventions for scheduled short-term counseling. The ISP must be cosigned by the member.
- Services are provided by a Certified Pre-screener or QMHP.
- If case management is being provided, there must be coordination with the case management agency.
- Crisis Intervention (H0036) and Crisis Stabilization (H2019) will not be reimbursed if the client is receiving Intensive In-Home Services.
- If other clinic services are billed while the individual is receiving Crisis Intervention services, documentation must clearly support the separation of the services with distinct treatment goals.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

Service Units and Maximum Service Limitations

- A unit of service is 15 minutes of Crisis Intervention. As of August 1, 2009 a claim edit will be in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. A maximum of 720 units of Crisis Intervention can be provided annually. Starting August 1, 2009 and each July 1st thereafter, all service limits will be set to zero. The fiscal year period for the start up of this process will be August 1, 2009 through June 30, 2010. All subsequent fiscal years will be July 1 through June 30.
- A face-to-face contact with the member must occur during the crisis episode in order to bill Medicaid for Crisis Intervention Services. Other contacts, such as telephone calls and collateral contacts during the crisis episode are reimbursable as long as the requirement for a face-to-face contact is met. Billable contacts
which are directed toward crisis resolution for the member may occur prior to the face-to-face contact.

- Reimbursement will be provided for short-term crisis counseling contacts scheduled within a 30-day period from the time of the first face-to-face crisis contact.

**Intensive Community Treatment (H0039)**

**Service Definition**

Intensive Community Treatment (ICT) is an array of mental health services for adults with serious emotional 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. It is available either directly or on call 24 hours per day, seven days per week, 365 days per year.

**Eligibility Criteria**

The individual is best served in the community. The individual also must meet one or more of the following criteria:

1. Is at high risk for psychiatric hospitalization or for becoming or remaining homeless, or requires intervention by the mental health or criminal justice system due to inappropriate social behavior.

2. Has a history (three months or more) of a need for intensive mental health treatment or treatment for serious mental illness and substance abuse and demonstrates a resistance to seek out and utilize traditional 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.

**Required Activities**

Medical 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.

- An initial service specific provider assessment by a QMHP that documents need for services must be completed. A LMHP reviews the service specific provider assessment within 30 day and certifies that the individual is in need of the services. Service authorization is not required to bill for the face-to-face service specific provider assessment. (Note Chapter V for the service specific provider assessment code and billing instructions).
An ISP is initiated at time of admission and fully developed by the QMHP within 30 days of service initiation; The ISP should be cosigned by the member.

Services are provided in accordance with the ISP;

Services are provided by a QMHP or a paraprofessional under the supervision of a QMHP or LMHP;

Documentation is created and maintained through a daily service log of time spent in the delivery of services and a description of the activities and services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives outlined in the ISP; and

Coordination to ensure there is no duplication in services or billing and to ensure continuity of care.

Service Units and Maximum Service Limitations

ICT may be provided based on an initial service specific provider assessment. This service may be provided for a maximum of 26 weeks with a limit of 130 units available annually. Continuation of service may be reauthorized at 26-week intervals based on written service specific provider assessment and certification of need by a LMHP.

The service provider must notify or document the attempts to notify the primary care provider of the member’s receipt of community mental health rehabilitative services.

A unit equals one hour. Time may be accumulated to reach a billable unit.

No billing is allowed during the same time period for any outpatient psychotherapy services or case management. Crisis stabilization may be billed if:

1. Services are provided in a community-based residential setting; and
2. Services meet the criteria for crisis stabilization services; and
3. ICT is not billed for the days that crisis stabilization is billed.

ICT services may be billed if the individual is brought to the clinic by ICT staff to see the psychiatrist. Documentation to support this intervention must be in the individual’s clinical record.

As part of ICT, psychotherapy and medication management are generally expected to be provided outside the clinic, hospital, or office setting. In preparation for transition to a lesser level of care, if an ICT member goes to the clinic independently (as part of the plan of care for transitioning to less intensive services) psychotherapy and medication management services may be billed as ICT services. The ICT plan of care must continue to document the need for the intense level of services provided in ICT. (If the individual regularly attends office based medical appointments that are no more than
twenty five percent of billed ICT time, the need for continuance of ICT services based on resistance and/or inability to benefit from a lesser level of intensity than ICT shall be documented in the clinical record). Time billed for psychotherapy, medication management, and other clinic services may not exceed twenty-five percent of the total time billed for ICT during this transition period. The transition period is limited to a maximum of eight (8) weeks.

- A maximum of 130 units of Intensive Community Treatment can be authorized annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

- Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement.

Crisis Stabilization (H2019)

Service Definition

Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Eligibility Criteria

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:

1. Experiencing difficulty in maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports.

2. 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.

3. Exhibiting such inappropriate behavior that immediate interventions by mental health, social services, or the judicial system are necessary.

4. Exhibiting difficulty in cognitive ability (e.g., the individual is unable to recognize personal danger or recognize significantly inappropriate social behavior).
If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Crisis stabilization 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 assessment, the ISP, and the progress notes.

**Required Activities**

- Psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling. Service may be provided in any of the following settings, but shall not be limited to: (1) the home of a member who lives with family or another primary caregiver; (2) the home of a member who lives independently; or (3) community based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

- If the face-to-face service specific provider assessment is performed by a certified prescreener or a QMHP it must be reviewed and approved by a licensed mental health professional within 72 hours of the service specific provider assessment.

- The ISP is developed or revised by the QMHP, a certified pre-screener, or a LMHP within ten business days of service specific provider assessment or re-service specific provider assessment. The ISP must be cosigned by the member.

- Services are provided in accordance with the ISP.

- Services are provided by a QMHP, a LMHP, or a Certified Pre-screener.

- Services must be documented through daily notes and a daily log of times spent in the delivery of services.

- If any case management is being provided, there must be coordination with the case management agency.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

**Limitations**

- Room and board, custodial care, and general supervision are not components of this service.

- Service is neither appropriate nor reimbursed for: (1) individuals with medical conditions which require hospital care; (2) individuals with a primary diagnosis of substance abuse; (3) individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are of imminent danger to
self or others; or (4) individuals receiving treatment in settings with a bed capacity that is greater than 16.

- Staff travel time is excluded.
- DMAS will reimburse only for services provided in facilities or programs with no more than 16 beds. The total number of beds will be determined by including all beds located within the program/facility, regardless of whether or not the services are billed Medicaid. If a provider operates separate residences that are 16 beds or less and are in distinctly different areas of a locality (for example, greater than one mile apart) the bed count will only apply to each residence. Each residence that is 16 beds or less will be eligible for Medicaid reimbursement.

Service Units and Maximum Service Limitations

- A billing unit is one hour.
- There is a limit of eight (8) hours a day for up to 15 consecutive days in each episode, up to 60 days annually. As of August 1, 2009 a claim edit will be in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Starting August 1, 2009 and each July 1st thereafter, all service limits will be set to zero. The fiscal year period for the start up of this process will be August 1, 2009 through June 30, 2010. All subsequent fiscal years will be July 1 through June 30.
- No concurrent billing is allowed during the same time period for Clinic Option Outpatient Mental Health Treatment or Intensive Community Treatment. Billing for medication management only is permitted.

Mental Health Support (H0046)

Service Definition

Mental health support services (MHSS) are training and support to enable individuals with significant psychiatric functional limitations to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. The recommended age to receive the service will increase from 16 to 18 years of age as this service is focused on assisting clients to live independently. Persons under 18 may still be eligible for Mental Health Support Serviced if medical necessity criteria are met. This service is not a substitution for mental health counseling or psychotherapy.

Eligibility Criteria

Effective July 18, 2011, an Independent Clinical Assessment must be conducted by the CSB/BHA prior to the authorization of new service requests for MHSS services for dates of service beginning on or after July 18, 2011. New services are defined as services for which the individual has been discharged from or never received prior to July 17, 2011.
Effective September 1, 2011, a completed Independent Clinical Assessment will be required for those individuals up to the age of 21 who are currently receiving services. CSBs/BHAs will conduct independent clinical assessments on and after August 1, 2011 for service re-authorizations with dates of service continuing on and after September 1, 2011.

For adult members 21 and older an Independent Clinical Assessment performed by the CSB or BHA is not required.

Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities and affects their ability to remain stabilized in the community. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, homelessness, or isolation from social supports.

2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.

3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

4. Require help in basic living skills, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.

Individuals eligible for this service may have a dual diagnosis of either mental illness and mental retardation or mental illness and substance abuse disorder. If an individual has co-occurring mental health and substance abuse disorders, integrated treatment for both disorders is allowed within Mental Health Support 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 assessment, the ISP, and the progress notes.

**Required Activities**

- The provider must maintain a copy of the entire Independent Clinical Assessment in each members’s file. The initial service specific provider assessment (H0032, U8) and the six month re-assessment must be done face-to-face by the LMHP or a LMHP-E. The service specific provider assessment may be completed no more than 30 days prior to the initiation of services.

- Continuation of services may be approved at six-month intervals or following any break in services by a LMHP or a LMHP-E based on a service specific
provider assessment and documentation of continuing need. A break in service is more than 30 days or if a case has been closed to this service.

- The six month re-assessment for the service provision (H0046) must be done face-to-face by the LMHP or the LMHP-E. Services may be authorized for up to six consecutive months.

- Service authorization is not required to bill for the face-to-face service specific provider assessment. (Note Chapter V for the service specific provider assessment code and billing instructions).

- This service is to provide training in or reinforcement of functional skills and appropriate behavior related to the individual’s health and safety, ADLs, and use of community resources; assistance with medication management, and monitoring health, nutrition, and physical condition.

- An ISP by a QMHP is fully completed within 30 days of the initiation of services and indicates the specific supports and services to be provided and the goals and objectives to be accomplished. The ISP should be cosigned by the member.

- The QMHP must meet face to face with the LMHP or the LMHP-E supervisor to review the ISP at least quarterly. This review must be documented in the client record.

- Services are provided in accordance with the ISP.

- At a minimum, services are provided by qualified paraprofessionals under the supervision of a QMHP.

- Supervision of a Qualified paraprofessional by the QMHP, LMHP or LMHP-E 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 consumer’s clinical record and signed by the QMHP, LMHP or LMHP-E. Individual, group, or a combination of individual and group supervision conducted by the QMHP, LMHP or LMHP-E with paraprofessionals is acceptable.

- Paraprofessionals, who do not meet the experience requirement listed in Chapter II, may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QMHP, LMHP or LMHP-E. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the individual’s progress towards achieving ISP goals and objectives, and recommendations for change based on the individual’s status. Supervision must occur and be documented in the clinical record monthly.

- A quarterly review of the ISP is required. The ISP must be rewritten at least annually.
Minimally documentation and description of services through a daily log of the time as well as a weekly summary note is required.

If the individual is receiving case management, there must be coordination with the case management agency.

The service provider must notify the primary care provider of the member’s receipt of this community mental health rehabilitative service.

Limitations

- Academic services are not reimbursable.
- Vocational services are not reimbursable. Support services and activities directly related to assisting a client to cope with a mental illness in the work environment are reimbursable. Activities that focus on how to perform job functions are not reimbursable.
- Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.
- Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.
- Only direct face-to-face contacts and services to the individual members are reimbursable.
- Staff travel time is excluded.

Service Units and Maximum Service Limitations

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day
- Three units = 5 to 6.99 hours per day
- Four units = 7+ hours per day

Time may be accumulated to reach a billable unit. Service delivery time must be added consecutively to reach a billable unit of service.

A maximum of 372 units of Mental Health Support Services may be prior authorized annually with coverage under State Plan Option service. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement.
Expanded Prenatal Services (BabyCare) - Substance Abuse Treatment Services for Pregnant and Postpartum Women

Substance Abuse Residential Treatment for Pregnant Women (H0018 Modifier HD)

Service Definition

Substance Abuse Residential Treatment for Pregnant Women services are comprehensive and intensive intervention services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.

Eligibility Criteria

The following criteria must be met for substance abuse treatment:

1) The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2) The woman must be pregnant at admission and intend to complete the pregnancy.

3) The woman must:
   a) Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or
   b) Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or
   c) Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4) The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.
Required Activities


The following types of services or activities must be provided:

1. A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic service specific provider assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.

2. Documented on the service specific provider assessment that Level III.3 or Level III.5 criteria are met for this service.

3. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

4. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

5. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

6. Personal health care training and assistance, including:
   - Education and referral for testing, counseling, and management of HIV;
   - Education and referral for testing, counseling, and management of tuberculosis; and
   - Education and referral for testing, counseling, and management of hepatitis.

7. Case coordination with providers of primary medical care, including obstetrical and gynecological services.

8. Training in decision-making, anger management, and conflict resolution.
The ISP must be fully developed by the qualified substance abuse professional within one week after admission, involving the woman, appropriate significant others, and a representative of the appropriate service agencies. The ISP must be reviewed and updated every two weeks. The ISP must be cosigned by the member.

Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.

A contractual relationship with a Medicaid enrolled OB/GYN.

An obstetric assessment must be completed by and documented within a 30 day period following admission.

The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural differences, and counseling.

Medical care must be coordinated by a registered nurse case manager. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff.

Access to services either through staff or contract:

- a) Psychiatric assessments, as needed, by a physician;
- b) Psychological assessments, as needed, by a licensed clinical psychologist;
- c) Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist;
- d) Medication management, as needed or at least quarterly, by a physician in consultation with the high-risk pregnancy unit, if appropriate; and
- e) Primary health care, if not available through other means including gynecological and obstetrical care.
17 Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.

18 The program director must document the reason for granting any absence in the clinical record of the member.

19 Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.

**Limitations**

- No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse Rehabilitative Services is available while the individual is participating in this program.

- Residential capacity shall be limited to 16 adults. No services may be provided to children of mothers in the program.

- The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.

- Days of unauthorized absence cannot be billed.

**Service Units and Maximum Service Limitations**

- A billing unit is one day.

- There is a limit of 300 days per pregnancy, not to exceed 60 days postpartum that can used annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

- Unauthorized absence of less than 72 hours is included in this limit.

- An unauthorized absence of more than 72 hours will result in termination of Medicaid reimbursement or retraction of payments already made.

**Substance Abuse Day Treatment for Pregnant Women (H0015 Modifier HD)**

**Service Definition**

Substance Abuse Day Treatment for Pregnant Women Services are comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle.
Eligibility Criteria
The following criteria must be met for substance abuse treatment:

1) The woman must agree to participate in developing her own treatment plan; to comply with the treatment plan; to participate, support, and implement the ISP; to utilize appropriate measures to negotiate changes in her treatment plan; to fully participate in treatment; to comply with program rules and procedures; and to complete the treatment plan in full.

2) The woman must be pregnant at admission and intend to complete the pregnancy.

3) The woman must:
   a) Have used alcohol or other drugs within six weeks before referral to the program. If the woman was in jail or prison prior to her referral to the program, the alcohol or drug use must have been within six weeks prior to her incarceration in jail or prison; or
   b) Be participating in less intensive treatment for substance abuse and be assessed as high risk for relapse without more intensive intervention and treatment; or
   c) Within 30 days of admission, have been discharged from a more intensive level of treatment, such as hospital-based inpatient or jail- or prison-based treatment for substance abuse.

4) The woman must be under the active care of a physician, who is an approved Virginia Medicaid provider and has obstetrical privileges at a hospital that is an approved Virginia Medicaid provider. The woman must agree to reveal to her obstetrician her participation in substance abuse treatment and her substance abuse history and also agree to allow collaboration between the physician, the obstetrical unit of the hospital in which she plans to deliver or has delivered, and the program staff.

Required Activities

The following types of services or activities must be provided:

1. A qualified substance abuse professional must conduct a face-to-face evaluation or diagnostic service specific provider assessment, or both, within 30 days prior to admission and must authorize the services. Re-authorizations must be conducted every 90 days and after any absence of less than 72 hours that is not authorized by the program director. The professional authorizing services cannot be the same professional providing non-medical clinical supervision.
2. Documented on the service specific provider assessment that Level II.1 or II.5 criteria are met for this service.

3. Substance abuse rehabilitation; counseling and treatment must include, but not necessarily be limited to, education about the impact of alcohol and other drugs on the fetus and on the maternal relationship; smoking cessation classes (if needed); relapse prevention to recognize personal and environmental cues that may trigger a return to the use of alcohol or other drugs; and the integration of urine toxicology screens and other toxicology screens, as appropriate, to monitor intake of illicit drugs and alcohol and provide information for counseling.

4. Training about pregnancy and fetal development, to be provided at a level and in a manner comprehensible for the participating women including, but not necessarily limited to, the impact of alcohol and other drugs on fetal development; normal physical changes associated with pregnancy as well as training in normal gynecological functions; personal nutrition; delivery expectations; and infant nutrition.

5. Symptom and behavior management as appropriate for co-existing mental illness, including medication management and ongoing psychological treatment.

6. Personal health care training and assistance, including:
   - Education and referral for testing, counseling, and management of HIV;
   - Education and referral for testing, counseling, and management of tuberculosis; and
   - Education and referral for testing, counseling, and management of hepatitis.

7. Case coordination with providers of primary medical care, including obstetrical and gynecological services.

8. Training in decision-making, anger management, and conflict resolution.

9. The ISP must be developed by the qualified substance abuse professional within 14 days after admission involving the woman, appropriate significant others, and representatives of appropriate service agencies. The ISP must be reviewed and updated every four weeks. The ISP must be cosigned by the member.

10. Extensive discharge planning, with the woman, significant others, and representatives of service agencies. Documented discharge planning shall begin at least 60 days prior to the estimated delivery date, involving the woman, appropriate significant others, and representatives of appropriate services agencies. The priority for discharge is to assure a stable, sober, and drug-free environment and treatment supports for the woman. If service is initiated less than 60 days prior to delivery date, discharge planning shall begin within two weeks of admission.

11. A contractual relationship with a Medicaid enrolled OB/GYN.
12. An obstetric assessment must be completed and documented within a 30 days period following admission.

13. The registered nurse case manager shall demonstrate competency in health assessment, mental health substance abuse, obstetrics and gynecology, case management, nutrition, cultural variances and counseling.

14. Medical care must be coordinated by a registered nurse case manager. The registered nurse case manager shall be responsible for coordinating the provision of all immediate primary care and shall establish and maintain communication and case coordination between the women in the program and necessary medical services, specifically with each obstetrician providing services to the women. In addition, the registered nurse case manager shall be responsible for establishing and maintaining communication and consultation linkages to high-risk obstetrical units, including regular conferences concerning the status of the woman and recommendations for current and future medical treatment.

15. A documented agreement with a high-risk pregnancy unit of a tertiary care hospital to provide 24-hour access to services and training and consultation to staff.

16. Access to services either through staff or contract:
   a) Psychiatric assessments, as needed, by a physician;
   b) Psychological assessments, as needed, by a licensed clinical psychologist;
   c) Psychological treatment, as appropriate, with clinical supervision by a licensed clinical psychologist;
   d) Medication management, as needed or at least quarterly, by a physician in consultation with the high-risk pregnancy unit, if appropriate; and
   e) Primary health care, if not available through other means including gynecological and obstetrical care.

17. Non-medical clinical supervision must be provided to staff at least weekly by a qualified substance abuse professional.

18. The program director must document the reason for granting any absence in the clinical record of the member.

19. Face-to-face therapeutic contact directly related to the ISP must be documented at least twice per week.

20. The minimum ratio of clinical staff to women shall assure sufficient staff to address the needs of the woman.
Limitations

- Only mental health crisis intervention services or mental health crisis stabilization may be reimbursed for members of day treatment services.

- More than two episodes of five-day absences from scheduled treatment without prior permission from the program director, or one absence exceeding seven (7) days of scheduled treatment without prior permission from the program director, shall terminate the services.

Services Units and Maximum Service Limitations

- A billing unit is a minimum of two (2) hours but less than four (4) hours.

There is a limit of 400 units per pregnancy, not to exceed 60 days postpartum. A claim edit is in place that will cut back payment or deny claims for services beyond maximum number of units allowed. The fiscal year period is July through June 30.

- One unit = 2 - 3.99 hours
- Two units = 4 - 6.99 hours
- Three units = 7+ hours

Mental Health Case Management (H0023)

A summary of the regulatory changes that affect providers of targeted case management services has been incorporated in this manual. For the entire notice with all provisions, please refer to the Federal Register (Vol. 74, No. 124 FR 31183) at http://edocket.access.gpo.gov/2009/pdf/E9-15345.pdf). CMS retained the following provisions, which went into effect on July 1, 2009

Service Definition

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 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 abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Population Definitions

The following definitions are referred to in the discussion of the appropriate populations for services.
1. **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 mental retardation 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-IV, Fourth Edition). 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:

1) 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.

2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.

3) Has difficulty establishing or maintaining a personal social support system.

4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.

5) 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:

1) 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).

2) 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.

2. 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-IV, or the child must exhibit all of the following:

a. Problems in personality development and social functioning that have been exhibited over at least one year’s time; and

b. Problems that are significantly disabling based upon the social functioning of most children that age; and

c. Problems that have become more disabling over time; and

d. Service needs that require significant intervention by more than one agency.

Children diagnosed with Serious Emotional Disturbance and a co-occurring substance abuse or mental retardation diagnosis are also eligible for Case Management for Serious Emotional Disturbance.

3. 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:

a. 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 mental retardation; or

b. 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

c. 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.).
Eligibility Criteria

- 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 service specific provider 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 days.

Required Activities

The following services and activities must be provided:

- A comprehensive service specific provider assessment must be completed by a qualified mental health case manager to determine the need for services. The CM service specific provider assessment is part of the first month of CM service and requires no service authorization.

- Service specific provider assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such).

- This service specific provider assessment then serves as the basis for the ISP.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

- The ISP must document the need for case management and be fully completed within 30 days of the initiation of the service. The ISP must be cosigned by the member. The case manager must modify the ISP as necessary, review it every three months, and rewrite it annually. The first quarterly review will be due the last day of the third month from the date of the ISP. Each subsequent review will be due by the last day of the third month following the month in which the last review was due and not on the date when the review was actually completed in the grace period. A grace period will be granted up to the last day of the fourth month following the month the review was due.

- 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.

• Coordinating services and treatment planning with other agencies and providers.

• Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

• Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

• 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 members. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.

• A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the member’s condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the member’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 member at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more members was consumer-specific. For example, the case manager needs to work with two consumers, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both members simultaneously for the purpose of helping each member obtain a financial entitlement and subsequently follow-up with each member to ensure he or she has proceeded correctly.
Service Units and Maximum Service Limitations

- A billing unit is one calendar month. There is a ‘grace period’ for CM which is considered 8/1/09 – 12/31/09 and is defined as the period where claims will pay without service authorization. After the allowed grace period (ends 12/31/09), all individuals (new and existing) are allowed 1 unit of CM without service authorization. The 1 unit without service authorization is effective 01/01/10. Once this 1 unit has been used, all subsequent requests require service authorization. We suggest that providers begin staggering requests for service authorization in order not to disrupt services to your members and to ensure claims will continue to pay.

- Effective 01/01/10, CM has 1 unit (service authorization) service limit before service authorization is required. If the provider has a service authorization for 12 months, and the service lapses sometime in that period, the provider will not request a concurrent service authorization for the subsequent 12 months. However 2 years later, the provider gets the same individual back to assess for CM. There is no longer a 1 unit service limit since it was used already. If the individual does not meet criteria for CM, the provider is unable to bill for case management visit.

- Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the face to face visit, or the date the monthly summary note has been documented, or a specific date service was provided. In order to support the 1 billing unit per calendar month, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. Providers are NOT to span the month for SPO CM services.

- Reimbursement is provided only for “active” case management consumers.

- Case management may not be used to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

- No other type of case management, from any funding source, may be billed concurrently with targeted case management.

- Reimbursement for case management services for individuals age 21-64 in Institutions for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

- There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical
facilities. Case management services may not be provided for institutionalized individuals who are age 65 and older and under age 21. Services rendered during the time the individual is not admitted to the IMD may be billed, even if during the same month as the admission to the IMD.

- To bill for case management services for clients that are in an acute care psychiatric units, two conditions must be met. The services may not duplicate the services of the hospital discharge planner, and the community case management services provided to the individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case management may not be billed when a child is receiving Intensive In-Home Services.

- Case management may not be billed when a client is open to Intensive Community Treatment.

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

- If the client qualifies for case management through a different population definition (‘at risk’, SED, or SMI) a new service authorization is not required as long as the client continues to meet the CM service criteria.

- Appendix C of this manual specifies the process used to obtain service authorization for Medicaid reimbursement.

**Case Management Agency Requirements**

1. The service specific provider assessment and subsequent re-assessments of the individual’s medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider assessment must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The member or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the member (or parent or guardian, when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.
4. A release form must be completed and signed by the member for the release of any information.

5. There must be an ISP from each provider rendering services to the member. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included. The ISP is defined in the “Exhibits” section at the end of this chapter.

6. Case management records must include the individual’s name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual’s needs.

**Monitoring and Re-Evaluation of The Service Need By The Case Manager**

The case manager must continuously monitor the appropriateness of the member’s ISP and make revisions as indicated by the changing support needs of the member. At a minimum, the case manager shall 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 must be documented in the case manager’s file. The case manager must have monthly activity regarding the member and a face-to-face contact with the member at least once every 90 days.

The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

**Substance Abuse Case Management (H0006)**

**Service Definition**

Substance Abuse case management assists children, adults, and their families with accessing needed medical, psychiatric, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs.

If an individual has co-occurring mental health and substance abuse disorders, the case manager shall include activities to address both the mental health and substance use disorders. Only one type of case management may be billed at one time. Please see the Limitations section.
Population Definitions

The Medicaid eligible member shall meet the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) diagnostic criteria for an Axis I substance-related disorder. Nicotine or caffeine abuse or dependence is not covered.

Eligibility Criteria

There must be documentation of the presence of a substance-related disorder which meets DSM-IV-TR criteria.

- The individual must require case management as documented on the ISP, which is developed by a qualified substance abuse case manager and based on an appropriate service specific provider assessment and supporting documentation. The individual must be receiving at least one SA service.

- 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 days. There must be at least one direct or client-related contact every 30 days.

Required Activities

The following services and activities must be provided:

- Service specific provider assessment and planning services, to include developing an ISP (does not include performing service specific provider assessments for severity of substance abuse or dependence, medical, psychological and psychiatric assessment but does include referral for such assessment).

- A service specific provider assessment must be completed by a qualified substance abuse case manager to determine the need for services. This service specific provider assessment then serves as the basis for the ISP.

- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

- The ISP must document the need for case management and be fully completed within 30 days of the initiation of the service. The ISP must be cosigned by the member. The case manager must modify the ISP as necessary, review it every three months, and rewrite it annually. The first quarterly review will be due the last day of the third month from the date of the ISP. Each subsequent review will be due by the last day of the third month following the month in which the last review was due and not on the date when the review was actually completed.
in the grace period. A grace period will be granted up to the last day of the fourth month following the month the review was due.

- 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 services and supports specified in the ISP. When available, service specific provider assessment and evaluation information should be integrated into the Individual Service Plan within two weeks of completion. The Individual Service Plan shall utilize accepted patient placement criteria and shall be fully completed within 30 days of initiation of service.

- Provide services in accordance with the ISP.

- Assisting the member directly for the purpose of locating, developing, or obtaining needed services and resources.

- Coordinating services and treatment planning with other agencies and providers.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment.

- Making collateral contacts with significant others to promote implementation of the service plan and community adjustment.

- 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 members. For example, group sessions on stress management, substance abuse, or family coping skills are not case management activities.

- A face-to-face contact must be made at least once every 90-day period. The purpose of the face-to-face contact is for the case manager to observe the member’s condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the member’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 member at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more members was consumer-specific. For example, the case manager needs to work with two consumers, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both members simultaneously for the purpose of helping each member obtain a financial entitlement and subsequently follow-up with each member to ensure he or she has proceeded correctly.

**Service Units and Maximum Service Limitations**

- The billing unit for case management is 15 minutes.
- Billing can be submitted for case management only when direct or client-related contacts, activity, or communications occur.
- Reimbursement is provided only for “active” case management consumers.
- No other type of case management may be billed concurrently with substance abuse case management including mental health, treatment foster care, or services that include case management activities such as Intensive Community Treatment or Intensive In-Home Services.
- Reimbursement for case management services for individuals who reside in an Institution for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness or substance abuse and is greater than 16 beds.
- A claim edit is place that will cut back payment or deny claims for services beyond the maximum number of units allowed. The maximum service limit for substance abuse case management services is 52 hours or 208 units annually. Each July 1st service limits will be set to zero. The fiscal year is from July 1-June 30.
- To bill for case management services, two conditions must be met. The services may not duplicate the services of the institutional discharge planner, and the community case management services provided to the institutionalized individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for institutionalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.
- Case management may not be billed when a child is receiving Intensive In-Home Services.
- Case management may not be billed when a client is receiving Intensive Community Treatment.
- Case management services for the same individual must be billed by only ONE type of case management provider.
Case Management Agency Requirements

- The service specific provider assessment and subsequent re-assessments of the individual’s medical, mental, substance use, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider assessment must also include current documentation of a medical examination, a psychological/psychiatric/substance abuse evaluation, and a social assessment.

- All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The member or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.

- There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the member (or parent or guardian when appropriate) verify freedom of choice of providers was offered and this provider was chosen.

- A release form must be completed and include the dated signature of the member for the release of any information.

- There must be an ISP from each provider rendering services to the member. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included. The ISP is defined in the “Exhibits” section at the end of this chapter.

- There must be documentation that notes all contacts made by the case manager related to the ISP and the individual’s needs.

Monitoring and Re-Evaluation of the Service Need By the Case Manager

The case manager must continuously monitor the appropriateness of the member’s ISP and make revisions as indicated by the changing support needs of the member. At a minimum, the case manager shall 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 must be documented in the case manager’s file. The case manager must have monthly activity regarding the member and a face-to-face contact with the member at least once every 90 days.
The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers changes. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

Substance Abuse Crisis Intervention (H0050)

Service Definition

Crisis intervention services are substance abuse treatment services, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the member or others; and
- To provide treatment in the least restrictive setting.

Eligibility Criteria

Substance abuse crisis intervention services are provided following a marked reduction in the member’s psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Crisis Intervention Services.

Required Activities

- A Certified BHA Pre-screener or QSAP must complete and document a face-to-face service specific provider assessment of the crisis situation; provide short-term counseling to stabilize the individual or family unit; provide access to further immediate assessment and follow-up; and link the individual and family with ongoing care to prevent future crises.

- Services may be provided to eligible individuals outside of the clinic and billed if it is clinically or programmatically appropriate, or both.

- There must be documentation of immediate substance abuse treatment 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.

- Services may include office visits, home visits, telephone contacts, or other client related activities for the prevention of institutionalization.
The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member’s receipt of community mental health rehabilitative services.

Monitoring and face to face support may be provided by a QSAP, a certified pre-screener, or a paraprofessional to ensure the client’s safety. A paraprofessional must be under the supervision of at least a QSAP and provide services in accordance with a plan of care.

**NOTE:** Medicaid cannot be billed for substance abuse crisis intervention services for a member under Emergency Custody Orders (ECOs) or Temporary Detention Orders (TDOs). Services may be billed up to the time an order for TDO or ECO is received. If the ECO ends without a TDO being called, services rendered after the ECO ends may be billed. Documentation of TDOs and ECOs must clearly delineate the separation of time. Refer to the Hospital Provider Manual, Appendix B, for further information.

- Staff travel time is excluded from billable time.
- Substance Abuse Crisis intervention services may involve the member’s family or significant others.
- An ISP is not required for newly admitted members. Inclusion of the service on the ISP is not required for the service to be provided to an active member on an emergency basis.
- An ISP prepared by a Certified Pre-screener or QSAP by the fourth face-to-face contact must be developed or revised to reflect treatment goals and interventions for scheduled short-term counseling. The ISP must be cosigned by the member.
- Services are provided by a Certified Pre-screener or QSAP.
- If case management is being provided, there must be coordination with the case management agency.
- If other clinic services are billed while the individual is receiving Crisis Intervention services, documentation must clearly support the separation of the services with distinct treatment goals.

**Service Units and Maximum Service Limitations**

- A unit of service is 15 minutes of Substance Abuse Crisis Intervention. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. A maximum of 720 units of Substance Abuse Crisis Intervention can be provided annually. Each July 1st all service limits will be set to zero.
• The fiscal year period is July 1 through June 30.

• A face-to-face contact with the member must occur during the crisis episode in order to bill Medicaid for Substance Abuse Crisis Intervention Services. Other contacts, such as telephone calls and collateral contacts during the crisis episode, are reimbursable as long as the requirement for a face-to-face contact is met. Billable contacts which are directed toward crisis resolution for the member may occur prior to the face-to-face contact.

• Reimbursement will be provided for short-term crisis counseling contacts scheduled within a 30-day period from the time of the first face-to-face crisis contact.

Substance Abuse Intensive Outpatient (H2016)

Service Definition

Substance Abuse Intensive Outpatient Treatment services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours per week. This service should be provided to those members who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. The maximum annual limit is 600 hours. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment services.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Substance Abuse Intensive Outpatient Treatment Services, individuals must meet the Diagnostic Statistical Manual diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Day Treatment.

Required Activities

• Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member’s behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.
A QSAP must perform a face-to-face evaluation/diagnostic service specific provider assessment and authorize the services prior to initiation of service.

The service provider must notify or document the attempts to notify the primary care provider of the member’s receipt of community mental health rehabilitative services.

An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the member.

Services must be provided in accordance with the ISP.

Progress notes for Substance Abuse Intensive Outpatient Treatment Services must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a dated staff signature.

Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

The QSAP must supervise the paraprofessional at least twice a month. Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the client’s clinical record and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.

Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the member’s progress towards achieving ISP goals and objectives, and recommendations for change based on the member’s status. Supervision must occur and be documented in the clinical record monthly.

The program must operate a minimum of two continuous hours in a 24-hour period.

A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.
• If case management is being provided, there must be coordination with the case management agency.

Limitations

• Individuals shall be discharged from this service when other less intensive services may achieve stabilization.

• Staff travel time is excluded.

Service Units and Maximum Service Limitations

• One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

• A maximum of 600 hours per year is allowed. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is July 1 through June 30.

Substance Abuse Day Treatment (H0047)

Service Definition

Substance Abuse Day Treatment services are programs of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week. Substance abuse day treatment may not be provided concurrently with IOP or opioid treatment services.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Substance Abuse Day Treatment Services, individuals must demonstrate a clinical necessity for the service by meeting the Diagnostic Statistical Manual diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Substance Abuse Day Treatment.

Required Activities

• Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention;
occupational and recreational therapy, or other therapies. Psycho-education refers to education on mental health and substance abuse topics to improve the member’s behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider assessment and authorize the services prior to initiation of service.
- The service provider must notify or document the attempts to notify the primary care provider of the member’s receipt of community mental health rehabilitative services.
- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the member.
- Services must be provided in accordance with the ISP.
- Progress notes for Substance Abuse Day Treatment must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a staff signature.
- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.
- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.
- The QSAP must supervise the paraprofessional at least twice a month. Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the client’s clinical record and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.
- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on-site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the member’s progress towards achieving ISP goals and objectives, and recommendations for change based on the member’s status. Supervision must occur and be documented in the clinical record monthly.
• A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

• If case management is being provided, there must be coordination with the case management agency.

Limitations

• Individuals shall be discharged from this service when less intensive services may achieve stabilization.

• Staff travel time is excluded.

Service Units and Maximum Service Limitations

• One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

• A maximum of 1,300 hours is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year period is from July 1 through June 30.

Opioid Treatment (H0020)

Service Definition

Opioid Treatment is provided in daily sessions. The treatment year service limit is 600 hours.

Eligibility Criteria

In order for individuals to receive Medicaid-reimbursed Substance Abuse Opioid Treatment Services, individuals must demonstrate a clinical necessity for the service by meeting the Diagnostic Statistical Manual diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within Opioid Treatment.

Required Activities

• Major substance abuse treatment and psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Psycho-education
refers to education on mental health and substance abuse topics to improve the member’s behavioral, mental, or emotional condition. Psycho-education may include communication skills, problem solving skills, anger management, and interpersonal communication.

- A QSAP must perform a face-to-face evaluation/diagnostic service specific provider assessment and authorize the services prior to initiation of service.

- The service provider must notify or document the attempts to notify the primary care provider of the member’s receipt of community mental health rehabilitative services.

- An ISP must be completed by a QSAP within 30 days of service initiation. The ISP must be cosigned by the member.

- Services must be provided in accordance with the ISP.

- Progress notes for Opioid Treatment Services must be completed when services are delivered. The documentation must include the date of the service, the service or activity provided, the units provided, the provider rendering the service, and a staff signature.

- Individual and group counseling, and family therapy, and occupational and recreational therapy must be provided by at least a QSAP.

- A QSAP or a paraprofessional, under the supervision of a QSAP, may provide education about the effects of alcohol and other drugs on the physical, emotional and social functioning of the individual, relapse prevention, occupational and recreational activities. A QSAP must be onsite when a paraprofessional is providing services.

- The QSAP must supervise the paraprofessional at least twice a month. Supervision shall include documented face-to-face meetings between the supervisor and the paraprofessional providing the services. Supervision may occur individually or in a group. Documentation of supervision shall be in the client’s clinical record and signed by the QSAP. Please see Chapter II for supervision requirements for certain QSAPs.

- Paraprofessionals who do not meet the experience requirement listed in Chapter II may provide services for Medicaid reimbursement if they are working directly with a qualified paraprofessional on-site and supervised by a QSAP. Supervision must include on site observation of services, face-to-face consultation with the paraprofessional, a review of progress notes, the member’s progress towards achieving ISP goals and objectives, and recommendations for change based on the member’s status. Supervision must occur and be documented in the clinical record monthly.
• A QSAP must perform a face-to-face evaluation and re-authorize services that are provided longer than 90 continuous days.

• If case management is being provided, there must be coordination with the case management agency.

Limitations

• Individuals shall be discharged from this service when less intensive services may achieve stabilization.

• Staff travel time is excluded.

Service Units and Maximum Service Limitations

• One unit of service is 15 minutes. Reimbursement is based on the level of professional providing the service.

• A maximum of 600 hours is allowed annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. Each July 1st all service limits will be set to zero. The fiscal year is from July 1 through June 30.

• Providers may submit reimbursement claims for opioids which are administered to persons receiving Opioid Treatment Services. Providers may enroll as a Pharmacy provider (please refer to the Pharmacy Manual) or submit the appropriate Healthcare Common Procedure Coding System (HCPCS) identifier for medication administration.

Pharmacies bill as point of sale. If the drug is provided through a clinic, then the appropriate HCPCS, J-code or S-code would be billed. For example, S0109 indicates 5 mg. of oral methadone. The HCPCS code, J8499 (unclassified non-chemotherapeutic drug, oral administration) may also be used to bill for the opioid drug. Members have the right to appeal and a fair hearing for any service.

Notification Requirements

Whenever an adverse action is taken, the member must receive written notification of the pending action at least 10 days before the effective date of the action, except for the following:

1. Advance notice will be reduced to five days if the facts indicate the action is necessary because of probable fraud; and

2. Advance notice does not need to be sent if:

   • The member has stated in writing that he or she no longer wishes to receive Medicaid services;
• The member gives information that requires the termination of Medicaid, and the member knows that this action is the result of giving the information;

• The member has been admitted to an institution where he or she is ineligible for services under the Virginia State Plan for Medical Assistance;

• The member moves to another state and has been determined eligible for Medicaid in the new jurisdiction; or

• The member’s whereabouts are unknown. The agency will determine that the member’s whereabouts are unknown if mail sent to the member is returned as undeliverable.

Qualified Medicare Beneficiaries - Coverage Limitations

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the member’s co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message “QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE CO-INSURANCE AND DEDUCTIBLE.” The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

Qualified Medicare Beneficiaries - Extended Coverage Limitations

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductibles, co-pays and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message “QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED.” These members are responsible for co-pay for pharmacy services, health department clinic visits, and vision services.

Client Medical Management (CMM) Program

As described in Chapters I and VI, the Medicaid Program may designate certain members to be restricted to specific physicians and pharmacists. When this occurs, it is noted on the member’s Medicaid card. A Medicaid-enrolled physician, who is not the designated primary provider, may provide and be paid for services to these members only,

• In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the member;

• On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to physicians affiliated with
the non-designated primary provider in delivering the necessary services; and

- For other services covered by DMAS, which are excluded from the CMM Program requirements.

The mental health services described in this chapter are excluded from the CMM Program, and none of the specific CMM provisions apply to these services. However, mental health providers are encouraged to coordinate treatment with the primary physician whose name appears on the member’s eligibility card as other services and medications are monitored routinely.
EXHIBITS

Sample Certificate of Need for the Level A&B Residential Programs 1
Sample Initial Plan of Care for Level A&B Residential Programs 2
Sample Comprehensive Individual Plan of Care for Level A&B Residential Programs 4
Sample 30 Review form for Comprehensive Individual Plan of Care for Level A&B Residential Programs 7
Pre-Admission Screening Report (DMH 224) 10
Individualized Service Plan (ISP) Guide 15
Qualified Paraprofessional Training Guide 16
Program Service Matrix 18
SAMPLE FORM

CERTIFICATION OF NEED FOR ADMISSION
TO
RESIDENTIAL PSYCHIATRIC TREATMENT

Child’s Name____________________________________________

Under each of the three sections below, a child-specific explanation must be provided.

1. Ambulatory/outpatient care does not meet the specific treatment needs of the member:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

2. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3. The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

For children who are Medicaid members, this form must be completed and signed by the local CSA interdisciplinary team or FAPT and signed by a physician member of the team. The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON. For Non-CSA children, a licensed professional must complete this form.

Team Signatures: ______________________Date_____       _______________________Date__________
______________________Date_____       _______________________Date__________
______________________Date______      _______________________Date_________

Physician Signature:  ___________________________________   Date: __________________________

DMAS 370,  8/04
INITIAL PLAN OF CARE

Name:

Medicaid Number:

Admission Date:

DSM-IV
  Axis I
  Axis II
  Axis III
  Axis IV
  Axis V

Describe Symptoms, Complaints, and Complications Indicating the Need for Admission to Residential Level of Care (Include problem behaviors 7 days prior to admission):

Functional Level (Medical issues, ability to do activities of daily living):

Long-Term Goal(s) with Measurable Treatment Objectives/Interventions:
  1.
  2.
  3.

Short-Term Goal(s) with Measurable Treatment Objectives/Interventions:
  1.
  2.
  3.
Medications prescribed (note name, dosage and frequency):

Therapies to be provided (type, frequency, duration)

Individual Therapy:

Family Therapy:

Other Therapies (describe):

List the 7 planned therapeutic interventions:

Discharge Plan (including estimated date of discharge):

Team Members Dated Signature (Name, title, handwritten date):

SIGNATURE                     TITLE                     DATE

SIGNATURE                     TITLE                     DATE

SIGNATURE                     TITLE                     DATE

Example form for DMAS purposes only. This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.
COMPREHENSIVE INDIVIDUAL PLAN OF CARE

Resident Name:

Medicaid Number:

Admission Date:

DSM-IV:
  Axis I
  Axis II
  Axis III
  Axis IV
  Axis V

Describe the Need for Residential Level of Care (symptoms and behaviors):

Measurable long-term goal(s) with target date for achievement with measurable treatment objectives/interventions:

1.
   MEASUREABLE GOAL

   __________________________________________________________
   TREATMENT OBJECTIVE/INTERVENTION

   __________________________________________________________
   TARGET DATE FOR ACHIEVEMENT

2.
   MEASUREABLE GOAL

   __________________________________________________________
   TREATMENT OBJECTIVE/INTERVENTION

   __________________________________________________________
   TARGET DATE FOR ACHIEVEMENT

3.
   MEASUREABLE GOAL

   __________________________________________________________
   TREATMENT OBJECTIVE/INTERVENTION

   __________________________________________________________
   TARGET DATE FOR ACHIEVEMENT
Measurable short-term goal(s) with target dates for achievement and each with measurable treatment objectives/interventions (should relate to long-term goals):

1. 
   **MEASUREABLE GOAL**
   
   **TREATMENT OBJECTIVE/INTERVENTION**
   
   **TARGET DATE FOR ACHIEVEMENT**

2. 
   **MEASUREABLE GOAL**
   
   **TREATMENT OBJECTIVE/INTERVENTION**
   
   **TARGET DATE FOR ACHIEVEMENT**

3. 
   **MEASUREABLE GOAL**
   
   **TREATMENT OBJECTIVE/INTERVENTION**
   
   **TARGET DATE FOR ACHIEVEMENT**

**Medications Prescribed** (note name, dosage and frequency):

**Planned Therapies** (note type, frequency, duration):

- **Individual Therapy:**
- **Family Therapy (if indicated):**

**Other Therapies (if indicated):**

- **List the 7 planned therapeutic interventions:**

**Summary of Progress and Justification for Continued Stay** (if there is no progress, describe how treatment is being adjusted to address the lack of progress):
**Discharge Plan** (including estimated date of discharge):  

---  

**TEAM MEMBERS DATED SIGNATURES**  

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>TITLE</th>
<th>DATE</th>
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</table>

DMAS  

*Example form for DMAS purposes only.* This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.
COMPREHENSIVE INDIVIDUAL PLAN OF CARE

30-DAY PROGRESS UPDATE

Resident Name:

Medicaid Number:

DSM-IV-Note any changes from the CIPOC:

Axis I
Axis II
Axis III
Axis IV
Axis V

Describe the Continued Need for Residential Level of Care (symptoms and behaviors that cannot be met at a lower level of care):

Describe member’s involvement/cooperation in treatment:

LONG-TERM GOAL(S) UPDATE:
Three measurable long-term goals with target dates for achievement and each with measurable treatment objectives/interventions (note if previous goals have been met, and if new goals have been established for unresolved or new problems):

1. ______________________________________________________________________

   MEASUREABLE GOAL

   TREATMENT OBJECTIVE/INTERVENTION

   TARGET DATE FOR ACHIEVEMENT

2. ______________________________________________________________________

   MEASUREABLE GOAL

   TREATMENT OBJECTIVE/INTERVENTION

   TARGET DATE FOR ACHIEVEMENT
3. ______________________________________________________________________

MEASUREABLE GOAL

___________________________________________________

TREATMENT OBJECTIVE/INTERVENTION

___________________________________________________

TARGET DATE FOR ACHIEVEMENT

SHORT-TERM GOAL(S) UPDATE:
Measurable short-term goal(s) with target dates for achievement and each with measurable treatment objectives/interventions (note if previous goals have been met, and if new goals have been established):

1. ______________________________________________________________________

MEASUREABLE GOAL

___________________________________________________

TREATMENT OBJECTIVE/INTERVENTION

___________________________________________________

TARGET DATE FOR ACHIEVEMENT

2. ______________________________________________________________________

MEASUREABLE GOAL

___________________________________________________

TREATMENT OBJECTIVE/INTERVENTION

___________________________________________________

TARGET DATE FOR ACHIEVEMENT

3. ______________________________________________________________________

MEASUREABLE GOAL

___________________________________________________

TREATMENT OBJECTIVE/INTERVENTION

___________________________________________________

TARGET DATE FOR ACHIEVEMENT

Note Changes to Medications (note name, dosage and frequency):

Individual Therapy (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not):
Family Therapy (as applicable) (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not):

Group Therapy (as applicable)

List any changes to the 7 therapeutic interventions:

Summary of Progress and Justification for Continued Stay (if there is no progress, describe how treatment is being adjusted to address the lack of progress. If new problems have arisen, describe them and how the treatment plan will address them):

Note Changes to Discharge Plan (including estimated date of discharge):

TEAM MEMBERS DATED SIGNATURES

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
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</table>

Example form for DMAS purposes only. This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.
### UNIFORM PREADMISSION SCREENING FORM

This form is to be completed by a qualified professional designated by the Community Services Board to determine if an individual meets criteria for civil commitment or is in need of voluntary or involuntary admission to a psychiatric hospital. Please refer to the Uniform Preadmission Evaluation Procedures and the Continuity of Care Guidelines.

**DATE** __________ **TIME** (From __________ To __________) **DISPOSITION:** VOL TDO OTHER **CASE NO.** __________

#### I. PERSONAL DATA

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
<td>Marital Status:</td>
</tr>
<tr>
<td>Physical description:</td>
<td></td>
<td>SSN:</td>
</tr>
<tr>
<td>Emergency Contact:</td>
<td></td>
<td>Relationship to Client:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone: Home (</td>
<td></td>
<td>(City or County)</td>
</tr>
<tr>
<td>Monthly Income: $</td>
<td>SSU/SSDI: $</td>
<td>Payee:</td>
</tr>
<tr>
<td>Insurance: Y N</td>
<td>(Name of Insurance Company)</td>
<td>(Group/Plan Number)</td>
</tr>
<tr>
<td>Medicaid: Y N</td>
<td>(If under 18) School Division:</td>
<td>School Attending:</td>
</tr>
<tr>
<td>Medicare: Y N</td>
<td>Grade:</td>
<td>Special Education: Y N</td>
</tr>
<tr>
<td>CSB of Origin:</td>
<td>Contacted: Y N N/A PRAIS Code</td>
<td></td>
</tr>
<tr>
<td>Name of CSB Staff Contacted:</td>
<td>Phone ( )</td>
<td></td>
</tr>
</tbody>
</table>

#### II. LEGAL DATA

Pending legal charges: Y N - If yes, complete the following information: Nature of charges (if known): __________

Date of hearing (if known): __________

NGRI Conditional Release: Y N | Probation/Parole: Y N | Contact: __________

#### III. COLLATERAL SOURCES OF INFORMATION

<table>
<thead>
<tr>
<th>Client Record</th>
<th>Individual Requesting</th>
<th>Primary Therapist</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Agency)</td>
<td>(Name &amp; Relationship to Patient)</td>
<td>(Name)</td>
<td>(Name &amp; Relationship to Patient)</td>
</tr>
</tbody>
</table>

#### IV. FOR LOCAL USE
V. MEDICAL

Primary Care Provider: 

Phone ( )

Medical History & Current Medical Problems/Symptoms:

<table>
<thead>
<tr>
<th>Medication: Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
</tbody>
</table>

Recent medication changes: Y  N  ? (If yes, explain)

Allergies or adverse side effects to medications: Y  N  ? (If yes, explain)

Has client complied with recommended medication and treatment plans? Y  N  ? (If no, describe nature of non-compliance)

VI. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT: Service providers (e.g., Eastern State Hospital, CSB, CSB contractual agency, private provider, etc.) and services and/or treatment provided.

<table>
<thead>
<tr>
<th>Service Provider/Facility</th>
<th>Services/Treatment Provided</th>
<th>Date Last Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tbody>
</table>

VII. PRESENT SITUATION (Include information such as precipitating events, stressors and variation, if any, from baseline level of functioning.)
VIII. MENTAL STATUS EXAM (Circle all that apply)

Poor Appearance: WNL unkept poor hygiene bizarre tense rigid

Behavior/Motor Disturbance: WNL agitation guarded tremor manic impulse psychomotor control retardation

Orientation: WNL disoriented time place person situation

Speech: WNL pressured slowed soft/loud impoverished slurred other

Mood: WNL depressed angry/hostile euphoric anxious anhedonic withdrawn

Range of Affect: WNL constricted flat labile inappropriate

Thought Content: WNL delusions grandiose ideas of reference paranoid obsessions phobias

Thought Process: WNL loose flight associations of ideas circumstantial blocking tangential perseverative

Perception/Sensorium: WNL hallucinations auditory visual olfactory tactile illusions

Memory: WNL impaired recent remote immediate

Appetite: WNL poor Weight: loss gain Appetite: increased decreased

Sleep: WNL hypersomnia onset maintenance problem problem

Insight: WNL blaming little none

Estimated Intellectual/Functional Capacity: above average average below average diagnosed MR

Explain clinically significant findings:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

IX. SUBSTANCE ABUSE ASSESSMENT (Check if no current use ________)

<table>
<thead>
<tr>
<th>Hx</th>
<th>Past 24 hrs</th>
<th>Blood Present</th>
<th>Drug of Choice</th>
<th>Frequent (Past 30 days)</th>
<th>Method</th>
<th>Last used</th>
</tr>
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<tbody>
<tr>
<td>Tremors</td>
<td>N/A</td>
<td>Primary:</td>
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<tr>
<td>Seizures</td>
<td>N/A</td>
<td>Secondary:</td>
<td></td>
<td></td>
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<tr>
<td>DT’s</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Vomiting</td>
<td>Y N</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Diarrhea</td>
<td>Y N</td>
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Comments/Test Results:
X. RISK ASSESSMENT

Suicide
Potential: 

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Homicide
Potential: 

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Specify:


XI. DIAGNOSIS: DSM IV (P=Provisional, H=Historical)  GAF: 

Axis I: 


Axis II: 


XII. FINDINGS (Circle)

X
Is / is not mentally ill and/or abusing substances.

X
Is / is not an imminent danger to self or others.

X
Is / is not able to care for self.

X
Is / is not capable of consenting to voluntary treatment/hospitalization.

X
Is / is not willing to be treated voluntarily.

X
There are / are not less restrictive community alternatives to serve this person.

XIII. DISPOSITION RECOMMENDATION (Check appropriate "PreDetention" box if evaluation is conducted prior to the issuance of a T.D.O. Check appropriate "PreHearing" box if evaluation is conducted after the issuance of a T.D.O. but prior to the commitment hearing.)

<table>
<thead>
<tr>
<th>PreDetention</th>
<th>PreHearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client does not meet criteria for hospitalization and/or commitment and should be encouraged to participate in community based services.</td>
<td></td>
</tr>
</tbody>
</table>

Not Applicable

Involuntary commitment to outpatient services because client meets criteria for involuntary commitment, community alternatives are available for involuntary commitment, and client is incapable or unwilling to consent to voluntary treatment.

Voluntary hospitalization because client does not meet criteria for involuntary commitment, has the capacity to consent to voluntary treatment, requires treatment in a hospital and has requested said treatment.

Not Applicable

Voluntary hospitalization because the client requires treatment in a hospital, has the capacity to consent to treatment, and if, in the presence of the special justice and under court order, the client agrees to a voluntary period of treatment up to 72 hours and to give 48 hours notice to leave in lieu of involuntary commitment for up to 180 days.

Involuntary hospitalization because client meets criteria for involuntary hospitalization and is incapable of consenting to voluntary treatment.

Involuntary hospitalization because client meets criteria for involuntary hospitalization, is capable of consenting to voluntary treatment, but is unwilling to be treated voluntarily.
**XIV. FINDINGS OF HEARING EVALUATOR** (To be completed if “PreHearing” Disposition Recommendation differs from “PreDetention” Disposition Recommendation):


**XV. TREATMENT AND DISCHARGE PLANNING** (to be completed only if inpatient treatment is recommended).

Individuals who can assist in treatment and discharge planning (i.e., family, discharge planner, therapist, family physician, etc.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone No.</th>
<th>Relationship to Client</th>
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<tbody>
<tr>
<td>1.</td>
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Inpatient treatment goals:


Services to be considered in planning for discharge:

- [ ] medication management  
- [ ] substance abuse services  
- [ ] housing/residential services  
- [ ] case management  
- [ ] financial support/entitlement  
- [ ] medical/dental/nutritional services  
- [ ] outpatient (ind., fam., group)  
- [ ] adult or child protective services  
- [ ] legal assistance/advocacy  
- [ ] psychosocial/day treatment  
- [ ] transportation  
- [ ] nursing home care  
- [ ] other

---

Signature of Prescreener  

Prescreening Agency/Board  

Print Name Here  

Date

Signature of Hearing Evaluator  

Print Name Here  

Date
Statement of Principle: A comprehensive assessment and an Individualized Service Plan (ISP) are the foundation of services designed specifically for a person.

I. Assessments of Person
   A. Face-to-face assessments will be conducted to identify a person’s physical, emotional, behavioral, and social strengths, preferences, and needs, as applicable.
   B. Assessments will be performed prior to development of the ISP.

II. Plan for Service
   A. An ISP defines and describes the goals, objectives, and expected outcomes of service(s).
   B. The person’s needs and preferences will be considered when the service plan is developed and revised.
   C. The person and principle service provider or service team are documented participants in service planning.
   D. Involvement of the family, guardian, or others in developing the ISP will be consistent with laws protecting confidentiality, privacy, and the rights of minors.

III. ISP - Minimum Required Elements
   The ISP will include, at a minimum:
   A. A summary or reference to the assessment;
   B. Goals and measurable objectives for addressing each identified need;
   C. The services, supports, and frequency of service to accomplish the goals and objectives;
   D. Target dates for accomplishment of goals and objectives;
   E. Estimated duration of service;
   F. The role of other agencies if the plan is a shared responsibility; and
   G. The staff responsible for coordination and integration of services, including the persons of other agencies if the plan is a shared responsibility.

IV. Progress Notes or Other Documentation
   Signed and dated progress notes or other documentation will be used to document the services provided, and the implementation and outcomes of service plans.

V. Services Plan Reviews
   Service plans will be reviewed as required for each specific service or at least every six months with goals and objectives updated, if indicated. Reviews will be conducted with the person and in consultation with other service providers and will be signed and dated by the person responsible for the coordination and integration of services.
Introduction

Completion of this training program will result in qualifying Para-Professionals as providers for Mental Health Rehabilitative Services. Programs of independent study must be documented and verified. Personnel records will document the overall successful completion of the employee’s individual training program. Providers will either indicate that this model will be used or will submit an alternative model to DMAS.

Core Areas of Training:

1) Orientation to Organization, Structure, Function and Services of the BHA of employment. 8 hours
2) CPR and First-Aid. 8 hours
3) Management of Aggressive Behavior. 8 hours
4) Universal Precautions/Blood Borne Pathogens, Other Health Related Concerns. 4 hours
5) Relationships, Boundaries and Ethics: Professional Conduct and Behavior, Confidentiality. 8 hours
6) Working in the Larger Community: Resources and Referral Sources, Collaboration with Other Professionals, Using Self-Help and Advocacy Groups, Family Contacts. 4 hours
7) Basic Introduction to Psychopathology and Mental Illness Classification. 8 hours
8) Principles and Practices of the Primary Service Area of Employment: Psychosocial Rehabilitation, Support Services, Therapeutic Day Treatment for Children and Adolescents, and Day Treatment/Partial Hospitalization. Staff are required to complete this core element for each service in which they will work as a service provider. 8 hours each service area.
9) Unique Characteristics of the Work Environment: Age Specific, Physical Disabilities, Ethnic, and/or Cultural Issues of the Program’s Participants. 4 hours
10) The ISP, Service Documentation and Review. 8 hours
11) Managing the Unexpected: Emergencies and Crisis Intervention, Insuring the Safety of Self and Others. 4 hours
12) Psychotropic Medications and Side Effects. 4 hours
13) Provider Specific Independent Study of Disorders, Service Populations and Programs. 14 hours (This training component will allow providers to add other elements unique to their system or necessary for the individual’s successful performance. Videotapes, assigned readings, and written reports can be used.)
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<th>Service Types</th>
<th>Intensive In-Home Services for Children and Adolescents (H2012)</th>
<th>Therapeutic Day Treatment for Children and Adolescents (H0035HA)</th>
<th>Day Treatment / Partial Hospitalization (H0035HB)</th>
<th>Intensive Community Treatment (H0039)</th>
<th>Crisis Intervention (H0036)</th>
<th>Crisis Stabilization (H2019)</th>
<th>SA Day Treatment for Pregnant Women (H0050HQ, HO)</th>
<th>SA Opioid Treatment (H0020)</th>
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X and shading indicates CMHRS that may not be clinically appropriate when provided concurrently and/or by two providers.