Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.state.va.us

MEDICAID MEMO

TO: Providers of Community Mental Health Rehabilitative Services, Managed Care Organizations

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/31/2013

SUBJECT: Changes to Community Mental Health Rehabilitative Services – Emergency Regulations Pertaining to Mental Health Support Services, Crisis Stabilization, and Crisis Intervention

The purpose of this memorandum is to notify providers of important changes that the Department of Medical Assistance Services (DMAS) will implement for Community Mental Health Rehabilitative Services (CMHRS) beginning on December 1, 2013. These changes relate specifically to Mental Health Support Services, and recent revisions to regulations that govern the DMAS behavioral health programs. The intent of Mental Health Support Services has and continues to be the provision of goal directed interventions that provide training to individuals who have severe, chronic mental illnesses or emotional disturbances so that they can reside independently in their communities in the least restrictive environment. These revisions include changing the service name to Mental Health Skill-building Services (MHSS) to emphasize the rehabilitative nature of the service, clarification of the service definition, program eligibility, and service provision, and updating the limits and exclusions. These changes will ensure appropriate utilization and cost efficiency for Medicaid or FAMIS reimbursed services, and will clarify the rehabilitative focus of Mental Health Skill-building Services.

DMAS collaborated with the Department of Behavioral Health and Developmental Services (DBHDS) as well as public and private stakeholders to develop and clarify these important program changes. The specific changes are described below. Providers must comply with the revised program requirements within the specified time frames in order to qualify for Medicaid reimbursement through DMAS or its behavioral health services administrator (BHSA).

Changes Effective December 1, 2013

Revised service definition, eligibility, and service provision criteria, limitations, and exclusions apply to all new MHSS service authorization requests and re-authorization requests required and submitted on or after December 1, 2013.

Revised Service Name:

Effective December 1, 2013, the service name shall be revised from Mental Health Support Services to Mental Health Skill-building Services (MHSS). In addition, the following service definition, eligibility,

and service provision requirements, limitations, and exclusions apply to all MHSS service authorizations, claims, and services rendered on and after December 1, 2013.

Service Definition and Service Authorization:

Mental health skill-building services shall be defined as goal directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS shall include goal directed training in the following areas in order to qualify for reimbursement by Medicaid or its BHSA: functional skills and appropriate behavior related to the individual's health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition. Providers shall be reimbursed only for training activities related to these areas, and only where services meet the revised service definition, eligibility, and service provision criteria and guidelines as described herein. In addition, service_authorization is required for MHSS in order to receive reimbursement through Medicaid or its BHSA. The service authorization duration shall be based upon satisfaction of these requirements where MHSS may be authorized for a period of up to six consecutive months.

Service Eligibility Requirements:

1. Individuals qualifying for Mental Health Skill-building Services must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized training to achieve or maintain stability and independence in the community.

2. Individuals age 21 and over shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

a. The individual shall have one of the following as a primary Axis I DSM diagnosis:
(1) Schizophrenia or other psychotic disorder as set out in the DSM,
(2) Major Depressive Disorder – Recurrent;
(3) Bipolar I; or Bipolar II;
(4) Any other Axis I mental health disorder that a physician has documented specific to the indentified individual within the past year to include all of the following: (i) that is a serious mental illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community.

b. The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.

c. The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization, Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or Temporary Detention Order (TDO) pursuant to the *Code of Virginia* §37.2-809(B) evaluation as a result of decompensation related to serious mental illness. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service.

d. The individual shall have had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service.

3. Individuals younger than 21 years of age shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

a. The individual shall be in an independent living situation or actively transitioning into an independent living situation. (If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition). Independent living situation means a situation in which an individual, younger than 21 years of age, is not living with a parent or guardian or in a supervised setting and is providing his own financial support.

b. The individual shall have one of the following as a primary, Axis I DSM diagnosis:

(1) Schizophrenia or other psychotic disorder as set out in the DSM;

(2) Major Depressive Disorder – Recurrent;

(3)Bipolar I; or Bipolar II;

(4) Any other Axis I mental health disorder that a physician has documented specific to the indentified individual within the past year to include all of the following: (i) that is a serious mental illness or serious emotional disturbance; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities which are documented in the individual's medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community.

c. The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management;

d. The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization, Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or TDO evaluation as a result of decompensation related to serious mental illness. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service, and;

e. The individual shall have had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of

medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service.

Requirements for Service Provision:

MHSS shall meet all of the following service provision criteria in order to qualify for reimbursement through Medicaid or its BHSA:

1. At admission, an appropriate face-to-face assessment must be conducted, documented, and signed and dated by an LMHP. Providers shall be reimbursed one unit for each assessment utilizing the assessment code H0032 with U8 modifier. Assessments shall be updated annually.

2. At the time of the regulation package development, DSM-IV was in effect and did require Axis I-V. With the release of DSM-5 in 2013, an Axis I psychiatric diagnosis as identified in the DSM-V shall be documented as part of the assessment by the LMHP performing the assessment.

3. The LMHP, QMHP-A, or QMHP-C shall complete, sign and date the Individualized Service Plan (ISP) within 30 days of the admission to this service. The ISP shall include documentation of how many days per week and how many hours per week are required to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. The ISP shall include the dated signature of the LMHP, QMHP-A, or QMHP-C and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of service.

4. Every three months, the LMHP, QMHP-A or QMHP-C shall review the ISP with the individual, modify as appropriate, and update the ISP. This review shall be documented in the record, as evidenced by the dated signatures of the LMHP, QMHP-A or QMHP-C and the individual. The ISP must be rewritten annually.

5. The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.

6. Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.

7. If the provider knows of or has reason to know of the individual's non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, QMHP-A or QMHP-C shall be informed of any medication regimen non-adherence. The LMHP, QMHP-A or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-adherence concerns. The provider shall document the following minimum elements of the contact between the LMHP, QMHP-A or QMHP-C and the prescribing physician:

    a. name and title of caller;
    b. name and title of professional who was called;
    c. name of organization that the prescribing professional works for;

d. date and time of call;
e. reason for care coordination call;
f. description of medication regimen issue or issues that were discussed; and
g. resolution of medication regimen issue or issues that were discussed.

8. The provider shall document evidence of the individual's prior psychiatric services history, as required above under eligibility requirements, by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. <u>Family member statements shall not suffice to meet this requirement.</u> The provider shall document the following minimum elements:
a. name and title of caller;
b. name and title of professional who was called;
c. name of organization that the professional works for;
d. date and time of call;
e. specific placement provided;
f. type of treatment previously provided;
g. name of treatment provider; and
f. dates of previous treatment.

9. The provider shall document evidence of the psychiatric medication history, as required by above under eligibility requirements by maintaining a photocopy of prescription information from a prescription bottle or by contacting a prior provider of health care services or pharmacy or after obtaining written consent from the individual. The current provider shall document the following minimum elements:
a. name and title of caller;
b. name and title of prior professional who was called;
c. name of organization that the professional works for;
d. date and time of call;
e. specific prescription confirmed;
f. name of prescribing physician;
g. name of medication and ;
f. date of prescription.

10.* Only direct face-to-face contacts and services to an individual shall be reimbursable.

11.* Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.

12.* Any services provided to individuals that are strictly vocational in nature shall not qualify for Medicaid reimbursement. However, support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable.

13.* Room and board, custodial care, and general supervision are not components of this service and are eligible for Medicaid reimbursement

14. Provider qualifications. The enrolled provider of mental health skill-building services shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the

provider to provide mental health skill-building services must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, QMHP-A, QMHP-C or QMHPP. The LMHP, QMHP-A or QMHP-C will supervise the care weekly if delivered by the qualified paraprofessional. Documentation of supervision shall be maintained in the MHSS record.

15.* Mental health skill-building services, which may continue for up to six consecutive months, must be reviewed and renewed at the end of the period of service authorization by an LMHP who must document the continued need for the services.

16. Mental health skill-building services must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.

17. If mental health skill-building is provided in a group home (Level A or B) or assisted living facility the ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate mental health skill-building services with the treatment plan established by the group home or assisted living facility and shall document all coordination activities in the medical record.

*Indicates no change from current practice.

Limitations and Exclusions:

1. Group home (Level A or B) and assisted living facility providers shall not serve as the mental health skill-building services provider for individuals residing in the providers' respective facility. Individuals residing in facilities may, however receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside.

2. MHSS shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS) waivers.

3. MHSS shall not be reimbursed for individuals who are also receiving Independent Living Skills Services, the Department of Social Services (DSS) Independent Living Program, Independent Living Services, or Independent Living Arrangement or any CSA-funded independent living skills programs.

4. Medicaid coverage for MHSS shall not be available to individuals who are receiving Treatment Foster Care.

5. Medicaid coverage for MHSS shall not be available to individuals who reside in ICF/IDs or hospitals.

6. Medicaid coverage for MHSS shall not be available to individuals who reside in nursing facilities, except for up to 60 days prior to discharge. If the individual has not been discharged from the nursing facility during the 60-day period of services, mental health skill-building services shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that mental health skill-building services are necessary. Such documentation shall include facts

demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of MHSS.

7. Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Centers – Level C facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.

8. MHSS shall not qualify for Medicaid reimbursement if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the ID Waiver, DD Waiver, the Elderly or Disabled with Consumer Direction Waiver, and the EPSDT services.

9. Medicaid coverage for Mental health skill-building services shall exclude services that are considered to be duplicative of other reimbursed services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, QMHP-A or QMHP-C to avoid duplication of services.

10. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving/ will not qualify for Medicaid coverage for mental health skill-building services unless their physician issues a signed and dated statement indicating that this service would benefit the individual by enabling them to achieve and maintain community stability and independence.

11. Medicaid coverage for MHSS for individuals with disorders not identified in Axis I, such as personality disorders and other mental health disorders that may lead to chronic disability, will not exclude provided that the individual has a primary Axis-I DSM diagnosis listed above and the provider can document and describe how the individual is expected to actively participate in and benefit from services, (and where the remaining MHSS service criteria and guidelines are satisfied).

12. The requirements for MHSS described in these regulations, and all others identified in this memo, in accordance with 12VAC30-50-226 and 12VAC30-60-143, apply to all requests for new service authorizations submitted to DMAS and/or its service authorization contractor on or after December 1, 2013. These requirements are not retroactive for individuals who are currently in service prior to December 1, 2013 and approved under the previous regulations.

Reimbursement Information

DMAS anticipates rate structure changes will occur in 2014. Once the modified rate structure is finalized, DMAS will notify providers.

Magellan Implementation

As noted in Medicaid Memos dated July 2, 2013, August 28, 2013, and October 29, 2013 (revised October 30, 2013), Magellan Health Services will function as Virginia's Behavioral Health Services Administrator (BHSA) and will administer the traditional and non-traditional behavioral health services

for all members covered through any DMAS behavioral health fee-for service program, regardless of the population served. The emergency regulations include a definition for the BHSA and outline its role. Other definitions related to MHSS services are also provided in the emergency regulations including Independent Living Situation, Individualized Training, QMHP-A, QMHP-C and Review of ISP.

These emergency regulations (12VAC30-50-226 and 12VAC30-60-143) also require satisfaction of service authorization requirements for crisis intervention and crisis stabilization. DMAS is actively collaborating with Magellan about these processes. Until the service authorization process is defined by DMAS, these services will require registration only and not a medical necessity review for authorization. Additional information will be forwarded to providers prior to December 1, 2013 and implementation of these regulations.

For information regarding what is required to obtain authorization through Magellan for MHSS, please visit the Magellan of Virginia website and stay informed on upcoming webinars and announcements regarding the December 1, 2013 implementation. This website offers information to members and providers regarding behavioral health services that will be administered by Magellan, which includes MHSS, as well as information regarding upcoming events i.e. webinars, forums offered by Magellan. Frequently asked questions pertaining to the BHSA contract will also be posted and updated routinely. Providers are encouraged to visit the new website at http://www.magellanofvirginia.com. DMAS will also maintain its behavioral health webpage (http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx) to provide updates regarding the Magellan contract as needed.

Managed Care Organizations

While this service is carved out of the Medicaid Managed Care contracts, members are still eligible to receive these services through DMAS and beginning December 1, 2013, through Magellan Health Services.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Prior to December 1, 2013, providers may also access behavioral health service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com. Effective December 1, 2013, providers may access behavioral health service authorization information via Magellan's website at http://www.magellanofvirginia.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.