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Community Mental Health Rehabilitative Services (CMHRS)	TBD	

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INTENSIVE IN-HOME SERVICES (IIH) FOR YOUTH (H2012)

Intensive In-Home Level of Care Guidelines	
Service Definition Critical Features & Service Components	Intensive in-home services (IIH) for youth under age 21 are intensive therapeutic interventions provided in the youth's residence (or other community settings as medically necessary and documented in the Comprehensive Needs Assessment and ISP), to improve family functioning, and significant functional impairments in major life activities that have occurred due to the youth's mental, behavioral or emotional illness in order to prevent an out of home placement, stabilize the youth, and gradually transition the youth to less restrictive levels of care and supports. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and include clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote benefits of psychoeducation in the home setting of a youth who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the youth.
Required Activities	In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to IIH: • Prior to the start of services, a valid Comprehensive Needs Assessment as described in Chapter IV shall be conducted in-person by the LMHP, LMHP-S, LMHP-R or LMHP-RP, documenting the youth's diagnosis and describing how service needs match the level of care criteria. • An ISP shall be developed within 30 calendar days of initiation of services. The ISP shall meet all of the requirements as defined in 12 VAC 30-50-130, 12VAC30-50-226 and the ISP Requirements section of Chapter IV. ISPs shall be required during the entire duration of services and shall be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement; • Individual and family counseling is a required component of this service and must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Counseling may be provided by the IIH provider or an outpatient service by a private provider as long as it is documented in the ISP and coordinated by the IIH provider. If the counseling is provided by a

private provider, the private provider would bill as an outpatient psychiatric services separate from the IIH services;

- The ISP shall be in effect and demonstrate the required need for a minimum of three hours a week of IIH. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the youth and family as documented in the ISP. In preparation of discharge, the ISP can be updated to show a reduction in the services to transition the youth~~child~~ and family to a lower level of care. The individualized discharge plan shall describe the transition from IIH to a lower level of care;

- Emergency assistance shall be available to the family, and delivered, as needed, by the IIH service provider 24 hours per day, seven days a week;

- All interventions and the settings of the intervention shall be defined in the ISP;

- Services shall be directed toward the treatment of the eligible youth and delivered primarily in the family's residence with the youth present;

- As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the youth and describe how it facilitates the implementation of the ISP;

- Training to increase appropriate communication skills shall be provided (e.g., counseling to assist the youth and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.);

- Services may be provided to facilitate 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. The youth and responsible parent/guardian shall be available and in agreement to participate in the transition.

	• At least one parent/legal guardian or responsible adult with whom the youth is living must be willing to participate in the intensive in-home services with the goal of keeping the youth with the family. • All services must be provided on a one-to-one basis with one staff person and one Medicaid member with the exception of family counseling and care coordination. **Care Coordination:** • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). •
Intensive In-Home Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	**Medical Necessity Criteria for IIH** Youth receiving 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 youth's functioning. Prior to the start of services, a valid Comprehensive Needs Assessment, as defined in Appendix A, shall be conducted in-person by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the youth's diagnosis and describing how service needs can best be met through intervention provided typically but not solely in the youth's residence. The Comprehensive Needs Assessment describes how the youth's clinical needs put the youth at risk of out-of-home placement. Youth shall meet all of the following criteria including Diagnostic, At Risk, Level of Care and Family Involvement to qualify for IIH services. **1. Diagnostic Criteria** Youth qualifying for this service shall demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities. The diagnosis must be the primary clinical issue addressed by services and must support the mental, behavioral or emotional illness attributed to the

recent significant functional impairments in major life activities.

2. At Risk Criteria

The impairments experienced by the member are to such a degree that they **shall meet at least two** of the criteria below, on a continuing or intermittent basis, for being at risk of out of home placement as defined in Appendix A.

a. 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 as defined in Appendix A of this manual because of conflicts with family or community; and/or
b. Exhibit such inappropriate behavior that **documented, repeated** interventions by the mental health, social services, or judicial system are or have been necessary resulting in being at risk for out of home placement; and/or
c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior resulting in being at risk for out of home placement.

3. Level of Care:

The impairments experienced by the member are to such a degree that they **shall meet one** of the criteria below:

a. When services that are far more intensive than outpatient clinic care are required to stabilize the youth in the family situation, or

b. When the youth's residence as the setting for services is more likely to be successful than a clinic.

4. Family Involvement:

At least one parent/legal guardian or responsible adult with whom the youth is living shall be willing to participate in the intensive in-home services with the goal of keeping the youth with the family. In the instance of this service, a responsible adult shall be an adult who lives in the same household with the youth~~child~~ and is responsible for engaging in

	counseling and service-related activities to benefit the youth.
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 any of the following apply: a. The youth is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms; b. The level of functioning has improved with respect to the goals outlined in the ISP and the youth can reasonably be expected to maintain these gains at a lower level of treatment; c. The youth~~child~~ is no longer in the home; or d. There is no parent or responsible adult actively participating in the service. Discharges shall also be warranted when the service documentation does not demonstrate that services meet the IIH service definition or when the services progress meets the "failed services" definition. Discharge is required when the youth has achieved maximal benefit from this level of care and their level of functioning has not improved despite the length of time in treatment and interventions attempted. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the youth with the service provider, the provider shall discharge the youth.
Exclusions and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • Services that meet the definition of "Failed Services" will not be eligible for reimbursement approval. • IIH may be billed only within 7 days prior to discharge from any residential treatment service or inpatient hospitalization. • Recreational activities outside the home, such as trips to the library, restaurants, museums, health clubs and shopping centers, 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 Comprehensive Needs Assessment and the ISP. • IIH may not be authorized or billed concurrently with Multisystemic Therapy (MST), Functional Family Therapy (FFT), Applied Behavior Analysis (ABA), Assertive Community Treatment, Mental Health Intensive Outpatient or Mental Health Partial Hospitalization Program services. IIH may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care. •
Intensive In-Home Provider Participation Requirements	
Provider Qualifications	Intensive In-Home Services providers must be licensed as a provider of Intensive In-Home Services (05-001) by DBHDS and be credentialed with the youth's Medicaid MCO for youth enrolled in Medicaid managed care or the Fee for Services (FFS) contractor for youth in FFS. Intensive In-Home providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	• All programs must have a LMHP who is responsible for the clinical oversight of the program. • IIH services may only be rendered by an LMHP, LMHP-S, LMHP-R, LMHP-RP; or a QMHP-C or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP or LMHP-S. • Assessments must be conducted by a LMHP, LMHP-S, LMHP-R or LMHP-RP. • Individual and Family Counseling must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. •
Intensive In-Home Service Authorization and Utilization Review	
Service Authorization	Service authorization is required (see Appendix C). The information provided for service authorization must be corroborated and

	in the provider's clinical record.
Documentation and ~~–~~Utilization Review	Refer to Chapters IV and VI of this manual for ~~all~~ documentation and utilization review requirements that apply to all providers of Mental Health Services.

Intensive In-Home Billing Requirements
1. One unit of service equals one hour. 2. Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use of the GT modifier for units billed for services provided through telemedicine. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

THERAPEUTIC DAY TREATMENT (TDT) FOR YOUTH (H2016)

TDT Level of Care Guidelines	
Service Definition Critical Features & Service Components	Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement the school day or year. The supporting diagnosis must be made by an LMHP practicing within the scope of his or her license. This service shall include assessment, assistance with medication management, interventions to build daily living skills or enhance social skills, and individual, group, and/or family counseling and care coordination. Services may be provided in groups or on a one-to-one basis as clinically indicated. These services shall be provided for two or more hours per day. Youth receiving TDT must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the youth's functioning.

	Successful service provision includes the active engagement of the service provider, any involved school, and the youth's parent/guardian. The service provider shall engage with the school and parent/guardian to reach the desired outcomes as outlined in the ISP. Ideally, if a school is involved, it will provide a secure space for service provision and liaison with the service provider. The licensed practitioner shall determine the frequency of visits based on the individual needs of the youth. DMAS recommends that family involvement, to include family counseling, family meetings or family contacts, occurs at least weekly from the beginning of treatment unless contraindicated as documented in the ISP and Comprehensive Needs Assessment. The licensed practitioner shall document justification for less than weekly family involvement if weekly involvement is contraindicating to the youth's needs. Youth receiving TDT should experience improvement on measurable objectives and goals documented in the ISP and ISP reviews that enable the youth to transition to a lower level of care. TDT is intended for youth who reside in the community with their parent(s)/guardian(s) in the family home or in a group home placement. TDT should provide stabilization during the school day or to supplement the school day or year, as medically necessary, for youth who are at risk to be placed in a higher level of care in order to address current symptoms, or who are transitioning from an acute or residential level of care to a home environment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the youth and family initially, with gradually reduced intensity progressing toward discharge.
Required Activities	In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to TDT: • The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., school based, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group therapeutic interventions and activities.

- Prior to the start of services, a Comprehensive Needs Assessment, as defined in Appendix A, shall be conducted in-person by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the youth's diagnosis and describing how service needs match the level of care criteria

- An ISP developed within 30 calendar days of initiation of services that meets all requirements of an ISP as defined in 12 VAC30-50-130, 12VAC30-50-226 and the ISP Requirements section of Chapter IV. ISPs shall be required during the entire duration of services and be current. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.

- Individual, group and/or family counseling is a required component of this service and must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. Counseling may be provided by the TDT provider, another provider or by the local education agency behavioral health staff, as long as it is documented in the ISP and coordinated by the TDT provider. If the counseling is provided by a private provider, the private provider would bill as an outpatient psychiatric service separate from the TDT services. If the counseling is provided by the local education agency, then the local education agency would need to provide services according to the Local Education Agency DMAS Provider Manual. If this youth~~child~~ is also receiving other Mental Health Services and counseling is a required component of that service, the counseling services shall be coordinated between service providers and documented in the youth~~child~~'s ISP and would be billed by the servicing provider.

- Services must be therapeutic in nature and align with the youth's ISP.

- The ISP, including the individualized discharge plan contained in the ISP, should be reviewed every 3 months (defined as 90 calendar days) at a minimum, but as frequently as medically necessary.

- When a youth~~child~~ transitions from school based TDT to non-school based TDT or from non-school based TDT to school based TDT, providers shall:
  - Review and update the Comprehensive Needs Assessment as described in the Comprehensive Needs Assessment of Chapter IV.
  - Update the ISP based on the activities being provided.

- Family meetings and contacts, either in person or by telephone, occurs at least once per week to discuss treatment needs and progress. Contacts with parents/guardian include at a minimum the youth's progress, any diagnostic changes, any ISP changes, and discharge planning. The parent/guardian should be involved in any significant incidents during the school day and be informed of any changes associated with the ISP. Family meetings are not considered to be the same as family therapy.

- If the youth is prescribed medication related to their behavioral health needs, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the youth and parent/ guardian and documented in the Comprehensive Needs Assessment, the ISP and progress notes. A QMHP-C must remain within the boundaries of their level of expertise and may consult with the service provider's clinical director, consult with current prescribing physician and school personnel such as school nurse, coordinate referrals for medication evaluation, monitor compliance, and provide developmentally appropriate education to the youth regarding medication adherence and side effects. The QMHP must involve the parent/guardian to monitor the youth's medication compliance/adherence. Response to medication and education, as well as compliance must be documented.

- Services must include providing individual and group therapeutic interventions and activities based on specific TDT objectives identified in the ISP. Examples include, but are not limited to, planning and implementing individualized pro-social skills interventions; problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations.

- For school based TDT, services must include providing feedback to the youth and direct skills training in the classroom based on specific TDT objectives identified in the ISP.

- For school based TDT, services must include responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day; services should include a "de-briefing" with the youth and family to discuss the incident; how to recognize triggers, identify alternative coping mechanisms and providing feedback on the use of those alternative coping mechanisms. A crisis

	plan should be kept onsite and in the medical record and reviewed throughout treatment. **Care Coordination:** • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). • Care coordination includes: consultation, collaboration, and coordination with teachers, concurrent service providers, and others involved in the youth's treatment to include scheduling appointments and meetings to improve care; planning and implementing individualized behavior modification programs; and monitoring treatment and ISP progress. The provider will be asked to explain what care coordination has taken place during treatment as well as in preparation for discharge and step down to lower levels of care with every request for services. •
TDT Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Youth must meet all of the following to include the Diagnostic, Clinical Necessity, and Level of Care criteria. **1. Diagnostic Criteria** Youth qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. The diagnosis must be the primary clinical issue addressed with the service targeted for treatment. The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities. **2. Clinical Necessity Criteria** Youth shall **meet at least two** of the following: a. 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** as defined

	in Appendix A because of conflicts with family or community; and/or b. Exhibit such inappropriate behavior that **documented, repeated** interventions by the mental health, social services or judicial system are or have been necessary: and/or c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. **3. Level of Care** Youth shall **meet at least one** of the following: a. The youth must require year-round treatment in order to sustain behavior or emotional gains; b. The youth's behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without: i. TDT programming during the school day; or ii. TDT programming to supplement the school day or school year; c. The youth would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning; d. The youth must (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality; or ~~e.~~ The youth is placed or pending placement in a preschool enrichment and/or early intervention program but the youth's emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted in these programs without TDT services. e.
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 any of the following applies:

	○ The youth no longer meets the diagnostic, clinical necessity, or level of care criteria; or ○ The level of functioning has improved with respect to the goals outlined in the ISP, and the youth can reasonably be expected to maintain these gains at a lower level of treatment. ○ When the youth has achieved baseline functioning (his or her level of functioning has not improved despite the length of time in treatment and interventions attempted) and his or her needs can be met in a less intensive service.. If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the youth.
Exclusions and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • Therapeutic group activities are limited to no more than 10 youth. • Medicaid will only reimburse for allowed service activities as defined in the ISP. • Activities that are not allowed / reimbursed: ○ Inactive time or time spent waiting to respond to a behavioral situation; ○ Transportation; ○ Time spent in documentation of youth and family contacts, collateral contacts, and clinical interventions; ○ Time required for academic instruction when no treatment activity that align with the goals and objectives in the youth's ISP is taking place; ○ Time spent monitoring behavior during the classroom when no treatment activity is occurring; and ○ Time when the youth is not present. • Services must not duplicate those services provided by the school, including interventions identified on the school's IEP for the youth. • TDT may not be authorized or billed concurrently with Assertive Community Treatment, Mental Health Intensive Outpatient or Mental Health Partial Hospitalization Program services. TDT may not be billed

	concurrently with Community Stabilization or Residential Crisis Stabilization Unit Services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.
TDT Provider Participation Requirements	
Provider Qualifications	Therapeutic Day Treatment (TDT) providers for children and adolescents must be licensed as a provider of Therapeutic Day Treatment Service for Children and Adolescents (02-029) by DBHDS and be credentialed with the youth's Medicaid MCO for youth enrolled in Medicaid managed care or the Fee for Services (FFS) contractor for youth in FFS. TDT providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. TDT providers are required to maintain a current Memorandum of Understanding (MOU) with the school system where services are being provided. A MOU must be reviewed and signed annually. A MOU must include all schools where services are being provided. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the Individualized Service Plan (ISP).
Staff Requirements	• TDT services may only be rendered by an LMHP, LMHP-S, LMHP-R, LMHP-RP; or a QMHP-C or QMHP-E under the supervision of an LMHP, LMHP-R, LMHP-RP or LMHP-S. • Assessments must be conducted by a LMHP, LMHP-S, LMHP-R or LMHP-RP. • Individual, Group and Family Counseling must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP.
TDT Service Authorization and Utilization Review	
Service Authorization	Service authorization is required. See Appendix C.

	Additionally, if the youth changes service settings the provider will be expected to provide supportive clinical information on a continued stay authorization request to support the modified service. Information gathered from an assessment or an updated assessment should be used to document the need for services on the authorization request along with the specific treatment goals and objectives as they are revised for summer programming.
Documentation and Utilization Review	Refer to Chapters IV and VI of this manual for ~~all~~ documentation and utilization review requirements that apply to all providers of Mental Health Services.

TDT Billing Requirements

1. Service units are based on medical necessity.
    - One unit = 2 to 2.99 hours per day
    - Two units = 3 to 4.99 hours per day
    - Three units = 5 plus hours per day

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

PSYCHOSOCIAL REHABILITATION (PSR) (H2017)

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

	a consistent program structure and environment. Services may be provided in groups or on a one-to-one basis as clinically indicated.
Required Activities	In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to PSR: • Prior to the start of services, a Comprehensive Needs Assessment, as defined in Appendix A, shall be conducted ~~in-person~~face to face by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. • An ISP shall be completed as described in the ISP Requirements of Chapter IV within 30 calendar days of service initiation. ISPs shall be required during the entire duration of services and be current. • Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-S, LMHP-R, or LMHP-RP to support that the individual continues to meet the medical necessity criteria. The LMHP, LMHP-R, LMHP-RP or LMHP-S shall determine and document the continued need for the service as described in the Comprehensive Needs Assessment section of Chapter IV. This review may be requested by DMAS or its contractor to receive approval of reimbursement for continued services. • Services must include social skills training, community resource development, and peer support among fellow members, which are oriented toward empowerment, recovery and competency, psycho educational activities to teach the individual about mental illness and appropriate medication to avoid complications and relapse. • Providers must 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. • The program shall operate a minimum of two continuous hours in a 24-hour period. • Time allocated for field trips may be used to calculate time and units if the goal is to provide training in an integrated setting, and to increase the

	individual's understanding or ability to access community resources and this is an identified need in the assessment and ISP. **Care Coordination:** • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). •
PSR Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	The Comprehensive Needs Assessment, as defined in Appendix A, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must **meet both Criteria A and B** to qualify for reimbursement. A. Individuals must meet **two** of the following criteria on a continuing or intermittent basis: 1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports; 2) Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized; 3) Exhibit such inappropriate behavior that repeated interventions **documented** by the mental health, social services, or judicial system are or have been necessary; or 4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. "Cognitive" is defined as the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability.

	B. The individual must meet **one** of the following criteria: 1) Have experienced long-term or repeated psychiatric hospitalizations; or 2) Experience difficulty in activities of daily living 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. 5)

Exclusions and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
	• The following services are specifically excluded from payment for psychosocial rehabilitation services:
	  • Vocational services,
	  • Prevocational services,
	  • Supported employment services
	• Psychosocial rehabilitation may not be authorized or billed concurrently with Mental Health Intensive Outpatient, Mental Health Partial Hospitalization Program or Applied Behavior Analysis services. Psychosocial rehabilitation may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.
	• Providers shall not bill for time when the individual is not present at the program.

PSR Provider Participation Requirements	
Provider Qualifications	Psychosocial Rehabilitation providers must be licensed as a provider of Psychosocial Rehabilitation by DBHDS and be credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Services (FFS) contractor for individuals in FFS. PSR providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.

Staff Requirements	• Psychosocial rehabilitation services may be provided by an LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH under the supervision of a QMHP-A, QMHP-C, LMHP, LMHP-S, LMHP-R, or LMHP-RP. • Assessments must be conducted by a LMHP, LMHP-S, LMHP-R or LMHP-RP. •
PSR Service Authorization and Utilization Review	
Service Authorization	Service authorization is required. See Appendix C
Documentation and Utilization Review	Refer to Chapters IV and VI of this manual for ~~all~~ documentation and utilization review requirements that apply to all providers of Mental Health Services. Services must be documented in the individual's record as having been provided consistent with the ISP. Daily documentation that describes the activities chosen by the individuals, such as logs and sign in sheets, will be necessary: to ensure that the documentation correlates with the units billed for each day of service; to convey a summary of the daily activities and group activities; the observations for each individual in the activity; and, to support the overall time billed for the day of programming. Progress notes for psychosocial rehabilitation services must be completed monthly. Notes must specifically describe the activities and interventions chosen by the member and other interventions that were provided by the program. Monthly progress notes should describe how the service provider has worked to provide interventions and work with the individual toward engagement in the therapeutic milieu and attainment of individualized service plan goals.
PSR Billing Requirements	
Service Units are based on medical necessity:	

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

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

MENTAL HEALTH SKILL BUILDING SERVICES (MHSS) (H0046)

MHSS Level of Care Guidelines	
Service Definition Critical Features & Service Components	Mental health skill-building services (MHSS) shall be defined as goal directed training and supports to enable restoration of an individual to the highest level of baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS services shall provide face to face activities, instruction, interventions, and goal directed trainings that are designed to restore functioning and that are defined in the ISP in order to be reimbursed by Medicaid. MHSS shall include goal directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. MHSS services include the following components: • Providing opportunities to enhance recovery plans that include but are not limited to: o Daily living activities and trainings on personal care/hygiene to restore and regain functional skills and appropriate behavior related to health and safety; and, o Skills training and reinforcement on the use of available

	community resources, such as public transportation to improve daily living and community integration skills and independent use of community resources, etc. • Recovery and symptom management activities that include but are not limited to: o Condition specific education and training and reinforcement of symptom identification designed to increase he individual's ability to recognize and respond to symptoms; and o Goal directed and individualized stress management and coping skills training to increase the individual's continued adjustment to management of mental illness; and o Training and coaching to facilitate improved communication, problems solving and appropriate coping skills, etc. • Assistance with medication management. • Conducting targeted exercises and coaching to restore and individual's ability to monitor and regulate their health, nutrition, and physical condition that includes but is not limited to: o Self-assessment exercises and recovery coaching that builds self-awareness of symptoms and how to identify and monitor symptoms; and o Coaching and training on maintaining adherence to recommended medical care such as scheduling and keeping medical appointments, etc. o
Required Activities	In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to MHSS: 1. A Comprehensive Needs Assessment shall be required prior to the start of services. The Comprehensive Needs Assessment must be conducted in-person by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The Comprehensive Needs Assessment, as defined in Appendix A, shall document the individual's behavior and describe how the individual meets criteria for this service. After any lapse in services of more than 31 calendar days, a new Comprehensive Needs Assessment shall be

required unless the provider has a valid Comprehensive Needs Assessment as defined in the Comprehensive Needs Assessment section of Chapter IV. If the provider has a valid Comprehensive Needs Assessment, the provider shall update the Comprehensive Needs Assessment following any lapse of greater than 31 calendar days. The LMHP, LMHP-R, LMHP-RP, LMHP-S performing the Comprehensive Needs Assessment shall document the primary mental health diagnosis on the Comprehensive Needs Assessment.

2. MHSS services that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S to support that the individual continues to meet the medical necessity criteria. The LMHP, LMHP-R, LMHP-RP or LMHP-S shall determine and document the continued need for the service in the individual's medical record as described in the Comprehensive Needs Assessment section of Chapter IV. This review may be requested by DMAS or its contractor to receive approval of reimbursement for continued services.

3. The ISP shall be developed as described in the ISP Requirements section of this found in Chapter IV within 30 calendar days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall 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. The ISP shall include the dated signature of the individual, if the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.

4. Every three months (defined as 90 calendar days), the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in the manner in which they~~he~~ may participate with the process, modify as appropriate, and update the ISP. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record no later than 15 calendar days from the

date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall 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 believe that the individual is not adhering to the medication regimen, medication compliance shall be a goal in the individual's ISP. If the care is delivered by the QPPMH, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any non-compliance. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-compliance concerns. The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:

   - name and title of caller;
   - name and title of professional who was called;
   - name of organization that the prescribing professional works for;
   - date and time of call;
   - reason for care coordination call;
   - description of medication regimen issue or issues to be discussed; and
   - resolution of medication regimen issue or issues that were discussed.

8. Documentation of prior psychiatric services history, to include psychiatric medication history, as described in Chapter ~~VI~~ IV of this manual shall be maintained in the individual's MHSS medical record.

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

10. ~~10.~~ 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. However, any service provided to individuals that are strictly vocational in nature shall not be billable.

11. ~~11.~~ Provider qualifications. The enrolled provider of MHSS shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide MHSS must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the MHSS record. All Registered QMHPs shall follow DHP licensing requirements for supervision.

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

13. ~~-~~If MHSS is provided in a Therapeutic Group Home, mental health supervised living setting 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 MHSS with the treatment plan established by the group home, mental health supervised living setting or assisted living facility and shall document all coordination activities in the medical record.

14. All services must be provided on a one-to-one basis with one staff person and one Medicaid member with the exception of care coordination.

Care Coordination:

	• Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). •
MHSS Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Individuals qualifying for MHSS 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 age 21 and over shall **meet all** of the following criteria in order to be eligible to receive MHSS: A. The individual shall have one of the following as a primary mental health diagnosis: 1) Schizophrenia or other psychotic disorder as set out in the DSM-5, 2) Major Depressive Disorder; 3) Bipolar I or Bipolar II; 4) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year that includes all of the following: (i) is a serious mental illness; (ii) results in severe and recurrent disability; (iii) produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) the individual requires individualized training in order to achieve or maintain independent living in the community. B. The individual shall require individualized goal directed training in order to acquire or maintain self-regulation of basic living skills such, as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support system; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources. C. The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) Ceommunity Sstabilization, 23-hour

Cerisis Sstabilization or Rresidential Cerisis Sstabilization Uunit Sservices, (iii) ICT or Program of Assertive Community Treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation pursuant to the Code of Virginia §37.2-809(B). This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service. See the Documentation and Utilization Review section for additional information.~~Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.~~

D. The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the Comprehensive Needs Assessment. 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 MHSS 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. See the Documentation and Utilization Review section for additional information. ~~Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, including psychiatric medication history, (ii) the dates of the treatment previously provided, and (iii) the name of treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.~~

Individuals 18-20 years shall **meet all** of the above medical necessity criteria listed in paragraphs 1 through 2 (A-D) in order to be eligible to receive MHSS and the following:

	E. The individual shall not be in a supervised setting as described in §63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition. Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance use disorder. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within MHSS as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the Comprehensive Needs Assessment, the ISP, and the progress notes.
Exclusions and Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: 1. TGH and assisted living facility providers shall not serve as the MHSS 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. "Affiliated" means any entity or property in which a group home or assisted living facility has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity. 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 intermediate care facilities for individuals with intellectual disabilities (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 calendar days prior to discharge. If the individual has not been discharged from the nursing facility during the 60 calendar day period of services, MHSS shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that MHSS 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 calendar days of MHSS.

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

8. MHSS shall be not reimbursed if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's MHSS 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 a Developmental Disabilities Waiver, CCC Plus Waiver, and EPSDT services.

9. MHSS shall not be duplicative of other 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, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP 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 MHSS unless their physicians issue a signed and dated statement indicating that this service

can benefit the individual by enabling them to achieve and maintain community stability and independence.

11. Individuals who are not diagnosed with a serious mental disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the MHSS services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 and that the provider can document and describe how the individual is expected to actively participate in and benefit from MHSS and the remaining MHSS service criteria and guidelines are satisfied.

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

13. 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.

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

15. Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.

16. Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and guidelines as described in the regulations and this manual. Only direct face-to-face contacts and services to the individual members are reimbursable.

17. Staff travel time is excluded.

18. MHSS may not be authorized or billed concurrently with Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Applied Behavior Analysis. MHSS may not be billed

	concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care. ~~19.~~ Service may not be provided in groups where one staff person provides services to two or more individuals at the same time. 19.
MHSS Provider Participation Requirements	
Provider Qualifications	MHSS providers must be licensed by DBHDS as a provider of Mental Health Community Support services and be credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Services (FFS) contractor for individuals in FFS. MHSS providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	• MHSS services may only be rendered by LMHP, LMHP-S, LMHP-R, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, LMHP-S, LMHP-R, or LMHP-RP. • ~~—~~Assessments must be conducted by a LMHP, LMHP-S, LMHP-R or LMHP-RP. •
MHSS Service Authorization and Utilization Review	
Service Authorization	Service authorization is required. See Appendix C.
Documentation and Utilization Review	Refer to Chapters IV and VI of this manual for ~~all~~ documentation and utilization review requirements that apply to all providers of Mental Health Services. MHSS Documentation Requirements – validating prior psychiatric and medication history 1. Documentation of prior psychiatric services history shall be maintained in the individual's MHSS medical record. This requirement can be met by either:

a. A copy of a discharge summary from a prior provider that clearly indicates: (i) the type of treatment provided; (ii) the dates of the treatment previously provided; and (iii) the name of treatment provider; OR

b. Documentation of a telephone contact with a prior provider that includes the following minimum elements: (i) name and title of the caller; (ii) name and title of the professional who was called; (iii) name of the organization that the professional works for; (iv) date and time of the call; (v) specific placement provided; (vi) type of treatment previously provided; (vii) name of the treatment provider; and (viii) dates of previous treatment.

2. The provider shall document evidence of psychiatric medication history. This requirement can be met by one of the following:
   a. Discharge summaries from prior providers that clearly indicate (i) the type of treatment provided, including psychiatric medication history, (ii) the dates of the treatment previously provided, and (iii) the name of treatment; OR
   b. Photocopies of prescription information from a prescription bottle; OR
   c. Prescription list from a pharmacy or other provider that contains the following: (i) the name of the prescribing physician; (ii) the name of the medication with dosage and frequency; (iii) the date of the prescription; OR
   d. Documentation of a contact with the pharmacy or other provider that includes the following minimum elements: (i) name and title of caller, (ii) name and title of professional who was called, (iii) name of organization that the professional works for, (iv) date and time of call, (v) specific prescription confirmed, (vi) name of prescribing physician, (vii) name of medication, and (viii) date of prescription

3. Providers may use their own records to validate prior psychiatric and medication history, however they must clearly document in a MHSS progress note where in the electronic record substantiating information (ex: doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date) can be found.

	When a provider uses their own records to validate prior psychiatric and medication history, the documentation referenced must meet the documentation requirements for prior psychiatric and psychiatric medication history outlined above. 4. Family member statements shall not suffice to meet documentation requirements for prior psychiatric and psychiatric medication history outlined above.

MHSS Billing Requirements

The provider shall clearly document details of the services provided during the entire amount of time billed. Service units are based on medical necessity.

- One unit = 1 to 2.99 hours per day
- Two units = 3 or more hours per day

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