Virginia Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

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

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or

excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

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

Intensive Outpatient Services

Mental Health Intensive Outpatient Services (MH-IOP) are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time-limited treatment programs that integrate evidence-based practices for youth (ages 6-17 years) and adults (18 years +). Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, children younger than age 6 may receive services based on medical necessity. MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care.

MH-IOP services are appropriate when an individual requires at least 6 hours of clinical services a week (for youth ages 6-17), or 9 hours of clinical services as week (for adults 18 years and older) over several days a week and totaling a maximum of 19 hours per week. A MH-IOP requires psychiatric oversight with medication management included in the coordinated structure of the treatment program schedule. MH-IOP tapers in intensity as an individual's symptoms improve as evidenced by their ability to establish community supports, resume daily activities, or participate in a lower level of care.

Admission Criteria

- The individual must meet all of the following criteria:
  - The individual must exhibit symptoms consistent with a DSM diagnosis (using the most current version of the DSM) that is documented in the initial assessment that requires and can reasonably be expected to respond to treatment interventions;
  - Within the past 30 days, the individual has experienced persistent or increasing symptoms associated with their primary DSM disorder which has contributed to decreased functioning in their home, school, occupational or community settings that has led to negative consequences and difficulties maintaining supportive, sustaining relationships with identified family and peers due to a psychiatric disorder. Interventions at lower levels of care or in alternative, community-based rehabilitation services have been attempted but have been unsuccessful in adequately addressing the symptoms and supporting recovery for the individual to baseline levels of functional capacity;
  - The individual is at risk for admission to inpatient hospitalization, residential treatment services, residential crisis stabilization or partial hospitalization as evidenced by acute intensification of symptoms, but has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; or the individual is stepping down from inpatient hospitalization, residential crisis stabilization, or a partial hospitalization program and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision;
  - The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours and a safety plan has been established;
  - The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team;
  - The individual can reliably attend, and actively participate in, all phases of the treatment program;
  - The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and
  - For youth, there is a family/caregiver resource that is available to engage with treatment providers and support and reinforce the tenets of the MH-IOP services.

Continuing Stay Criteria

- The individual meets all of the following:
  - Another less intensive level of care would not be adequate to administer care;

- Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care;
- The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria, and the treatment plan (ISP) has been revised to incorporate new goals;
- The individualized treatment plan (ISP), updated every 30 calendar days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan (ISP);
- Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan (ISP) is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;
- A psychiatric medical evaluation documents that medication options have been considered or initiated;
- The individual's natural supports (e.g. individually identified family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway; and
- Documentation demonstrates that coordination of care and vigorous, active discharge planning has been ongoing from the day of admission with the goal of transitioning individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.

- If the above criteria are not met, there are some circumstances under which authorization may be extended for up to 10 calendar days. These circumstances include any of the following:
  - The individual has clearly defined treatment objectives that can reasonably be achieved through continued MH-IOP treatment, such treatment is necessary in order for the discharge plan to be successful, and there is no less intensive level of care available in which the objectives can be safely accomplished;
  - Individuals can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the individual to be discharged directly to a less intensive community rather than to a more restrictive setting; and/or
  - The individual is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued by the provider delivering the service but are not available (including but not limited to such resources as placement options, substance use treatment or mental health appointments, therapeutic mentoring, etc.);
  - Individuals may be authorized to participate in less than nine hours a week for adults and six hours a week for youth as a transitional step down to lower level services for one to two weeks prior to transitioning to promote recovery. Providers should seek approval for such a transition from Optum and the provider shall document the rationale in the individual's ISP.

Discharge Criteria

- The individual meets discharge criteria if any of the following are met:
  - The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available;
  - Required consent for treatment is withdrawn or not obtained;
  - The individual does not appear to be participating in the treatment plan (ISP) and has not benefited from MH-IOP despite documented efforts to engage the individual. For youth, there is lack of treatment progress attributable to lack of involvement and engagement by the identified family/caregivers;
  - The individual's ISP goals have been met, and an appropriate aftercare treatment plan has been established;
  - If there is any lapse in service indicative of a need for another level of care;
  - If there is a lapse in service greater than 7 consecutive calendar days;
  - The individual's level of functioning has improved with respect to the goals outlined in the ISP, and there is reasonable expectations that the individual can, to maintain this recovery process at a lower level of treatment; or
  - The individual is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, residential crisis stabilization unit or other residential treatment setting for more than 7 days and is not ready for discharge to home.

Service Delivery

- Critical Features
  - MH-IOP is an active treatment program of services that includes an individualized treatment plan describing the coordination of those services and how they will address the individual's goals. MH-IOP services include structured schedules for participants. Treatment goals should be measurable, person-centered, recovery oriented, trauma-

informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission.
    - Critical features of MH-IOP include:
        - The integration and documentation of evidence based practices to address family, social and community risk factors and provide coping skills to improve symptoms and functioning; and
        - The promotion of behavior change in the individual's natural environment, with the overriding goal of empowering the individuals, their identified family natural supports to promote improved functioning; and
        - The inclusion of rigorous quality assurance mechanisms that focus on achieving individual outcomes through monitoring treatment fidelity and progress and adjusting treatment goals and plans to address individual needs and barriers as they arise.
    - This service is appropriate for individuals who do not require the intensive level of care of inpatient, residential or partial hospitalization services, but do require more intensive services than traditional outpatient psychiatric services, and would benefit from a structured setting.
    - MH-IOP services include both the comprehensive, structured delivery of evidence-based therapy services in combination with care coordination activities that seek to support recovery and movement into a lower level of care, such as traditional outpatient psychiatric services. Care coordination services should focus on identification of additional needs to support recovery (e.g. housing, employment, food stability, mentoring, and parenting supports) and connecting the individual and natural supports to appropriate referrals to meet these needs.
    - Covered service components include assessment, treatment planning, individual, family and group therapy, skills restoration/development, health literacy counseling/psychoeducational activities, crisis intervention, peer recovery support services and care coordination.
- Required Activities
    - In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-IOP:
        - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter 4 for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-IOP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter 4 for details).
        - An evaluation for medication management by a physician, nurse practitioner or physician assistant must be conducted within 72 hours of admission into the service. The provider must coordinate medication management with existing medical and psychiatric providers.
        - Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.
        - ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.
        - MH-IOP must be available to allow for 9-19 hours of intervention a week (for adults) or 6-19 hours of intervention a week (youth ages 6-17) with programming to occur across 3-4 days of services weekly.
        - Components of the treatment program must include all of the following:
            - Individualized treatment planning;
            - Individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others) in the assessment, treatment, and continuing care of the individual;
            - Skill restoration / development;
            - Health literacy counseling / psychoeducational activities;
            - Care coordination & referral for consultation, supplemental, or step-down service providers;
            - Crisis intervention;
            - Peer Recovery Support Services;
            - Medication management.
    - Occupational therapy, as an optional supplement, when it is directly related to the behavioral health goals; and
    - Psychological assessment / testing as an optional supplement.

- Care coordination through referrals to higher and lower levels of care, as well as community and social supports, should include the following:
  - The provider should collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;
  - The provider should establish and maintain referral relationships with step-down programs appropriate to the population served;
  - The provider should, with individual's consent, collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.
- A minimum of 2 distinct service components must be provided daily. If the minimum service components are not met, providers must document the reason in the individual's medical record. If the session involves a Comprehensive Needs Assessment no other component shall be required in order to bill the per diem.
- A minimum of 2 hours of therapy (individual, group or family) by a LMHP, LMHP-R, LMHP-RP or LMHP-S shall be provided per individual per week. Individuals may be pulled out of scheduled skill-based groups to participate in therapy. If the individual continues to meet with an existing outpatient therapy provider, the MH-IOP provider must coordinate the treatment plan with the provider.
- Group therapy shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the licensed mental health professional.
- A minimum of 3 sessions of group-based delivery of skills-restoration/development shall be provided per week.
- An updated assessment conducted by a LMHP LMHP-R, LMHPRP, LMHP-S, nurse practitioner or physician assistant is required at every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued stay. DMAS or its contractor(s) may request the results of this assessment to evaluate approval of reimbursement for continued services.
- Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.
- Whenever possible, crisis intervention should be delivered by the MH-IOP staff, including after program hours.
- In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record and notify Optum Utilization Management (UM) staff when the minimum sessions have not been provided (see service authorization section for additional information).
- If the individual consistently deviates from the required services in the ISP, the provider should work with Optum care coordination to reassess for another level of care or model to better meet the individual's needs.
- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

- Provider Qualifications
  - MH-IOP service providers shall be accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), DNV Healthcare or Joint Commission, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of Mental Health Intensive Outpatient Services, and credentialed with Optum.
  - For newly DBHDS licensed providers, documentation from the accrediting body that accreditation has been initiated must be submitted to Optum. Full accreditation must be completed within two years of the date on the documentation submitted. MH-IOP service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
  - MH-IOP services should occur in a clinic type setting. Schools may serve as settings for co-location of MH-IOP programs for youth, and their design should take place in coordination with the school to assure that an appropriate school-based clinic setting is available. Regardless of setting, these programs should not be disruptive of the school day or provided as part of the school day structure for youth participants.
- Staff Requirements
  - MH-IOP service providers shall meet the staff requirements as follows:
    - A multidisciplinary treatment team is comprised, at a minimum, of the following:
      - Clinical Director – Licensed Clinical Psychologist (LCP), Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT);
      - Physician/Nurse Practitioner/Physician Assistant (to provide assessments and weekly medication management);
      - LMHP, LMHP-R, LMHP-RP, or LMHP-S;
      - QMHP-A, QMHP-C or QMHP-E;

        - Registered Peer Recovery Specialist;
        - Occupational Therapists (Required only for specialty programs, provided at least 2 days per month).
    - Staff shall be cross-trained to understand behavioral health disorders, signs and symptoms of substance use disorders, be able to understand and explain the uses of psychotropic medications, and understand interactions with substance use and other addictive disorders.
    - Staffing ratios should not exceed one staff member per five individuals in the program. Clinical supervision of staff should not exceed one supervisor for six direct care workers.
    - Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S.
    - Skills Restoration/Development, Crisis Intervention and Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E.
    - Health literacy counseling / psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist, or a Registered Nurse (RN) or Licensed Practical Nurse (LPN) with at least one year of clinical experience.
    - Peer recovery support services must be provided by a Registered Peer Recovery Specialist.
    - RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians, Physician Assistants and Occupational Therapists shall hold an active license issued by the Virginia Board of Medicine.
- Service Authorization
    - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Additional service authorization information is located in Appendix C to this manual.
        - One unit of service is one day.
        - A minimum of 3 sessions is required to achieve 9 to 19 hours of services per week for adults; a minimum of 2 sessions is required to achieve 6 to 19 hours of services per week for youth. The provider shall document any deviation from the ISP in the individual's medical record and reason for the deviation.
        - A maximum of 5 units may be billed per week.
        - In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must notify Optum Utilization Management (UM) staff when the minimum sessions have not been provided. Documentation of any ISP deviation as well as reason for the deviation should be submitted at the time of the next authorization review.
        - If the individual consistently deviates from the required services in the ISP, the provider should work with Optum UM staff to reassess for another Level of Care or model to better meet the individual's needs.
    - Additional information on service authorization is located in Appendix C of the manual.
- Service Limitations
    - In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
        - MH-IOP may not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0 (with the exception of ASAM level 3.1), Mental Health Partial Hospitalization Programs, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment, or inpatient admission. A seven day overlap with any outpatient or community based behavioral health service may be allowed for care coordination and continuity of care.
        - If an individual has an authorization for a behavioral health service prior to admission to MH-IOP that is not allowed to be authorized concurrently with MH-IOP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-IOP within 31 days. Contact Optum for authorization requirements.
        - MH-IOP may be billed only within 7 days prior to discharge from Residential Levels of Care, as the individual is transitioning to a lower level of care.
        - Activities that are not reimbursed or authorized:
            - Time spent in any activity that is not a covered service component;
            - Transportation;
            - Staff travel time;
            - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions;
            - Time spent in snacks or meals;

    - Time when the individual is not present at the program;
    - Time spent in educational instruction; nor
    - Supervision hours of the staff.
  - Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.

Exclusions

- Individuals meeting any of the following are ineligible for MH-IOP:
  - Functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100;
  - The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;
  - The individual's psychiatric disorder can be effectively treated, or recovery process safely maintained at a less intensive level of care;
  - The individual, their authorized representative, or their guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment;
  - The individual requires a level of structure and supervision beyond the scope of the program;
  - The individual has medical conditions or impairments that needs immediate attention;
  - The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration; and/or
  - Presenting issues are primarily due to Substance Use Disorder; in this case, the individual should be evaluated for Addiction and Recovery Treatment Services.

Partial Hospitalization

Mental Health Partial Hospitalization Programs (MH-PHPs) services are short-term, non-residential interventions that are more intensive than outpatient services and that are required to stabilize an individual's psychiatric condition. The service is delivered under physician direction to individuals at risk of psychiatric hospitalization or transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a medical necessity for the service arising from behavioral health disorders that result in significant functional impairments in major life activities.

Mental Health Partial Hospitalization Programs (MH-PHPs) are highly structured clinical programs designed to provide an intensive combination of interventions and services similar to an inpatient program, but available on a less than 24-hour basis. MH-PHPs are active, focused and time-limited treatment programs intended to stabilize acute symptoms in youth (6-17 years old) and adults (18 years +). Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, children younger than age 6 may receive services based on medical necessity. The average length of stay may be four to six weeks, though length of stay should reflect individual symptom severity, needs, goals and medical necessity criteria. MH-PHP can serve as a transition program, such as a step-down option following an inpatient hospitalization. MH-PHP can serve as a diversion for an individual from inpatient care, by providing an alternative that allows for intensive clinical services without hospital admission. The target population consists of individuals that would likely require inpatient hospitalization in the absence of receiving this service. MH-PHPs may occur in either a hospital- or community-based location.

MH-PHP services are appropriate when an individual requires at least four hours of clinical services a day, over several days a week and totaling a minimum of 20 hours per week. A MH-PHP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-PHP tapers in intensity and frequency as an individual's symptoms improve, they are able to establish/reestablish community supports, and they are able to resume daily activities or are able to participate in a lower level of care.

Admission Criteria

- Must meet all of the following criteria:

- The individual must exhibit symptoms consistent with a DSM diagnosis (using the most current version of the DSM) that is documented in the initial assessment that requires and can reasonably be expected to respond to treatment interventions;
- There is a clinical determination that in the last 14 days, the individual has manifested an acute and significant or profound impairment in daily functioning in the home, school, community or occupational setting that has led to negative consequences and difficulties maintaining supportive, sustained relationships with identified family and peers due to a psychiatric disorder;
- The individual is at risk for admission to inpatient hospitalization, residential treatment services or residential crisis stabilization as evidenced by acute intensification of symptoms, but has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; or the individual is stepping down from inpatient hospitalization or residential crisis stabilization and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision;
- The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours and a safety plan has been established;
- The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team, including psychiatric interventions for medication management;
- The individual can reliably attend, and actively participate in, all phases of the treatment program necessary to stabilize his/her condition;
- The severity of the presenting symptoms cannot be safely or adequately addressed in a less intensive level of care;
- The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and
- If an individual is being admitted to MH-PHP primarily for an eating disorder, the following must also be met:
  - The individual exhibits symptoms consistent with an eating disorder diagnosis and requires at least two of the following:
    - As a result of eating disorder behaviors, weight stabilization above 80% IBW (or BMI 15-17); or
    - Daily, or near daily supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight management behavior, such as caloric restriction, intake refusal, vomiting/purging, excessive exercise, compulsive eating/binging; or
    - Individual misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) and cannot be treated at a lower level of care.
    - Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require 24-hour medical monitoring or procedures provided in a hospital level of care.
    - If the above criteria are not met, service authorization requests and medical necessity will be assessed on an individualized basis to determine if the individual's treatment needs can be best met in this setting and can be delivered in a safe and effective manner.

Continuing Stay Criteria

- The individual meets all of the following:
  - The individual continues to meet admission criteria;
  - Another less intensive level of care would not be adequate to administer care;
  - Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care;
  - The individualized treatment plan (ISP), updated every 30 calendar days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan (ISP);
  - Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan (ISP) is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;
  - A psychiatric medical evaluation documents that medication options have been considered or initiated;
  - The individual's natural supports (e.g. individually identified family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway;
  - Documentation demonstrates that coordination of care and vigorous, active discharge planning has been ongoing from the day of admission with the goal of transitioning individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning; and
  - If an individual is being admitted to MH-PHP for an eating disorder, then one of the following must also be met:
    - Individual has had no stabilization of weight since admission or there is continued instability in food intake; or

        - The eating disorder behaviors persist and continue to put the individual's medical status in jeopardy.
    - If the above criteria are not met, there are some circumstances under which authorization may be extended for up to 10 calendar days. These circumstances include any of the following:
        - The individual has clearly defined treatment objectives that can reasonably be achieved through continued MH-PHP treatment, such treatment is necessary in order for the discharge plan to be successful, and there is no less intensive level of care available in which the objectives can be safely accomplished;
        - Individuals can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the individual to be discharged directly to a less intensive community rather than to a more restrictive setting; and/or
        - The individual is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued by the provider delivering the service but are not available (including but not limited to such resources as placement options, substance use treatment or mental health appointments, therapeutic mentoring, etc.).
    - Individuals may be authorized to participate in less than 20 hours a week as a transitional step down to lower level services for one to two weeks prior to transitioning to promote recovery. Providers should seek approval for such a transition from Optum and the provider shall document the rationale in the individual's ISP.

Discharge Criteria

- The individual meets discharge criteria if any of the following are met:
    - The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available;
    - Required consent for treatment is withdrawn or not obtained;
    - The individual does not appear to be participating in the treatment plan (ISP) despite documented efforts to engage the individual;
    - The individual's level of functioning has improved with respect to the goals outlined in the ISP, and there is reasonable expectations that the individual can, to maintain this recovery process at a lower level of treatment;
    - For eating disorders, individual has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care; and/or
    - If there is a lapse in service greater than seven consecutive calendar days, including circumstances where this lapse is due to admission for a medical or psychiatric inpatient hospitalization.

Service Delivery

- Critical Features
    - MH-PHP involves a multidisciplinary team approach under the direction of a physician. MH-PHP programs include structured schedules for participants. MH-PHP must be available at a minimum of 20 hours per week, a minimum of five days per week, four hours per day. Treatment goals should be measurable, person-centered, recovery oriented, trauma informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission. Emergency services must be available through the MH-PHP 24-hours a day and seven days a week.
    - Programs for youth should accommodate for or integrate required academic instruction in coordination with the appropriate funding source, but the academic instruction itself is not a critical feature or eligible for Medicaid reimbursement.
    - Covered service components include:
        - assessment,
        - treatment planning,
        - individual, family and group therapy,
        - skills restoration/development,
        - health literacy counseling/psychoeducational activities,
        - crisis intervention,
        - peer recovery support services and,
        - care coordination.
    - In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-PHP:
        - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment

(see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-PHP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details).
    - Initial medication evaluation must be conducted by the Psychiatrist, Nurse Practitioner, or Physician Assistant with the individual via in person or telemedicine evaluation within 48 hours of admission.
    - Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service. The treatment planning process should be collaborative but must be directed and authorized by a
    - LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.
    - ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.
- Components of the treatment program must include all of the following:
    - Individualized treatment planning;
    - Daily individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others);
    - Skill restoration/development and health literacy counseling/psychoeducational interventions;
    - Medication management as well as additional clinically indicated psychiatric and medical consultation services must be available. Referrals for consultation to external prescribing providers are allowable and must be made via formal agreement.
    - The provider must coordinate medication management with existing medical and psychiatric providers;
    - Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral;
    - Crisis intervention and safety planning support available 24/7;
    - Peer recovery support services, offered as an optional supplement for individuals;
    - Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:
        - The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;
        - The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;
        - The provider shall, with individual's consent, collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.
- At least three of the following service components shall be provided per day based on the treatment needs identified in the initial comprehensive assessment:
    - Daily therapeutic interventions with a planned format including individual, group or family therapy;
    - Medication management (as clinically indicated; minimum of weekly);
    - Skill restoration/development;
    - Health literacy counseling/psychoeducation interventions; and
    - Occupational and/or other therapies performed by a professional acting within the scope of their practice.
- If the session involves a Comprehensive Needs Assessment as a service component, only one of the above listed components shall be required in order to bill the per diem that day.
- The minimum number of service hours per week is 20 hours with at least four service hours per session, a minimum of 5 days per week.
- In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record and notify Optum Utilization Management (UM) staff at the next service authorization request (see service authorization section for additional information).
- If the individual consistently deviates from the required services in the ISP, the provider will work with the Optum care coordinator to reassess for another level of care or model to better meet the individual's needs.
- Group mental health therapy by LMHPs, LMHP-Rs, LMHP-RPs and LMHP-Ss shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the LMHP, LMHP-R, LMHP-RP, and LMHPS.

- If the individual continues to meet with an existing outpatient therapy provider, the MH-PHP provider must coordinate the treatment plan with the provider.
- Whenever possible, crisis intervention should be delivered by the MH-PHP staff, including after hours.
- An updated assessment conducted by a LMHP LMHP-R, LMHPRP, LMHP-S, nurse practitioner or physician assistant is required at every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued services. DMAS or its contractor(s) may request the results of this assessment to evaluate approval of reimbursement for continued services. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.
- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

- Provider Qualifications
  - MH-PHP service providers shall be licensed by DBHDS as a provider of a Mental Health Partial Hospitalization Program, be Medicare certified as a partial hospitalization program and credentialed with Optum.
- Staff Requirements
  - MH-PHP service providers shall meet the staff requirements as follows:
    - A multidisciplinary treatment team is comprised, at a minimum, of the following:
      - Board certified/board eligible psychiatrist. For children under age 14, the psychiatrist must be a board certified/board eligible child and adolescent psychiatrist; and/or
      - Licensed Nurse Practitioner; and
      - Licensed Mental Health Professional (LMHP)
      - Registered Peer Recovery Specialist
  - Staff shall be cross-trained to understand behavioral health disorders, signs, and symptoms of substance use disorders, and be able to understand and explain the uses of psychotropic medications and interactions with substance use and other addiction disorders.
  - Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
  - Health literacy counseling/psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, Occupational Therapist or a RN or LPN with at least one year of clinical experience.
  - Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C or QMHP-E.
  - Skills restoration/development and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E.
  - Peer recovery support services must be provided by a Registered Peer Recovery Specialist.
  - Registered Nurses (RN), Licensed Practical Nurses (LPN), and Nurse Practitioners (NP) shall hold an active license issued by the Virginia Board of Nursing. Physicians, Physician Assistants and Occupational Therapists shall hold an active license issued by the Virginia Board of Medicine.
- Service Authorization
  - MH-PHP requires prior authorization and shall be delivered by a service provider who meets the provider qualifications listed above.
  - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt. Additional service authorization information is located in Appendix C to this manual.
  - An individual may participate in MH-PHP services concurrent with Opioid Treatment Services/Medication Assisted Treatment. The MH-PHP provider and the buprenorphine-waivered practitioner shall collaborate and corroborate these efforts in documentation.
  - One unit of service is one day.
  - The minimum number of service hours per week is 20 hours with at least four service hours per service day, a minimum of 5 days per week.
  - In cases that an individual does not complete the minimum of four clinical service hours per service day or attend treatment a minimum of five days per week, the provider shall:
    - Document any ISP deviation as well as the reason for the deviation in the individual's medical record; and
    - Notify the Optum Utilization Management (UM) staff when they have not been able to provide the minimum required sessions. The provider shall submit documentation at the time of the next authorization review.
    - If the individual consistently deviates from the required services in the ISP, the provider should work with the Optum UM staff to reassess for another Level of Care or model to better meet the individual's needs.

- Service Limitations
  - In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
    - MH-PHP shall not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Applied Behavior Analysis, Mental Health Intensive Outpatient Services, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment, or Inpatient Hospitalization. A seven day overlap with any outpatient or community based behavioral health service may be allowed for care coordination and continuity of care.
    - If an individual has an authorization for a behavioral health service prior to admission to MH-PHP that is not allowed to be authorized concurrently with MH-PHP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-PHP within 31 days. Contact Optum for authorization requirements.
    - If an individual is participating in Assertive Community Treatment and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services.
    - Activities that are not reimbursed or authorized include:
      - Time spent in any activity that is not a covered service component;
      - Transportation;
      - Staff travel time;
      - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions;
      - Time spent in snacks or meals;
      - Time when the individual is not present at the program;
      - Time spent in educational instruction; nor
      - Supervision hours of the staff.
  - Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.

Exclusions

- Individuals meeting any of the following are ineligible for MH-PHP:
  - The individual's functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100;
  - The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;
  - The individual's psychiatric disorder can be effectively treated, or recovery process safely maintained at a less intensive level of care;
  - The individual, their authorized representative, or their guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment;
  - The individual requires a level of structure and supervision beyond the scope of the program;
  - The individual has medical conditions or impairments that needs immediate attention; and/or
  - The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
  - Presenting issues are primarily due to Substance Use Disorder; in this case the individual should be evaluated for Addiction and Recovery Treatment Services.

Therapeutic Day Treatment

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

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

Admission Criteria

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

Discharge Criteria

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

Service Delivery

- Prior to admission, Comprehensive Needs Assessment shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria. Comprehensive Needs Assessment shall be required at the onset of services and ISPs shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. If there is a lapse in service greater than 31

consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, new intake/admission documentation shall be prepared, and a new service authorization shall be required.

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

Substance-Related Disorders: All levels of care

Please refer to the ASAM Criteria.

Assertive Community Treatment

Assertive Community Treatment (ACT) provides long term needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness especially those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services in the community. ACT services are offered to outpatients outside of clinic, hospital, or program office settings for individuals who are best served in the community.

ACT is a highly coordinated set of services offered by group of medical, behavioral health, peer recovery support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals' needs, and is oriented around individuals' personal goals. A fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.

Admission Criteria

- Individuals must meet all of the following criteria:
  - The individual must be 18 years or older; (as required by EPSDT, youth below age 18 may receive ACT if medically necessary);
  - Prior to the start of services, the following must occur:
    - An assessment inclusive of the components of the Comprehensive Needs Assessment shall be completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant to document the individual's diagnosis(es) and describe how service needs match the level of care criteria;
    - This assessment must support a diagnosis from the current version of the Diagnostic and Statistical Manual (DSM) that is consistent with a serious and persistent mental illness (i.e. schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder).
      - Individuals with psychiatric illnesses that fall outside the serious mental illness definition may be eligible depending on the level of associated long-term disability; in these cases, a Physician letter justifying this exception should accompany the service authorization request.
    - Individual has significant functional impairment as demonstrated by at least one of the following conditions:
      - Significant difficulty in consistent performance of the range of routine tasks required for basic adult functioning in the community (for example, caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives;
      - Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities); or
      - Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities);
  - Individual has one or more of the following problems, which are indicators of continuous high-service needs:
    - High use of acute psychiatric hospital (multiple admissions to or at least one recent long-term stay of 30 days or more in an acute psychiatric hospital inpatient setting within the last two years) or psychiatric emergency services (more than four interventions in the last 12 months);
    - Intractable (persistent or recurrent) severe psychiatric symptoms (affective, psychotic, suicidal, etc.);
    - Coexisting mental health and substance use disorders of significant duration (more than 6 months);
    - High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation) as a result of the individual's mental health disorder symptoms;
    - Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness as a result of the individual's mental health disorder symptoms;
    - Residing in an inpatient setting (e.g. state hospital or other psychiatric hospital) or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring a residential or institutional placement if more intensive services are not available; and/or
    - Difficulty in consistent participation in traditional office-based outpatient services.

Continuing Stay Criteria

- Continuation of services may be authorized at one year intervals based on written service-specific provider re-assessment and certification of need by an LMHP.
- Individuals must meet all of the following:
  - The individual continues to meet admission criteria;
  - Another less intensive level of care would not be adequate to support recovery;
  - ACT participation remains necessary due to continued risk that without the service, the individual is at risk for the following:
    - Compromised engagement in or ability to manage medication in accordance with the treatment plan
    - Increased use of crisis services;
    - Inpatient psychiatric hospitalization;
    - Decompensation of social and recreational skills (e.g. communication and interpersonal skills, forming and maintaining relationships);
    - Decompensation in functioning related to activities of daily living;

        - Fracture or loss in the individual's community supports due to individual's challenges with symptoms and functioning (Health, Legal, Transport, Housing, Finances, etc.);
        - Decompensation of vocational skills or vocational readiness.
    - The individualized treatment plan (ISP), includes evidence suggesting that the identified problems are likely to benefit from continued ACT participation and the goals are consistent with the components of this service;
    - The individual's natural supports, as appropriate, (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway; and
    - Coordination of care and discharge planning are documented and ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of care. These efforts should include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.

Discharge Criteria

- The philosophy that guides the ACT model underscores that individuals participating in the service are expected to struggle with engagement given the severity of their mental illness. Individuals should therefore not be discharged from the service due to perceived "lack of compliance" with a treatment plan (ISP) or challenges integrating interventions into their lives towards recovery. Rather, discharge should be considered based on the criteria that follow.
    - The individual meets discharge criteria if any of the following are met:
        - The individual and team determine that ACT services are no longer needed based on the attainment of goals as identified in the ISP and a less intensive level of care would adequately address current goals;
        - The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available;
        - Required consent for treatment is withdrawn or not obtained.
        - Extenuating circumstances occur that prohibit participation including:
            - Change in the individual's residence to a location outside of the service area
            - The individual becomes incarcerated or hospitalized for a period of a year or more
            - The individual chooses to withdraw from services and documented attempts by the program to re-engage the individual with the service have not been successful.
    - In circumstances where an individual is discharged from ACT because the individual becomes incarcerated or hospitalized, the provider is expected to prioritize these individuals for ACT services upon their anticipated return to the community, as long as the individual consents to returning to this service and ACT remains an appropriate and medically necessary service for the individual's needs.

Service Delivery

- Critical Features
    - An ACT team assists individuals in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g. worker, daughter, resident, spouse, tenant, or friend). Because an ACT team often works with individuals who may demonstrate passive or active resistance to participation in services, an ACT team must carry out thoughtfully planned assertive engagement techniques including rapport building strategies, facilitating the individual in meeting basic needs, and motivational interviewing interventions. The team uses these techniques to identify and focus on individuals' life goals and motivations to change. Likewise, it is the team's responsibility to monitor individuals' mental status and provide needed supports in a manner consistent with their level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care. Individuals receiving ACT should also be engaged in a shared decision-making model, assistance with accessing medication, medication education, and assistance in medication to support skills in taking medication with greater independence. The team promotes self-determination, respects the person participating in ACT as an individual in their own right, and engages registered peer recovery specialists to promote hope that recovery from mental illness and regaining meaningful roles and relationships in the community are possible.
        - Critical features of ACT include:
            - ACT staff availability either directly or on-call 24 hours per day, seven days per week and 365 days per year;
            - Crisis response and intervention that is available 24 hours per day, seven days per week, and 365 days per year, including telephone and face-to face contact;
            - Team is to be the first line (and generally sole provider) of all the services that individuals may need by providing individualized, intensive treatment/rehabilitation and support services in the community;

- Team develops and has access to each individual's individualized crisis plan and the team has the capacity to directly engage with each individual to help directly address emerging crisis incidents and to support stabilization;
- Team provides a higher frequency and intensity of community based contacts with a staff-to-individual ratio no greater than 1:9; and
- Team provides services that are community based, flexible and appropriately adjusted based on the individuals evolving needs.

- ACT teams must offer and have the capacity to provide the following covered service components to address the treatment needs identified in the initial comprehensive needs assessment:
  - Assessment and treatment planning
  - Integrated dual disorders treatment for co-occurring substance use*
  - Crisis assessment and treatment/intervention
  - Health literacy counseling
  - Medication management
  - Skills restoration/development
    - Social Skills
    - Wellness self-management and prevention
    - Symptom management
    - Skills required for activities of daily and community living
  - Peer recovery support services;*
  - Empirically supported therapeutic interventions & therapies;*
- ACT service coordination (care coordination) consisting of facilitating access to:
  - Employment and vocational services
  - Housing access & support
  - Other services based on client needs as identified in the Individualized Service Plan (ISP)

  *As clinically indicated and supported by staff capacity and client engagement, these services components can be provided in an individual and/or group setting.

- Required Activities
  - The following required activities apply to ACT:
    - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for ACT and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details).
    - Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.
    - ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.
    - Medication prescription monitoring must be provided by a psychiatrist or psychiatric nurse practitioner who completes a psychiatric evaluation on the day of admission and has contact with individuals on a quarterly basis.
    - For individuals with a co-occurring substance use diagnosis, the ACT team will provide individual and group modalities for dual disorders treatment based on the principles of Integrated Dual Disorder Treatment and aligned with the individual's readiness/stage of change. In addition, the ACT team will provide active substance use counseling and relapse prevention, as well as substance use education.
    - Registered peer recovery support specialists shall be a part of the ACT team with services to include coaching, consulting, wellness management and recovery strategies to promote recovery and self-direction. Registered peer recovery support specialists may also model and provide education on recovery principles and strategies to fellow team members.
    - If the individual consistently deviates from the required services in the ISP, the provider should work with Optum to reassess for another level of care or model to better meet the individual's needs.

- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

- Provider Qualifications
  - ACT service providers shall be licensed by DBHDS as a provider of Assertive Community Treatment and credentialed with Optum. ACT service providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
  - ACT Team Fidelity Standards
    - ACT Teams are required to undergo the standardized rating process using the Tool for Management of Assertive Community Treatment (TMACT).
    - ACT reimbursement rates are tiered based on the size of the team and fidelity rating status; information on these rates is available in the "Billing Guidance" section of this appendix.
- Staff Requirements
  - ACT service providers shall meet the staff requirements as follows:
    - ACT Team Sizes
      - ACT team sizes and definitions as defined herein are consistent with the national standards for the practice. In accordance with ACT fidelity standards, providers in urban locations should implement mid-size to large teams. Providers in more rural locations will likely implement small or mid-size teams as large teams may be impractical in a sparsely populated area. ACT teams should operate from a single home office as opposed to a collection of satellite locations to promote team coordination and collaboration.
        - Small teams serve a maximum of 50 individuals, with one team member per eight or fewer individuals;
        - Mid-size teams serve 51-74 individuals, with one team member per nine or fewer individuals; and
        - Large teams serve 75-120 individuals, with one team member per nine or fewer individuals.
  - To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACT intakes (no more than 4 total per month)* to gradually build up capacity to serve no more than 100–120 individuals (with a 1:9 ratio) and no more than 42–50 individuals (a 1:8 ratio) for smaller teams. Movement of individuals onto (admissions) and off of (discharges) the team caseload may temporarily result in breaches of the maximum caseload; thus, teams shall be expected to maintain an annual average not to exceed 50, 74, and 120 individuals, respectively.

*During the 2021 implementation, providers who were previously licensed as Intensive Community Treatment (ICT) teams and contracted with the MCOs or Magellan of Virginia will be allowed to join the network and provide services to their existing caseloads as long as they meet the client to staff ratios as defined above.

- ACT Team Composition and Roles

  ACT teams should be composed of individuals who have the strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of biopsychosocial rehabilitation services. While all staff shall have some level of competency across disciplines, the team should emphasize areas of individual staff expertise and specialization to fully benefit ACT service participants. As noted in the critical features section, there are some ACT components that are necessary for fidelity to the model but are not currently covered services within the Medicaid program; this discrepancy is also reflected in the team composition. The service components that are eligible for Medicaid reimbursement must be delivered by providers who are Medicaid- approved and within professional scope for those services. For information on team composition, see DBHDS Emergency Regulations, 12VAC35-105-1370 available at https://townhall.virginia.gov/L/ViewXML.cfm?textid=14853.
  - As required by DBHDS Emergency Regulations, a multidisciplinary ACT treatment team is comprised of the following professionals:
    - Team Leader
    - Psychiatric Care Provider
    - Nurse
    - SUD/Co-Occurring Disorder Specialist
    - Registered Peer Recovery Specialist
    - Vocational Specialist (must be QMHP)
    - Dedicated Office-Based Program Assistant
    - Generalist Clinical Staff Member
  - Medication prescription monitoring must be provided by a Psychiatrist or Psychiatric Nurse Practitioner who completes an initial assessment and has contact with individuals on a quarterly basis.

- Medication administration must be provided by a Psychiatrist, Psychiatric Nurse Practitioner or appropriate licensed nursing professional based on ACT team size.
- Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S or CATP.
- Health literacy counseling /psychoeducational interventions must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CATP, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management.
- Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
- Skills restoration / development must be provided by a LMHP, LMHP-R,LMHP-RP, LMHP-S, QMHP-A, QMHP-E or a QPPMH under the supervision of at least a QMHP-A.
- Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-E, CSAC*, CSAC Supervisee* CSAC-A* or a QPPMH under the supervision of at least a QMHP-A.
- Peer recovery support services must be provided by a Registered Peer Recovery Specialist.

*CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2

- RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.

- Service Authorization
  - ACT requires service authorization and the service providers delivering ACT shall meet the provider qualifications listed above.
  - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the day of receipt. Additional service authorization information is located in Appendix C to this manual.
  - If the psychiatric evaluation required for admission is unable to be conducted on the same day as the comprehensive needs assessment, the provider shall submit the service authorization request within one business day of completing the psychiatric evaluation. If submitted in this timeframe, the MCO or FFS contractor shall honor the date of the comprehensive needs assessment as the start date of services, however, ACT services other than the comprehensive needs assessment or psychiatric evaluation may not be provided until both the comprehensive needs assessment and psychiatric evaluation are completed.
  - In circumstances where a team discharges an individual from ACT to another behavioral health service provider (including another ACT provider) within the team's service area or county, the ACT team should continue to monitor the transition for 31 days to assure that if an individual does not transition with success to these new services, they are able to voluntarily return to the ACT service. During this 31 day period, the ACT Team shall maintain contact with the new provider to monitor the transition in support of that provider's role in the individual's continued recovery and evolving goals.
  - Additional information on service authorization is located in Appendix C of the manual.
- Service Limitations
  - In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
    - An individual can participate in ACT services with only one ACT team at a time.
    - Group therapy by LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss and CATPs shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the professional providing the service.
    - ACT may not be authorized concurrently with Individual, Group or Family Therapy, Addiction and Recovery Treatment Services (ARTS) and Mental Health (MH) Intensive Outpatient, Outpatient Medication Management, Therapeutic Day Treatment, Intensive In Home Services, Community Stabilization, Mental Health Skill Building, Applied Behavior Analysis, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment Facility (PRTF), Therapeutic Group Home (TGH), ARTS Level 3.1-3.7 or Peer Recovery Support Services, as the activities of these services are included in the per diem. Up to a fourteen calendar day service authorization overlap with these services is allowed as individuals are being transitioned to ACT from other behavioral health services. Up to a 31 calendar day service authorization overlap with these services is allowed as individuals are being transitioned from ACT to other behavioral health services (see service authorization section). Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with ACT.

- If an individual is participating in ACT and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services.
- Activities that are not authorized for reimbursement include:
    - Contacts that are not medically necessary.
    - Time spent doing, attending, or participating in recreational activities.
    - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
    - Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
    - Respite care.
    - Transportation for the individual or family. Additional medical transportation for service needs which are not considered part of ACT program services may be covered by the transportation service through Optum. Medical transportation to ACT providers may be billed to the transportation broker.
    - Covered services that have not been rendered.
    - Services rendered that are not in accordance with an approved authorization.
    - Services not identified on the individual's authorized ACT Treatment Plan.
    - Services provided without service authorization by the department or its designee.
    - Services not in compliance with the ACT National Provider Standards and not in compliance with fidelity standards.
    - Services provided to the individual's family or others involved in the individual's life that are not to the direct benefit of the individual in accordance with the individual's needs and treatment goals identified in the individual's plan of care.
    - Services provided that are not within the provider's scope of practice.
    - Anything not included in the approved ACT service description.
    - Changes made to ACT that do not follow the requirements outlined in the provider contract, this appendix, or ACT fidelity standards.
    - Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.
    - Time spent when the individual is employed and performing the tasks of their job.

  Note: ACT does include non-job specific vocational training, employment assessments, and ongoing support to maintain employment. ACT may provide the necessary medical services that enable the individual to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling or crisis management that enable the individual to remain in and/or function in the workplace.

Exclusions

- Individuals meeting any of the following are ineligible for ACT:
    - The individual's functional impairment is solely a result of a substance use disorder, personality disorder, developmental disability, traumatic brain injury or autism spectrum disorder without a co-occurring psychiatric disorder;
    - The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required;
    - The individual's psychiatric disorder can be effectively treated, or recovery process safely maintained at a less intensive level of care;
    - The individual or their authorized representative does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment;
    - The individual requires a level of structure and supervision beyond the scope of the program;
    - The individual has medical conditions or impairments that needs immediate attention;
    - The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration.

Intensive In-Home (IIH) Services For Children And Adolescents

Intensive In-Home (IIH) Services For Children And Adolescents are time-limited interventions provided in the individual's residence and when clinically necessary in community settings. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual.

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

Admission Criteria

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

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

Discharge Criteria

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

Service Delivery

- Prior to admission, Comprehensive Needs Assessment shall be conducted by the licensed mental health professional (LMHP), LMHP-supervisee, LMHP-resident, or LMHP-RP, documenting the individual's diagnosis and describing how service needs match the level of care criteria.
- Individual Service Plans (ISPs) shall be required during the entire duration of services. Services based upon incomplete, missing, or outdated service-specific provider intakes or ISPs shall be denied reimbursement. If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the service provider, the provider shall discharge the individual. If the individual continues to need services, then a new intake/admission shall be documented, and a new service authorization shall be required.
- An individual service plan shall be fully completed, signed, and dated by either a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, a QMHP-C, or a QMHP-E and the individual and individual's parent/guardian within 30 days of initiation of services.
- It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. The ISP shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual.

- Although the pattern of service delivery may vary, intensive in-home services is an intensive service provided to individuals for whom there is an ISP in effect which demonstrates the need for a minimum of three hours a week of intensive in-home service, and includes a plan for service provision of a minimum of three hours of service delivery per individual/family per week in the initial phase of treatment. It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service. Service plans shall incorporate an individualized discharge plan that describes transition from intensive in-home to less intensive services.
- Emergency assistance shall be available to the family, and delivered, as needed, by the 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 individual and delivered primarily in the family's residence with the individual present.
- As clinically indicated, the services may be rendered in the community if there is documentation, on that date of service, of the necessity of providing services in the community. The documentation shall describe how the alternative community service location supports the identified clinical needs of the individual and describe how it facilitates the implementation of the ISP.

Mental Health Case Management

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

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

- Serious Mental Illness
  - Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.
    - a. Diagnosis
      - There must be a major mental disorder diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM). These disorders are:
        - schizophrenia;
        - major affective disorders;
        - paranoia, organic or other psychotic disorders;
        - personality disorders, or other disorders that may lead to chronic disability;
        - a diagnosis of adjustment disorder or a V-Code diagnosis cannot be used to satisfy these criteria.
    - b. Level of Disability
      - There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis:
        - Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
        - Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
        - Has difficulty establishing or maintaining a personal social support system.
        - Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.

        - Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
    - c. Duration of Illness
  - The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria:
    - The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).
    - The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
- Serious Emotional Disturbance
  - Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM, or the child must exhibit all of the following:
    - Problems in personality development and social functioning that have been exhibited over at least one year's time; and
    - Problems that are significantly disabling based upon the social functioning of most children that age; and
    - Problems that have become more disabling over time; and
    - Service needs that require significant intervention by more than one agency.

    Note: Children diagnosed with Serious Emotional Disturbance and a co-occurring substance abuse or developmental disability diagnosis are also eligible for Case Management for Serious Emotional Disturbance.
- At Risk of Serious Emotional Disturbance
  - Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least one of the following criteria:
    - The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities; or
    - Parents, or persons responsible for the child's care, have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance abuse, mental illness, or other emotional difficulties, etc.); or
    - The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.).

Admission Criteria

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

Service Delivery

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such). An assessment must be completed by a qualified mental health case manager to determine the need for services or included as a recommended service on a Comprehensive Needs Assessment conducted by a LMHP, LMHP-R, LMHP-RP or LMHP-S. If completed by a qualified case management who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the assessment is conducted as part of the first month of case management service. Case Management assessments and intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services. The assessment serves as the basis for the ISP.
- The ISP must document the need for case management and be fully completed within 30 calendar days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the

fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review. The ISP shall be updated at least annually.

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

Mental Health Skill Building Services

Mental Health Skill Building Services provide goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS shall include goal directed training in the following areas in order to qualify for reimbursement: (i) functional skills and appropriate behavior related to the individual's health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition. Providers shall be reimbursed only for training

activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and guidelines as described in the regulations and this manual.

Admission Criteria

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

Service Delivery

- A Comprehensive Needs Assessment shall be required at the onset of services. The service specific provider intake must be conducted face-to-face by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The Comprehensive Needs Assessment shall document the individual's behavior and describe how the individual meets criteria for this service. The Comprehensive Needs Assessment may be completed no more than 31 days prior to the initiation of services and must indicate that service needs can best be met through mental health skill-building services. The LMHP, LMHP-R, LMHP-RP, LMHP-S performing the intake shall document the primary mental health diagnosis on the intake form.
- Comprehensive Needs Assessments shall be repeated upon any lapse in services of more than 30 calendar days. Services of any individual that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service in the individual's medical record.
- Service authorization is not required to bill for the face-to-face Comprehensive Needs Assessment.
- A review of Mental Health Skill Building Services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individual who have received at least 6 months of Mental Health Skill Building Services to determine the continued need for this service.
- The LMHP, LMHP-R, LMHP-S or LMHP-RP must then document the need for the continuation of services by indicating that the individual is continuing to meet eligibility requirements and is making progress towards Individual Service Plan (ISP) goals. Clinically it may be helpful for the LMHP, LMHP-R, LMHP-S or LMHP-RP to complete a new Comprehensive Needs Assessment to review clinical progress and assess the medical necessity of continuing MHSS. However, DMAS regulations do not specifically require the provider to complete a Comprehensive Needs Assessment every six months when providing MHSS.
- Providers may bill for service hours or bill for the Comprehensive Needs Assessment to complete the six month MHSS review requirement. The Comprehensive Needs Assessment must be updated annually.
- The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall complete, sign and date the ISP within 30 days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP.
- The total time billed for the week shall not exceed the frequency established in the individual's ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall include the dated signature of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of service. If the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.
- Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in the manner in which he may participate with the process, modify as appropriate, and update the ISP. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record no later than 15 calendar days from the date of the review, as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.
- The ISP must be rewritten annually.
- The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.
- Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.
- If the provider knows of or has reason to know of the individual's non-adherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the QPPMH, the supervising LMHP, LMHPR, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any non-adherence to the prescribed medication regimen. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any medication regimen non-adherence concerns. The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:
    - Name and title of caller;
    - Name and title of professional who was called;
    - Name of organization that the prescribing professional works for;
    - Date and time of call;

- Reason for care coordination call;
- Description of medication regimen issue or issues to be discussed; and
- Resolution of medication regimen issue or issues that were discussed.

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

  Family member statements shall not suffice to meet this requirement.
- The MHSS regulations outline specific documentation requirements in order to satisfy the criteria for validating medication history. Examples include either photocopies of the prescription information from the bottle or contacting the prior provider. Providers may use their own records to validate medication history (doctors' order for the meds, written report from a prescriber or hospital within the 12 months prior to the assessment date), however they must clearly document in the MHSS note where in the electronic record substantiating information can be found.
- In the absence of such documentation, the current provider shall document all contacts (i.e. telephone, faxes, electronic communication) with the pharmacy or provider of health care services with the following minimum elements:
  - Name and title of the caller;
  - Name and title of prior professional who was called;
  - Name of organization that the professional works for;
  - Date and time of call;
  - Specific prescription confirmed;
  - Name of prescribing physician;
  - Name of medication; and
  - Date of prescription.
- Only direct face-to-face contacts and services to an individual shall be reimbursable.

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

Mental Health Peer Support Services And Family Support Partners

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

Family Support Partners are Peer Recovery Support Services and is a strength-based member, and team-based service provided to the caregiver of Medicaid-eligible youth under age 21, with a mental health or substance use disorder or co-occurring mental health and substance use disorder that is the focus of support. The services provided to the caregiver must be directed exclusively toward the benefit of the Medicaid-eligible youth. Services are expected to improve outcomes for youth with complex needs who are involved with multiple systems and increase the youth and family's confidence and capacity to manage their own services and supports while promoting recovery and healthy relationships. These services are rendered by a PRS who is (i) a parent of a minor or adult child with a similar a mental health or substance use disorder or co-occurring mental health and substance use disorder, or (ii) an adult with personal experience with a family member with a similar a mental health or substance use disorder or co-occurring mental health and substance use disorder with experience navigating substance use or behavioral health care services. The PRS shall perform the service within the scope of their knowledge, lived-experience, and education

Admission Criteria Mental Health Peer Support Services

- Members 21 years or older qualifying for MH Peer Support Services will meet the following requirements:
  - Have a documented mental health disorder diagnosis;
  - Require recovery oriented services for the acquisition of skills needed to engage in and maintain recovery; the development of self-advocacy skills to achieve a decreasing dependency on formalized treatment systems; and increasing responsibilities, wellness potential, and shared accountability for the member's own recovery; and

- Demonstrate moderate to severe functional impairment because of the diagnosis that interferes with or limits performance (relative to the person's ethnic or cultural environment) in at least one of the following domains: educational (e.g., obtaining a high school or college degree); social (e.g., developing a social support system); vocational (e.g., obtaining part-time or full-time employment); self-maintenance (e.g., managing symptoms, understanding his or her illness, living more independently).

Admission Criteria Mental Health Family Support Services

- Caregivers of youth under age 21 who qualify to receive MH Family Support Partners will (i) have a youth with a mental health disorder, who requires recovery oriented services, and (ii) meets two or more of the following:
  - Member and his caregiver need peer-based recovery oriented services for the maintenance of wellness and the acquisition of skills needed to support the youth;
  - Member and his caregiver need assistance to develop self-advocacy skills to assist the youth in achieving self-management of the youth's health status;
  - Member and his caregiver need assistance and support to prepare the youth for a successful work/school experience;
  - Member and his caregiver need assistance to help the youth and caregiver assume responsibility for recovery.
- Note: Members 18-20 years old who meet the medical necessity criteria stated above for MH Peer Support Services, who would benefit from receiving peer supports directly, and who choose to receive MH Peer Support Services directly instead of through MH Family Support Partners shall be permitted to receive MH Peer Support Services by an appropriate PRS.

Continuing Stay Criteria

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

Discharge Criteria

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

Service Delivery

- Service delivery is based on the member's identified needs, established medical necessity criteria, consistent with the assessment of the practitioner who recommended services, and goals identified in the member Recovery Resiliency and Wellness Plan. The level of services provided, and total time billed by the enrolled/credentialed provider for the week shall not exceed the frequency established in the Recovery, Resiliency, and Wellness Plan. As determined by the goal(s) identified in the Recovery, Resiliency and Wellness Plan, services may be rendered in the provider's office or in the community, or both. Peer Support Services and Family Support Partners shall be rendered on a member basis or in a group. Services shall be delivered in compliance with the following minimum contact requirements:
  - Billing will occur only for services provided with the member present. Telephone time is supplemental rather than replacement of face-to-face contact and is limited to 25% or less of total time per recipient per calendar year. Justification for services rendered with the member via telephone shall be documented. Any telephone time rendered over the 25% limit will be subject to retraction.
  - Contact will be made with the member receiving Peer Support Services or Family Support Partners a minimum of twice each month. At least one of these contacts must be face-to-face and the second may be either face-to-face or telephone contact, subject to the 25% limitation described above, depending on the member's support needs and documented preferences.
  - In the absence of the required monthly face-to-face contact and if at least two unsuccessful attempts to make face-to-face contact have been tried and documented, the provider may bill for a maximum of two telephone contacts in that specified month, not to exceed two units. After two consecutive months of unsuccessful attempts to make face-to-face contact, discharge shall occur.
  - Peer Support Services or Family Support Partners may operate in the same building as other day services; however, there must be a distinct separation between services in staffing, program description, and physical space. Services

shall not be delivered at the time within the same space of another service. Peer Support Services shall be an ancillary service and shall not impede, interrupt, or interfere with the provision of the primary service setting.

- Specific strategies and activities will be rendered and fully align with the Recovery, Resiliency, and Wellness Plan. Strategies and activities shall include at a minimum:
  - Person centered; strength based planning to promote the development of self-advocacy skills;
  - Empowering the member to take a proactive role in the development and updating of their Recovery, Resiliency, and Wellness Plan;
  - Crisis support; and
  - Assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the Recovery Resiliency and Wellness Plan so that the member:
    - Remains in the least restrictive setting;
    - Achieves their goals and objectives identified in the Recovery Resiliency and Wellness Plan;
    - Self-advocates for quality physical and behavioral health services; and
    - Has access to strength-based behavioral health services, social services, educational services and other supports and resources.

Limitations

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

Psychosocial Rehabilitation

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

Admission Criteria

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

- Individuals must meet both Criteria A and B to qualify for services:
  - A. Individuals must meet two of the following criteria on a continuing or intermittent basis:
    - Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness or isolation from social supports;
    - Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;
    - Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary;
      Or
    - Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. "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:
    - Have experienced long-term or repeated psychiatric hospitalizations; or
    - Experience difficulty in activities of daily living and interpersonal skills; or
    - Have a limited or non-existent support system; or
    - Be unable to function in the community without intensive intervention; or
    - Require long-term services to be maintained in the community.

Service Delivery

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

Exclusions

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

Applied Behavior Analysis

"Applied Behavior Analysis" or "ABA" means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Admission Criteria

- All of the following criteria must be met:
  - The youth must have a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or have a provisional psychiatric diagnosis as developed by an LMHP when no definitive diagnosis has been made;
  - The youth must meet at least two of the following criteria on a continuing or intermittent basis:
    - Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language;
    - Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness;
    - Frequent intense behavioral outbursts that are self-injurious or aggressive towards others;
    - Disruptive obsessive, repetitive, or ritualized behaviors; or
    - Difficulty with sensory integration.
  - There is a family/caregiver available to participate in services.

Continuing Stay Criteria

- Within the past thirty (30) calendar days, the youth has continued to meet the admission criteria for ABA as evidenced by at least one of the following:
  - The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria;
  - The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP;
  - Progress toward identified plan of care goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved.

- To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following:

  - An individualized ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention;
  - Progress toward objectives is being monitored as evidenced in the 30 calendar day ISP review documentation;
  - The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement;
  - The type, frequency and intensity of interventions are consistent with the ISP;

- The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care.
- If youth does not meet criteria for continued treatment, ABA may still be authorized for up to an additional 10 calendar days under any of the following circumstances:
  - There is no less intensive level of care in which the objectives can be safely accomplished; or
  - The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or
  - The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.

Discharge Criteria

- The provider must terminate ABA if the service is no longer medically necessary. The service is no longer deemed medically necessary if one of the following criteria is met within a 30 day time period:
  - No meaningful or measurable improvement has been documented in the youth's behavior(s) despite receiving services according to the ISP; there is reasonable expectation that the family and /or caregiver are adequately trained and able to manage the youth's behavior; and termination of the current level of services would not result in further deterioration or the recurrence of the signs and symptoms that necessitated treatment;
  - Treatment is making the symptoms persistently worse, or youth is not medically stable for ABA to be effective;
  - The youth has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate;
  - The youth demonstrates an inability to maintain long-term gains from the proposed ISP; or
  - The family and/or caregiver refuses or is unable to participate meaningfully in the behavior treatment plan.

If there is a lapse in service for more than 30 consecutive calendar days, the provider must discharge the youth from services and notify Optum. If services resume after a break of more than 30 consecutive calendar days, a new service authorization request including a new assessment and ISP must be submitted to Optum.

Service Delivery

- Critical Features
  - ABA services must include the following four characteristics:
    - An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection.
    - Importance given to understanding the context of the behavior and the behavior's value to the individual, the family, and the community.
    - Utilization of the principles and procedures of behavior analysis such that the client's health, independence, and quality of life are improved.
    - Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making.
- Family training related to the implementation of ABA shall be included. ABA may be provided in the home or community settings where the targeted behaviors are likely to occur. ABA may also be provided in clinic settings. Limited services are allowed in the school setting (see service limitations section). The setting must be justified in the ISP.
- Required Activities
  - The following required activities apply to ABA:
    - An initial assessment for ABA consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria must be completed at the start of services. The initial assessment must:
    - Be completed by the LBA, LABA or LMHP acting within the scope of practice. Other qualified staff may assist with the completion of an assessment (see staff requirements section);
    - Be conducted in person with the youth and the youth's family/caregivers;
    - The youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual (DSM) relevant to the need for ABA;
    - Include a functional assessment using validated tools completed by the LBA, LABA or LMHP acting within the scope of practice;

- Include the reasons the youth needs ABA including how the youth meets medical necessity and eligibility criteria for the service;
- Include information about the targeted behaviors including frequency, duration, and intensity.

- The LBA, LABA or LMHP must, at a minimum, observe the youth monthly. Assessments must be reviewed and updated at least annually by the LBA, LABA or LMHP.
- Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. ISPs must be reviewed at a minimum of every 30 calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 day review as well as additional quarterly review requirements. In addition to the requirements in Chapter IV, ISPs must include:
  - Youth Focused Behavior Modification Goals and Objectives
    - All preliminary goals and objectives presented in a way that summarizes and defines the overall approach to the youth's treatment based on the clinical needs and target behaviors as defined in the assessment summary;
    - Prioritization of the treatment focus defined according to the severity of need;
    - Description of how the provider will measure progress;
    - Baseline status (as identified during the assessment and parent interviews) describing the intensity, frequency and duration of each behavior that is targeted for therapy; and
  - Parent and Caregiver Goals and Objectives
    - Describe the goals for parent/caregiver education related to the youth's behaviors to be achieved within the authorized time period;
    - Describe the specific objectives and the methods used to measure progress within each goal area; and
    - Describe the goals for other care provider's education related to the youth's behaviors. Other care providers may include Medicaid Home and Community Based Waiver funded attendants and relatives who routinely come in contact with the youth.
  - Care Coordination Goals
    - Specific description of the care coordination and/or referral activities that will be implemented by the provider within the authorized time period to facilitate ISP outcomes based on the assessed needs of the youth and family including the families desired outcomes from receiving services;
    - Specific care coordination treatment goals and the desired outcome based on the services provided by the ancillary service provider;
    - Referrals to medical services (such as Speech-Language Pathology services, Occupational Therapy, Physical Therapy, Neurological services and Psychiatric services) and case management services to facilitate access to desired medical services including the desired outcome from the collaborative efforts with each therapeutic discipline including the target dates for achievement; and
    - All goals and objectives presented in a way that summarizes and defines the overall approach including the prioritization of the treatment goals based on the clinical needs and target behaviors as defined in the assessment summary.
- Providers must communicate the results of the assessment and treatment planning to the youth's primary care provider. Care coordination with the youth's primary care provider is an essential component of the provision of ABA services and must be documented in the youth's record.
- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
- Family training related to the implementation of ABA must be included. Family training involving the youth's family and significant others shall:
  - Be for the direct benefit of the youth and not for the treatment needs of the youth's family or significant others;
  - occur with the youth present except when it is clinically appropriate for the youth to be absent in order to advance the youth's treatment goals; and
  - Be aligned with the goals of the youth's ISP.
- Direct family involvement in the treatment program is required at a minimum of weekly but the amount of direct interaction with the treatment provider will vary according to the clinical necessity, progress as documented, and the youth and family goals in the ISP. Family involvement includes, but is not limited to, assessment, family training, family observation during treatment, updating family members on the youth's progress and involving the family in updating treatment goals.
- Clinical supervision shall be required for services rendered by a LABA, LMHP-R, LMHP-RP, or LMHP-S. Clinical supervision must be consistent with the scope of practice as described by the applicable Virginia Department of Health Professions (DHP) regulatory board.

- Supervision of unlicensed staff shall occur at least weekly twice a month by the licensed supervisor. As documented in the youth's medical record, supervision shall include a review of progress notes and data and dialogue with supervised staff about the youth's progress and effectiveness of the ISP. Supervision shall be documented by, at a minimum, the contemporaneously dated signature of the licensed supervisor.

- Provider Qualifications
  - ABA providers shall be licensed by the applicable health regulatory board at the Virginia Department of Health Professions (DHP), credentialed with Optum for youth enrolled in Medicaid. ABA providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
- Staff Requirements
  - ABA may be provided by:
    - An LBA or LMHP acting within the scope of practice defined by the applicable health regulatory board;
    - An LMHP-R, LMHP-RP or LMHP-S under supervision as defined by the applicable Virginia Health Regulatory Board;
    - An LABA under the supervision of a LBA as specified in 12VAC85-150-120;
    - Personnel under the supervision of a LBA or LABA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations; and
    - Personnel under the supervision of a Licensed Clinical Psychologist in accordance with §54.1-3614.

Note: Tasks performed by unlicensed personnel cannot constitute the practice of behavior analysis. Unlicensed personnel includes, but is not limited to Registered Behavior Technicians (RBTs).

- Service Authorization
  - Assessment CPT codes do not require service authorization.
  - All treatment service hours require service authorization. Providers shall submit services authorization requests by the requested start date of services. If submitted after the required time-frame, the begin date of authorization will be based on the date of receipt.
  - The ABA provider must submit the following information to Optum for the initial service authorization:
    - Initial Service Authorization Request Form;
    - The provider assessment completed by the LBA, LABA or LMHP;
    - The preliminary ISP; and
    - A description of the preliminary discharge plan to include referrals as service goals are met.
  - For all requests exceeding 20 hours (80 units) or more per week, the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the ABA treatment. Each session must clearly be related to the successful attainment of the treatment goals. The therapeutic function of all scheduled sessions must be clearly defined regarding the number of hours requested.
  - Continuation of service requests must include:
    - Continued Stay Service Authorization Form;
    - Original Comprehensive Needs Assessment and an addendum to this assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery;
    - An updated ISP that reflects the current goals and interventions;
    - A summary of the youth's treatment progress that contains the following information:
      - Graphical presentation of progress on each goal and objective in the ISP;
      - Overview of family involvement during service period with regards to the youth's ISP to include: who has been involved; progress made and continuing needs of family goals/training to include reasons the youth and parent/caregiver need continued ABA;
      - A summary of progress towards generalization of adaptive functioning in multiple settings to include assessing for maintenance of the skills acquired and updating the ISP as needed to test for generalization of skills in multiple environments;
      - Progress toward the anticipated date of discharge from services including any plan to gradually reduce services and consultative actions as planned to include identifying lower levels of care, natural supports care coordination needs;
      - A summary of the care coordination activities.
  - Based on the needs of the child and family/caregiver, it may be appropriate to request a service authorization extension at a reduced number of hours to assist the child and family to successfully transition from a higher intensity of ABA services to a lower level of service.

- The provider must notify Optum of all service discharges or transfers within three business days of the last date of service.
- Additional information on service authorization is located in Appendix C of the manual.

- Documentation Requirements
  - Refer to Chapter VI of this manual for documentation and utilization review requirements. Additional documentation requirements include:
    - An assessment of adaptive functioning required to support medical necessity criteria;
    - Documentation of the family's agreement for participation in therapy as defined in the ISP;
    - Ongoing treatment documentation data including graphical analysis of goals and objectives as defined by the most current ISP for those dates of service;
    - Description of any assessment tools used;
    - Documentation that indicates the coordination of treatment with the youth's primary care provider and other health disciplines and coordination of the relevant documentation necessary for ongoing behavioral treatment;
    - The initial assessment completed by the LBA, LABA or LMHP including: the assessment instruments used; dates of services and face to face contacts; documentation of other interviews conducted as part of the assessment process; staff and participant names; and staff credentials and signatures;
    - Documentation of the activities provided, length of services provided, the reaction to that day's activity, and documentation of performance in each treatment objective. At a minimum, the description of treatment progress should be documented through daily data collection as well as a weekly summary note;
    - Documentation of family education and their application of effective behavior strategies as designed in the ISP;
    - Documentation shall be prepared to clearly demonstrate efficacy using baseline and service-related data that shows clinical progress. Documentation shall include demonstration of generalization for the youth and progress for family members toward the therapy goals as defined in the service plan.
    - Documentation of all billed services shall include the amount of time or billable units spent to deliver the service and shall be signed and dated on the date of the service by the practitioner rendering the service and include any applicable supervisor co-signature.
- Service Limitations
  - In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
    - Group treatment should include no more than five youth. Multiple family group treatment should include no more than five caregivers. Groups may exceed this size based on the clinical determination of the LBA, LABA or LMHP. The LBA, LABA or LMHP must document the clinical justification for larger group sizes.
    - ABA CPT codes are limited to 97151, 97152, 97156 and 97157 in Residential Treatment Services settings including Therapeutic Group Homes (TGHs) and Psychiatric Residential Treatment Facilities (PRTFs).
    - Services cannot be authorized concurrently with:
      - Intensive In-Home,
      - Mental Health Skill Building,
      - Psychosocial Rehabilitation,
      - Partial Hospitalization Program,
      - Assertive Community Treatment.
      - 14-calendar day service authorization overlap with these services is allowed as youth are being admitted or discharged from ABA to other behavioral health services (see service authorization section)
    - The following shall not be covered under ABA:
      - Services that are based upon an incomplete, missing, or outdated assessment or ISP.
      - Sessions that are conducted for recreation respite or childcare.
      - Services rendered primarily by a relative or guardian who is legally responsible for the youth's care.
      - Services that are provided in the absence of the youth or a parent or other authorized caregiver identified in the ISP.
      - Services provided by a local education agency. ABA may only be provided in the school setting when the purpose is for observation and collaboration related to behavior and skill acquisition (not direct therapy) and services have been authorized by the school, parent and provider and included in the ISP.

Exclusions

- Services cannot be authorized concurrently with Intensive In-Home, Mental Health Skill Building, Psychosocial Rehabilitation, Partial Hospitalization Program or Assertive Community Treatment. 14-calendar day service authorization

overlap with these services is allowed as youth are being admitted or discharged from ABA to other behavioral health services (see service authorization section).

Community Stabilization

Community Stabilization services are available 24 hours a day, seven days a week, to provide for short-term assessment, crisis intervention, and care coordination to individuals experiencing a behavioral health crisis. Services may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Services involve advocacy and networking to provide linkages and referrals to appropriate community-based services and assisting the individual and their natural support system in accessing other benefits or assistance programs for which they may be eligible.

The goal of Community Stabilization services is to stabilize the individual within their community and support the individual and natural support system during the following: 1) between an initial Mobile Crisis Response and entry in to an established follow-up service at the appropriate level of care if the appropriate level of care is identified but not immediately available for access 2) as a transitional step-down from a higher level of care if the next level of care is identified but not immediately available or 3) as a diversion from a higher level of care.

Admission Criteria

- Individuals must meet all of the following criteria:
  - Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with an International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates to a Diagnostic and Statistical Manual diagnosis in the most recent version of the manual; and
  - The individual has demonstrated a level of acuity indicating that they are at risk for crisis-cycling or dangerous decompensation in functioning and additional support in the form of community stabilization is required to prevent an acute inpatient admission; and
  - Prior to admission the individual must meet either A. or B. below:
    - A. The individual is residing in a Therapeutic Group Home or ASAM 3.1; or
    - B. The individual needs community stabilization as a transition due to either i. or ii. below and also meets iii. below:
      - i. A LMHP, LMHP-R, LMHP-RP or LMHP-S at a Community Services Board (CSB) same day access intake, a Managed Care Organization, or Fee-For-Service contractor determines Community Stabilization is needed to support a transition in care and link an individual to appropriate services; or
      - ii. The individual is being discharged from one of the below services:
        - (a) 23-Hour Crisis Stabilization
        - (b) Acute Psychiatric Inpatient Services
        - (c) ASAM levels 3.1 – 4.0
        - (d) Hospital Emergency Department
        - (e) Short-term detention or incarceration
        - (f) Mobile Crisis Response
        - (g) Partial Hospitalization Program (Mental Health or ARTS)
        - (h) Psychiatric Residential Treatment Facility
        - (i) Residential Crisis Stabilization Unit
        - (j) Therapeutic Group Home
      - iii. Individuals meeting either criteria i. or criteria ii. above must also meet all the following additional criteria:
        - (a) The service that the individual needs and is recommended by a professional listed in item i. above or a professional coordinating the discharge plan from services listed in item ii. above is not currently available for immediate access;
        - (b) There is evidence that if immediate access to the intended referral service is not available, the individual is likely to go into crisis or experience a dangerous decompensation in functioning and thus community stabilization is necessary in order to maximize the chances of a successful transition to the intended service;
        - (c) A clinically appropriate and specific behavioral health service provider referral(s) has been identified and a plan for the timeline of transition from Community Stabilization to that provider has been established and documented. If the timeline for this transition exceeds 2 weeks, the

Community Stabilization provider has documented communications with additional, specific service providers to support additional service options or potentially faster access to the recommended service type.

Continuing Stay Criteria

- All of the following criteria must be met:
  - The individual's condition continues to meet admission criteria;
  - Treatment is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan;
  - Safety plan includes support system involvement unless contraindicated;
  - There is documented, active discharge planning starting at admission; and
  - There is documented active coordination of care with other service providers. If care coordination is not successful, the reasons are documented, and efforts to coordinate care continue. If the timeline for this transition exceeds 2 weeks, the Community Stabilization provider has documented communications with additional, specific service providers to support additional service options or potentially faster access to the recommended service type.

Discharge Criteria

- Once an individual meets criteria for discharge, services are no longer eligible for reimbursement.
- At least one of the following discharge criteria is met:
  - The individual no longer meets admission criteria;
  - A safe discharge plan has been established and an appropriate level of care has been initiated;
  - An effective safety plan has not been established and the individual requires a higher level of care;
  - The individual and/or support system is not engaged in treatment. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues;
  - The individual's physical condition necessitates transfer to an acute inpatient medical facility.

Service Delivery

Critical Features

- Critical Features of Community Stabilization include:
  - Recovery-oriented, trauma-informed, culturally congruent and developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;
  - Assessment and screening, including explicit screening for suicidal or homicidal ideation;
    - Care Coordination:
      - Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care;
      - Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use;
      - Engaging peer/natural and family support to strengthen the individual's participation and engagement;
    - Crisis Intervention
      - Brief Therapeutic Interventions;
      - Crisis education, safety, prevention planning, and support;
      - Interventions to integrate natural supports in the de-escalation and stabilization of the crisis;
    - Skills Restoration
      - Skill building;
      - Psychoeducation
- Covered Services components of Community Stabilization include:
  - Assessment, including telemedicine assisted assessment
  - Care Coordination
  - Crisis Intervention
  - Health Literacy Counseling
  - Individual and Family Therapy
  - Peer Recovery Support Services
  - Skills Restoration

- Treatment Planning
- Required Activities
  - In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to Community Stabilization:
    - The provider must engage with the DBHDS crisis data platform prior to initiating services.
  - Assessment
    - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S must conduct an assessment to determine the individual's appropriateness for the service. This assessment must be done in person or through a telehealth assisted assessment. The assessment requirement can be met by one of the following:
      - A Comprehensive Needs Assessment (see Chapter IV for requirements).
      - Prescreening Assessment: If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment.
      - A DBHDS approved assessment for crisis services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
  - Care Coordination:
    - Community Stabilization services shall link/transition the individual to follow-up services and other needed resources to stabilize the individual within their community. Active transitioning from Community Stabilization to an appropriate level of care for ongoing behavioral health services shall be required; which includes care coordination and communication with the individual's MCO or FFS contractor, service providers and other collateral contacts.
    - Discharge planning and transition to an appropriate level of care must occur as soon as possible.
    - Services must be provided in-person with the exception of the telemedicine assisted assessment and care coordination activities.
    - Services must be available to the individual 24 hours per day, seven days per week, in their home, workplace, or other setting that is convenient and appropriate for the individual.
    - Service delivery must be individualized. Group delivery of service components is not appropriate for this service.
    - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
  - Crisis Intervention:
    - Development of a plan to maintain safety in order to prevent the need for a higher level of care; or
    - Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; or
    - If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.
  - Treatment Planning:
    - Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S.
  - Provider Qualifications
    - Community Stabilization service providers must be licensed by DBHDS as a provider of Outpatient Crisis Stabilization services and be enrolled as a provider with DMAS.
    - Community Stabilization providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
    - Community Stabilization providers must complete DBHDS required training for this service.
    - Community Stabilization Teams must have an active Memorandum of Understanding with the regional crisis hub via DBHDS by July 31, 2022.
  - Staff Requirements
    - Community Stabilization service providers may offer delivery of the service through different staffing complements depending on what activities are being delivered and what staffing is required to provide such activities. (See Community Stabilization Billing Requirements below)
    - Staffing/Team Composition (s)
      - 1 QMHP-A or QMHP-C or 1 CSAC*
      - 1 Licensed*
      - 1 Licensed* and 1 PRS or 1 Licensed* and 1 CSAC-A

- 1 Licensed* and 1 QMHP-E or QMHP-C or QMHP-A or 1 Licensed* and 1 CSAC*

*Includes those in their regulatory board approved residency/supervisee Status.

- Assessments must be provided by a LMHP, LMHP-S, LMHP-R, LMHP-RP.
- Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
- Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, or CSAC Supervisee*
- Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
- Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC*, or CSAC Supervisee*.
- Individual and Family Therapy must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S.
- Skills Restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E.
- Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.
- All Community Stabilization staff must be in possession of a working communication device in order to provide care coordination, engage natural/family supports and link the individual to needed follow-up services.

*CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2.

- Service Authorization
  - Community Stabilization requires prior service authorization and service providers delivering Community Stabilization shall meet the provider qualifications listed above.
  - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt.
  - Service authorization requests must include, at a minimum:
    - A complete service authorization request form. The service authorization form must be submitted with the required DBHDS crisis data platform reference number.
    - Documented referral from discharging provider, if applicable. The referral must include the name of both the referring provider and the community stabilization provider.
  - Service units are authorized based on medical necessity with a unit equaling fifteen minutes.
  - If additional services are clinically required, the provider shall submit an authorization request to the FFS contractor or MCO through a continued stay service authorization request submitted no earlier than 48 hours before the requested start date of the continued stay and no later than the requested start date accompanied by the following items:
    - a. A Comprehensive Needs Assessment (see Chapter IV for requirements); or
    - b. Prescreening assessment: If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment; or
    - c. A DBHDS approved assessment for crisis services if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; and
  - A current addendum to the above assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria;
  - A safety plan; and
  - Documentation of care coordination activities. Service authorization requests may require the submission of documentation of referrals to post-discharge services at the appropriate level of care based on the assessed needs of the individual; and
  - Any housing needs must be noted on the service authorization request form for the purposes of care coordination.
  - The information provided for service authorization must be corroborated and in the provider's clinical record. An approved service authorization is required for any units of Community Stabilization to be reimbursed. Units billed must reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria.
  - The referring provider must determine what other services the individual is receiving prior to referring to Community Stabilization. It is the responsibility of both the referring provider and the Community Stabilization

provider to determine if the individual has another community behavioral health provider and should contact Optum, caregivers and natural supports prior to initiating Community Stabilization services.
    - Additional information on service authorization is located in Appendix C of the manual.
- Community Stabilization Billing Requirements
    - One unit of service equals fifteen minutes.
    - The staff who deliver the activities for each contact determine the billing code modifier and the reimbursement rate associated with that unit of service.
    - To bill for a team Medicaid rate for team compositions #3 - #4 (see below), both team members must be present for the duration of the unit billed as evidenced by, at a minimum, both team member signatures on progress notes. The exception to this rule is when a team member separates from their teammate and the individual participating in the service in order to conduct care coordination activities. Documentation must still indicate that both team members were providing a covered service for units billed.
    - Staff working physically alone without their teammate in team compositions #3-4 are not allowed to bill the team Medicaid reimbursement rate. If only one member of the team is required based on the individual's treatment needs, the provider may bill for staff compositions #1 or #2 (see below) depending on the credentials of the staff member providing the service.
    - Community Stabilization staff must be engaged and actively delivering services to the eligible individual, family member or collateral contact during the time billed.
    - Teams that consist of two LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss (any combination) may bill using the HT modifier even if one of the team members is not registered with DHP as a QMHP.
    - A service overlap of Community Stabilization with other community behavioral health services is allowed with documented justification of time needed to transition from Community Stabilization to other services as part of a safe discharge plan. Overlap durations will vary depending on the documented needs of the individual and the intensity of the services but in no instances may exceed 48 hours.
    - Mobile Crisis Response, 23-Hour Crisis Stabilization and RCSU may be billed on the same day as Community Stabilization; however, services may not be delivered simultaneously.
    - Providers of telemedicine assisted assessment 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 a telemedicine assisted assessment. Providers should not bill originating site fees. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.
    - Billing Code: S9482 with appropriate modifier; Unit – 15 minutes; Description - Community Stabilization; Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
    - Team 1: Modifier – HN; Modifier Meaning -1 QMHP-A or QMHP-C or 1 CSAC[x]
    - Team 2: Modifier – HO; Modifier Meaning - 1 Licensed[x]
    - Team 3: Modifier - HT, HM; Modifier Meaning - 1 Licensed[x] and 1 Peer or 1 Licensed[x] and 1 CSAC-A
    - Team 4: Modifier – HT; Modifier Meaning -1 Licensed[x] and 1 QMHP-E or QMHP-C or QMHP-A or 1 Licensed[x] and 1 CSAC[x]

    [x] Includes those in their regulatory board approved residency/supervisee status.

Exclusions and Service Limitations

- Individuals who meet any of the following criteria are not eligible to receive Community Stabilization services:
    - An individual receiving community based behavioral health services (MHS and ARTS). Community based behavioral health services means Mental Health and ARTS services more intensive than standard outpatient psychiatric services for mental health and substance use disorders, unless approved by Optum;
    - An individual receiving inpatient or specific residential treatment services including psychiatric residential treatment facility (PRTF) or ASAM levels 3.3 – 4.0;
    - The individual's psychiatric condition is of such severity that it can only be safely treated in this level of care;
    - The individual's acute medical condition is such that it requires treatment in an acute medical setting.
- In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
    - Temporary housing shall not be conditioned upon an individual receiving any crisis service and housing (including temporary housing) is not a reimbursable component of this service. If an individual meets admission criteria for this service and housing is an assessed need, this should be noted as a need on the service authorization request submitted to support coordination of resources for the individual. While loss or lack of housing may contribute to a

behavioral health crisis, the solution to the housing need must be addressed through non-Medicaid funding or services related to housing. Community Stabilization should address the behavioral health crisis triggered by the stressor of a housing problem using interventions and a plan directed explicitly at the behavioral health needs and symptoms. Providers are prohibited from using Medicaid reimbursement to cover housing costs for an individual and any funds used for this purpose will be retracted.
    - Services may not be provided in groups where one staff person or a team of staff provides services to two or more individuals at the same time.

Mobile Crisis Response

Mobile Crisis Response services are available 24 hours a day, seven days a week, to provide for provides rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. Services are deployed in real-time to the location of the individual experiencing a behavioral health crisis. The purpose of this is to i) de-escalate the behavioral health crisis and prevent harm to the individual or others; ii) assist in the service prevention of an individual's acute exacerbation of symptoms; iii) development of an immediate plan to maintain safety and; iv) coordination of care and linking to appropriate treatment services to meet the needs of the individual.

- Mobile Crisis Response is designed to support individuals in the following manner:
    - Provide rapid response to individuals experiencing a behavioral health crisis;
    - Meet the individual in an environment where they are comfortable to facilitate service engagement, stabilization and resolution of the crisis when possible;
        - Services provided in community locations where the individual lives, works, participates in services or socializes. Locations include but are not limited to schools, homes, places of employment or education, or community settings.
    - Provide appropriate care/support/supervision in order to maintain safety for the individual and others, while avoiding unnecessary law enforcement involvement, emergency room utilization, and/or avoidable hospitalization;
    - Prevent further exacerbation of symptoms that would put the individual at risk of an out of home placement or disruption in current living environment;
    - Refer and link to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care (including pre-admission screening in appropriate cases conducted by DBHDS Certified Preadmission Screening Clinician.

Admission Criteria

- This service is available to any individual meeting the below criteria, regardless of diagnosis. Individuals must meet all of the following criteria:
    - The individual must be in an active behavioral health crisis; and
    - Urgent intervention is necessary to stabilize or prevent escalation of the individual's behavioral health crisis; and
    - The individual or collateral contact reports at least one of the following:
        - a. suicidal/assaultive/destructive ideas, threats, plans or actions; or
        - b. an acute or increasing loss of control over thoughts, behavior and/or affect that could result in harm to self or others; or
        - c. functional impairment or escalation in mood/thought/behavior that is disruptive to home, school, or the community or impacting the individual's ability to function in these settings; or
        - d. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; and
    - Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community.

Continuing Stay Criteria

Not available for this level of care. If additional units are needed, providers should submit a new registration form with the Managed Care Organization (MCO) or Fee-For-Service (FFS) Contractor and any necessary call center engagement in accordance with DBHDS guidelines. Individuals must meet admission criteria.

Discharge Criteria

The individual shall be discharged when the individual no longer meets admission criteria and/or an appropriate aftercare treatment plan has been established and the individual has been linked or transferred to appropriate community, residential or in-patient behavioral health services.

Documentation and Utilization Review

The individual's clinical record must reflect either resolution of the crisis which marks the end of the current episode or the discharge plan to an appropriate service to manage the ongoing symptoms associated with the crisis.

Service Delivery

Critical Features

- Mobile Crisis Response is appropriate for individuals who have emergent behavioral health needs that require immediate assessment, crisis interventions, and care coordination to resolve the potential for harm to self or others.
- Critical features of Mobile Crisis Response include:
  - Recovery-oriented, trauma-informed, developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles;
  - An approach to the individual in crisis that is sensitive to their cultural identity and demonstrates humility and respect for their lived experiences and preferences in participating in care;
  - Assessment and screening of behavioral health crisis needs, including screening for suicidal or homicidal risk;
  - When necessary and in any location where the individual may be located, DBHDS Certified Preadmission Screening Clinician may complete screening for the purposes of involuntary commitment within this service;
  - Crisis Intervention
    - De-escalation and resolution of the crisis, including on-site interventions for immediate de-escalation of presenting emotional or behavioral symptoms;
    - Brief therapeutic and skill building interventions;
    - Safety/crisis planning
  - Care Coordination:
    - Engaging peer/natural and family support;
    - Coordination with the DBHDS crisis call center;
    - Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care including community stabilization;
    - Coordination and collaborate effectively and successfully with law enforcement, emergency responders, and state-certified uniform pre-screeners.
  - Covered service components of Mobile Crisis Response include:
    - Care Coordination
    - Crisis Intervention
    - Health Literacy Counseling
    - Individual and Family Therapy
    - Peer Recovery Support Services
    - Pre-admission screening for involuntary commitment
    - Treatment Planning
- Required Activities
  - In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to Mobile Crisis Response:
    - The provider must engage with the DBHDS crisis call center and crisis data platform prior to initiating services.
  - Assessment
    - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S must conduct an assessment to determine the individual's appropriateness for the service. This assessment must be done in-person, through telemedicine, or through a telehealth assisted assessment. At a minimum, the assessment must include the following elements: risk of harm; functional status; medical, addictive and psychiatric co-morbidity; recovery environment; treatment and recovery history; and the individual's ability and willingness to engage. The assessment requirement can also be met by one of the following:
      - A Comprehensive Needs Assessment (see Chapter IV for requirements).

        - Prescreening assessment: If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment.
        - A DBHDS approved assessment for crisis services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
    - Care Coordination
        - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
        - Active transitioning from Mobile Crisis Response to an appropriate level of care for ongoing behavioral health services shall be required; which includes care coordination and communication with the individual's MCO or FFS contractor, service providers and other collateral contacts.
        - Crisis Intervention:
            - Development of an immediate plan to maintain safety in order to prevent the need for a higher level of care; or
            - Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement.
        - Services must be provided in-person with the exception of the assessment and care coordination activities.
        - Services must be available to the individual 24 hours per day, seven days per week, in their home, workplace, or other setting that is convenient and appropriate for the individual.
        - Service delivery must be individualized. Group delivery of service components is not appropriate for this service.
- Provider Qualifications
    - Mobile Crisis Response providers must be licensed by DBHDS as a provider of Outpatient Crisis Stabilization services and be enrolled as a provider with DMAS (see Chapter II).
    - Mobile Crisis Response providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.
    - Mobile Crisis Response providers must have an active, DBHDS approved, Memorandum of Understanding with the regional crisis hubs via DBHDS by July 31, 2022.
- Staff Requirements
    - Mobile Crisis Response providers must meet at least one of the below team staffing composition requirements (#1-5). (See Mobile Crisis Response Billing Requirements below)
        - 1. 1 Licensed*
        - 2. 1 QMHP-A/QMHP-C/CSAC* and 1 PRS or 1 QMHP-A/QMHP-C/CSAC* and 1 CSAC-A
        - 3. 1 Licensed* and 1 PRS or 1 Licensed* and 1 CSAC-A
        - 4. 2 QMHPs (QMHP-A, QMHP-C and/or QMHP-E) team compositions cannot consist or 2 QMHP-Es or 2 CSACs* or 1 QMHP-A/QMHP-C and 1 CSAC*
        - 5. 1 Licensed* and 1 QMHP(QMHP-A, QMHP-C or QMHP-E) or 1 Licensed* and 1 CSAC*

      *Includes those in their regulatory board approved residency/supervisee/trainee status in accordance with DHP regulations and Certified Preadmission Screening Clinicians who are not a LMHP, LMHP-R, LMHP-RP or LMHP-S directly supervised by a LMHP.
    - Assessments must be provided by a LMHP, LMHP-S, LMHP-R, LMHP-RP.
    - Pre-admission screenings must be provided by a DBHDS Certified Preadmission Screening Clinician. If the DBHDS Certified Preadmission Screening Clinician is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the pre-screening must be directly supervised and signed off by an LMHP.
    - Care Coordination must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC-Supervisee*, CSAC-A*.
    - Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
    - Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC* or CSAC-Supervisee*
    - Individual and Family Therapy must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S.
    - Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.
    - Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee*.

      *CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2.

- All Mobile Crisis Response staff must be in possession of a working communication device in order to provide care coordination, engage natural/family supports and link the individual to needed follow-up services.

- Service Authorization
  - Providers must submit a registration to the individual's MCO or FFS contractor within one business day of admission. The registration form must be submitted with the required DBHDS crisis data platform reference number. The registration permits eight hours (32 units) in a 72 hour period. Units billed must reflect the treatment needs of the individual and be based on individual meeting medical necessity criteria. The 72 hours must be consecutive hours during the registration period but may occur over four calendar days.
  - If additional units are needed, providers should submit a new registration form with the MCO/FFS contractor and engage in required DBHDS call center and /crisis data platform engagement in accordance with DBHDS guidelines. Individuals must meet admission criteria. Registrations may have overlapping dates with a previous registration based on medical necessity.
  - Concurrent registrations/billings with two separate Mobile Crisis Response teams are allowable only if a pre-screening evaluation is needed to allow pre-screening activities to be completed and billed.
  - Additional information on service authorization is located in Appendix C.
- Mobile Crisis Response Billing Requirements
  - One unit of service equals 15 minutes.
  - To bill for a team Medicaid rate for team compositions #2 - #5, both team members must be present for the duration of the unit billed as evidenced by, at a minimum, both team member signatures on progress notes. The exception to this rule is when a team member separates from their teammate and the individual participating in the service in order to conduct care coordination activities. Documentation must still indicate that both team members were providing a covered service for units billed.
  - Unlicensed staff working physically alone without their teammate in team compositions #2-5 do not meet the staff qualifications required to receive Medicaid reimbursement. The exception to this rule is when a team member separates from their teammate and the individual participating in service in order to conduct care coordination activities.
  - DBHDS Certified Preadmission Screening Clinician billing for the purpose of conducting a prescreening must be a LMHP, LMHP-R, LMHP-RP or LMHP-S or directly supervised and the prescreening approved and signed by an LMHP.
  - Mobile Crisis Response teams must be engaged and actively delivering one of the service components with the eligible individual, family member or collateral contact during the time billed in order to qualify for reimbursement.
  - Teams that consist of two LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss (any combination) may bill using the HT modifier. LMHPs are not required to be registered with DHP as a QMHP to bill using this modifier.
  - Teams #2 and #4 must bill the rate for team # 1, #3 or #5 for the timeframe the assessment was completed by the LMHP.
  - Providers conducting an assessment through telemedicine or a telemedicine assisted assessment 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 assessments completed through telemedicine or a telemedicine assisted assessment. Mobile Crisis Response services are not eligible for originating site fee reimbursement. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.
  - Procedure Code: H2011 and modifier (s) as appropriate;
    - Unit: 15 minutes;
    - Description: Mobile Crisis Response;
- Provider Qualifications: Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
  - Team 1: Modifier - HO; Modifier Meaning -1 Licensed[x]
  - Team 2: Modifier – HT, HM; Modifier Meaning - 1 QMHP-A/QMHP-C/CSAC[x] and 1 PRS or 1 QMHP-A/QMHP-C/CSAC[x] and 1 CSAC-A
  - Team 3: Modifier – HT, HO; Modifier Meaning - 1 Licensed[x] and 1 PRS or 1 Licensed[x] and 1 CSAC-A or
  - Team 4: Modifier – HT, HN; Modifier Meaning - 2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – cannot consist of 2 QMHP-Es or 2 CSACs[x] or 1 QMHP-A/QMHP-C and 1 CSAC[x]
  - Team 5: Modifier – HT; Modifier Meaning - 1 Licensed[x] and 1 QMHP (QMHP-A, QMHP-C or QMHP-E) or 1 Licensed[x] and 1 CSAC[x]
- Modifiers can be used as an addition to Team 1, 3, or 5.

- Modifier 32; Modifier Meaning - Prescreening under an Emergency Custody Order (ECO) 1 Certified Preadmission Screening Clinician (LMHP, LMHP-R, LMHP-RP, LMHP-S or DBHDS Certified Preadmission Screening Clinician directly supervised by an LMHP)
- Modifier HK; Prescreening not under an ECO 1 Certified Preadmission Screening Clinician (LMHP, LMHP-R, LMHP-RP, LMHP-S or DBHDS Certified Preadmission Screening Clinician directly supervised by an LMHP).

[x] Includes those in their regulatory board approved residency/supervisee status in accordance with DHP regulations.

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. Mobile Crisis Response may only be provided in inpatient hospital settings for the explicit purpose of pre-admission screening by a DBHDS Certified Preadmission Screening Clinician.
  - 2. Services may not be provided in groups where one staff person or a team of staff provides services to two or more individuals at the same time.

Multi-Systemic Therapy

Multi-Systemic Therapy (MST) is an intensive family and community-based treatment which addresses the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST is provided using a home-based model of service delivery for youth and families, targeting youth between the ages of 11 - 18 who are at high risk of out- of-home placement, or may be returning home from a higher level of care. MST services are delivered in the natural environment (e.g., home, school, community) with the treatment plan being designed in collaboration with the youth, family, and all relevant child serving systems (e.g. DJJ, DSS, Mental Health, PCP, Education, Faith-based organizations, etc.) Multi-systemic therapy (MST) is an intensive, evidence-based treatment program provided in home and community settings for youth who have received referral for the treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. MST is targeted towards youth between the ages of 11 - 18, however, the service is available to any youth under the age of 21 who meets medical necessity criteria.

MST is appropriate for youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes an engagement with the youth's family, caregivers and natural supports and professionals delivering interventions in the recovery environment. MST is a short-term and rehabilitative service that may serve as a step-down or diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and neighborhood/community.

Admission Criteria

- Individuals must meet all of the following criteria for admission to MST:
  - The youth must be under the age of 21;
  - The initial assessment completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S provides evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, or substance use or trauma and stressor-related disorders. There may be additional primary behavioral health diagnoses that may benefit from the interventions of MST that may be considered on a case-by-case basis under EPSDT.
  - Within the past 30 calendar days, the youth has demonstrated at least one of the following:
    - Persistent and deliberate attempts to intentionally inflict serious injury on another person;
    - Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others, are difficult to control, causes distress, or negatively affects the young person's health;
    - Increasing and persistent symptoms associated with depression (e.g. chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, ...) or anxiety (e.g. rumination, panic attacks, hypervigilance, dissociation, ...), in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community;
    - Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community;

        - The youth is returning home from out-of-home placement and MST is needed as step down service from an out-of-home placement.
    - The youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the MST model. Participation in an alternative community-based service would not provide the same opportunities for effective intervention for the youth's problem behaviors;
    - There is a family member or other committed caregiver available to participate in this intensive service;
    - Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the MST program as clinically indicated.

Continuing Stay Criteria

- Within the past thirty (30) calendar days MST continues to be the appropriate level of care for the youth as evidenced by at least one of the following:
    - The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria;
    - The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP;
    - Progress toward ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved;
    - To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following:
        - An ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support community integrative objectives including the development of the youth's network of personal, family, and community support. Treatment objectives are related to readiness for discharge and MST specific expected outcomes;
        - Progress toward objectives is being monitored weekly within fidelity to the model as evidenced in the 30 calendar day ISP review documentation;
        - The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement;
        - The type, frequency and intensity of interventions are consistent with the plan of care and fidelity to the model;
        - The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service practitioners, community partners, and natural supports that will meet the needs of the client;
        - The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care.
    - If youth does not meet criteria for continued treatment, MST may still be authorized for up to an additional 10 calendar days under any of the following circumstances:
        - There is no less intensive level of care in which the objectives can be safely accomplished; or
        - The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or
        - The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.

Discharge Criteria

- The youth meets discharge criteria if any of the following are met:
    - The youth's documented ISP goals have been met, and the discharge plan has been successfully implemented;
    - The youth and family are not engaged in treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care;
    - The youth is placed in an out of home placement, including, but not limited to a hospital, skilled nursing facility, psychiatric residential treatment facility, or therapeutic group home and is not ready for discharge within 31 consecutive calendar days to a family home environment or a community setting with community-based support;
    - Required consent for treatment is withdrawn; or
    - There is a lapse in service greater than 31 consecutive calendar days.

Service Delivery

Critical Features

- Critical Features of MST include the following:
  - Integration of evidence-based therapeutic interventions to address a comprehensive range of risk factors across family, peer, school, and community contexts;
  - Promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers;
  - Rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change; and
  - MST professionals on call 24/7 to provide safety planning and crisis intervention.
- MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when many of them have serious and multiple needs of their own. One primary goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case.
- MST Professionals may provide the therapeutic interventions involved in MST in a range of community settings such as the youth's home, school, homeless shelters, libraries, etc. MST includes therapeutic intervention and care coordination to assist the youth in meeting their specific goals.
- MST Professionals deliver this service primarily face-to-face with the youth and their natural supports in locations outside of the provider's facility. MST therapeutic intervention sessions are tailored by an MST Treatment Plan. Service intensity varies with the needs of the youth and family/caregiving system. Early in treatment, the MST Professional may meet with the family several times a week, but as treatment progresses, the intensity tapers. The frequency of therapeutic interventions is flexible based on clinical need, allowing the service to be responsive to periods of crisis or high risk and to decrease the intensity for families with lower levels of need. The MST model expects the MST Professional to take the lead on coordinating care while youth are participating in MST services.
- Therapeutic interventions and collateral contacts may range from brief check-ins to more intensive sessions lasting up to two hours or more. The required supervision, consultation and monitoring provided through the evidence-based MST model work to uphold treatment fidelity expectations around service delivery intensity/frequency. The frequency, intensive and duration of MST services is dependent on the needs of the youth as described in the ISP. If not in conflict with the ISP for a particular youth, the MST model expects an average of 10-20 therapeutic interventions occur within the first month but should ultimately be tailored to the needs of the youth. These initial therapeutic interventions typically occur multiple times per week in frequency. For the second and third months of MST, an average of six therapeutic interventions typically occur per month, though vary based on the needs of the youth. The MST model expects that service frequency will be tapered over the duration of the treatment period based on the individual's needs. Close to treatment termination, the MST professional contacts the family as needed to assure that treatment gains have been maintained by the family. Documentation should be made of each therapeutic intervention or collateral contact and include the reason, outcome and next steps; these details should all relate to the goals of the ISP.
- Service components of MST include:
  - Assessment
  - Therapeutic interventions
  - Crisis intervention and
  - Care Coordination
- Required Activities
  - In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MST:
  - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria.
  - Individual Service Plans (ISPs, see Chapter IV) shall be required during the entire duration of services and must be current. The MST Weekly Case Summary form may be used as the ISP if it meets the requirements of an ISP. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. In cases where the MST Professional is a QMHP-E, QMHP-C, CSAC or CSAC-supervisee, the MST Supervisor directs and authorizes the treatment planning process as part of the MST model.
  - ISPs must be reviewed as necessary at a minimum of every 30-calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements. These 30 day reviews are consistent and comply with the

routine activities required for fidelity in the MST model and include treatment team meetings, consultations with MST supervisors and consultants, meetings with youth and natural supports and administration of fidelity measures.
    - Crisis intervention must be available on a 24 hours a day, seven days a week, 365 days a year basis.
    - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
- Provider Qualifications
    - MST service providers shall be licensed by DBHDS as a provider of Intensive In-Home Services, be certified and maintain an active program certification with MST Services, Inc., and be credentialed with Optum. MST providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
    - MST providers must have the ability to deliver services in the youth's natural environment and community. Organizations that provide MST must provide crisis intervention on a 24 hours a day, seven days a week, 365 days a year basis, to youth who are receiving this service.
    - New MST Teams: Any team that is new to enrolling as a Medicaid provider with Optum. Teams are considered new from the date they are credentialed/contracted through an 18-month period.
    - Established MST Teams: Any team that has been enrolled with Optum past an 18-month period.
    - Bachelor's Established Team - One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be (LMHP, LMHP-R, LMHP-S, or LMHP-RP).
    - Master's/Licensed Established Team - One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be LMHP, LMHP-R, LMHP-S, LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.
    - Bachelor's New Team - One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be (LMHP, LMHP-R, LMHP-S, or LMHP-RP).
    - Master's/Licensed New Team - One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S, or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.
- Staff Requirements
    - The MST team composition includes a full-time LMHP, LMHP-R, LMHP-RP, or LMHP-S who acts as the MST Supervisor, and a minimum of two to a maximum of four MST Professionals or at a minimum of one MST Professional and one MST Supervisor if approved by MST, LLC who provide available 24-hour coverage, 7 days a week.
    - MST Professionals include LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees who meet the requirements of this section. QMHP-E, QMHP-C, CSAC and CSAC-supervisee staff that meet these requirements must be limited to only one MST Professional per MST team and cannot operate as MST Professionals outside of their identified team. CSACs and CSAC-supervisees may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2
    - MST supervisors are, at minimum, LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (e.g., Structural Family Therapy and Strategic Family Therapy). All teams must follow Department of Health Professions (DHP) regulations for clinical supervision requirements of QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees and LMHP-Rs, LMHP-RPs or LMHP-Ss.
    - A full-time MST supervisor may supervise:
        - A single MST Team; or
        - Two MST teams in the same geographical area; or
        - One MST team and provide MST services to one or two youth.
    - A MST Professional, on average, may provide service to four to six youth at one time. MST Professionals provide direct intervention and also arrange, coordinate, and monitor services on behalf of the youth.
    - All MST team members are required to participate in MST introductory training and quarterly training on topics directly related to the needs of youth receiving MST and their family on an ongoing basis.
    - The MST model requires that all staff on the MST team shall participate in weekly MST-specific group supervision facilitated by the MST supervisor per MST model standards. All staff on the MST team shall also participate in weekly MST-specific telephone consultation provided by MST Services, Inc. or a licensed MST Network Partner training organization, with no more than 6 weeks a year without consultation due to the occurrence of quarterly trainings and holidays.
    - Assessments must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S who meets the qualifications of this section.
    - Therapeutic interventions, crisis intervention and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-E, QMHP-C, CSAC or CSAC-supervisee who meets the qualifications of this section.

- Service Authorization
  - This service requires prior authorization and can only be provided by a treatment provider who is licensed by MST Services, and licensed by the Department of Behavioral Health and Developmental Services for Intensive In-home Services.
  - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time-frame, the begin date of authorization will be based on the date of receipt.
  - Service units are authorized based on medical necessity with a unit equaling fifteen minutes.
  - The following should be included with Continued Stay requests:
    - The continued stay service authorization form
    - Updated ISP that reflects the current goals and interventions
    - Original Comprehensive Needs Assessment and an addendum to this assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery.
  - The information provided for service authorization must be corroborated and, in the provider's, clinical record. An approved Service Authorization is required for any units of MST to be reimbursed.
  - Additional information on service authorization is located in Appendix C of the manual.
- Service Limitations
  - In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
    - The provision of MST is limited to individuals under the age of 21.
    - Youth can participate in MST services with only one MST team at a time.
    - MST may not be authorized concurrently for the youth* with
      - Group or Family Therapy,
      - ARTS Levels 2.1, 2.5, 3.1 and 3.3-4.0,
      - Community Stabilization,
      - Functional Family Therapy,
      - Mental Health Skill Building,
      - Intensive In-Home Services,
      - Mental Health Partial Hospitalization Program,
      - Mental Health Intensive Outpatient, or
      - Assertive Community Treatment

    *other family members may be receiving one of the above services and still participate in MST as appropriate for the benefit of the youth receiving MST services.
  - If the youth continues to meet with an existing outpatient therapy provider, the MST provider must coordinate the treatment plan with the provider.
  - Other Mental Health and ARTS services, Inpatient Services, and Residential Treatment Services may be authorized and billed concurrently for no more than 14 consecutive calendar days, as the youth are being admitted or discharged from MST to other behavioral health services.
  - Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with MST, as are E/M outpatient services for the purposes of psychiatric medication evaluation and management.
  - Activities not authorized or reimbursed within MST:
    - Inactive time or time spent waiting to respond to a behavioral situation;
    - Therapeutic interventions that are not medically necessary;
    - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor;
    - Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
    - Respite care;
    - Transportation for the youth or family. Additional medical transportation for service needs which are not considered part of MST program services may be covered by the transportation service through Optum. Medical transportation to Medicaid providers may be billed to the transportation broker;
    - Services not in compliance with the MST manuals and not in compliance with model fidelity standards;

- Any art, movement, dance, or drama therapies outside the scope of the MST model fidelity. Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers, which are not part of the ISP;
- Services not identified on the youth's authorized ISP;
- Anything not included in the approved MST service description;
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.

Exclusions

- Youth who meet any one of the criteria below are not eligible to receive MST:
  - The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of MST.
  - The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
  - The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors.
  - The youth's functional impairment is solely a result of Developmental Disability, as defined in the Code of Virginia § 37.2-100.

Functional Family Therapy

Functional Family Therapy (FFT) is a short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including co-occurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT addresses both symptoms of serious emotional disturbance in the identified youth as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver's ability to function as a family. The FFT model serves as a step-down or diversion from higher levels of care and seeks to understand and intervene with the youth within their network of systems including, family, peers, school and neighborhood/community. FFT is targeted towards youth between the ages of 11 - 18, however, the service is available to any youth under the age of 21 who meets medical necessity criteria.

Admission Criteria

- Individuals must meet all of the following criteria for admission to FFT:
  - The youth must be under the age of 21.
  - The initial assessment completed by a LMHP, LMHPR, LMHP-RP, LMHP-S provides evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, or substance use or trauma and stressor-related disorders. There may be additional primary behavioral health diagnoses that may benefit from the interventions of FFT that may be considered on a case-by-case basis under EPSDT.
  - Within the past 30 calendar days the youth has demonstrated at least one of the following that puts the youth at risk of out of home placement:
    - Persistent and deliberate attempts to intentionally inflict serious injury on another person;
    - Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others are difficult to control, cause distress, or negatively affect the youth's health;
    - Increasing and persistent symptoms associated with depression (e.g. chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, etc.) or anxiety (e.g. rumination, panic attacks, hypervigilance, dissociation, etc.), in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community;
    - Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community;
    - The youth is returning home from out-of-home placement and FFT is needed as step down service from an out-of-home placement.

- The youth's successful maintenance or reintegration in the community is dependent upon an integrated and coordinated treatment approach, that involves intensive family/caregiver partnership through the FFT model. Participation in an alternative community-based service would not provide the same opportunities for effective intervention for the youth's problem behaviors.
- There is a family member or other committed caregiver available to participate in this intensive service.
- Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the FFT program as clinically indicated.

Continuing Stay Criteria

- Within the past thirty (30) calendar days, FFT continues to be the appropriate level of care for the youth as evidenced by at least one of the following:
  - The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria;
  - The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP;
  - Progress toward identified ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved.
- To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following:
  - An ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support community integrative objectives including the development of the youth's network of personal, family, and community support. Treatment objectives are related to readiness for discharge and FFT specific expected outcomes;
  - Progress toward objectives is being monitored weekly within fidelity to the model;
  - The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement;
  - The type, frequency and intensity of interventions are consistent with the ISP and fidelity to the model;
  - The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service practitioners, community partners, and natural supports that will meet the needs of the client;
  - The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care.
- If youth does not meet criteria for continued stay criteria, FFT may still be authorized for up to an additional 10 calendar days under any of the following circumstances:
  - There is no less intensive level of care in which the objectives can be safely accomplished; or
  - The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or
  - The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.

Discharge Criteria

- The youth meets discharge criteria if any of the following are met:
- The youth's documented ISP goals and objectives have been substantially met and all FFT phases have been completed;
  - The youth no longer meets admission criteria due to the following:
    - The youth's needs can be met at a lower level of care;
    - The youth's current level of function requires a higher level of care;
    - The youth or the youth's family have not benefited from FFT despite documented efforts to engage the youth or family and there is no reasonable expectation of progress at this level of care despite ISP changes or the youth or the youth's family has achieved maximal benefit from this level of care;
    - The youth is placed in a hospital, skilled nursing facility, residential treatment facility, or other residential treatment setting and is not ready for discharge within 14 consecutive calendar days to a family home environment or a community setting with community-based support;
    - Required consent for treatment is withdrawn; or
    - If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the youth.

Service Delivery

Critical Features

- FFT is a phase-based service that addresses youth behavior problems by systematically targeting risk and protective factors at multiple levels in the youth's environment. In order to accomplish these changes in the most effective manner, FFT includes five major phases that build upon each other through treatment. These phases include engagement, motivation, relational assessment, behavior change and generalization.
- Specific fidelity standards guide the delivery of FFT services and providers are required to follow these standards. The critical features of the FFT model include:
  - A philosophy about people that includes an attitude of respectfulness, of individual difference, culture, ethnicity, and family composition.
  - A focus on family that involves alliance building and involvement with all family members with FFT professionals who do not "take sides" and who avoid being judgmental.
  - A change model of care focused on risk and protective factors.
  - An inclusive list of interventions that are specific and individualized for the unique challenges, diverse qualities, and strengths of all families and family members.
  - An inter-relational focus versus individual problem focus.
- FFT is primarily a home-based service, but providers may conduct the service in clinic settings, as well as in schools, child welfare facilities, probation and parole offices/aftercare systems and mental health and Substance Use Disorder treatment facilities. The FFT professional meets with the whole family and does not organize service delivery around an individual participant. FFT delivery includes both the clinical interventions as well as the care coordination activities that are necessary for the participants in the service.
- FFT professionals work with families to assess family behaviors that maintain problem behaviors, modify dysfunctional family communication, train family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalize changes to community contexts and relationships. Each of the FFT phases has its own goals, focus and intervention strategies/techniques, and these are summarized below:
  - Engagement
    - Goals: Enhancing the youth's perceptions of FFT professional responsiveness and credibility;
    - FFT Professional's Focus: Immediate responsiveness to family needs and maintaining a strength-based relational perspective; and
    - Activities: High availability, therapeutic interventions with as many family members as possible.
  - Motivation
    - Goals: Creating a positive motivational context by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members;
    - FFT Professional's Focus: Changing the meaning of family relationships by emphasizing possible hopeful alternatives, maintaining a non-judgmental approach and conveying acceptance and sensitivity to diversity; and
    - Activities: Interruption of negative interaction patterns, sequencing and reframing of themes presented by family interactions, changing meaning through a strength-based relational focus.
  - Relational Assessment
    - Goals: Identifying patterns of interaction within the family to understand the positive interpersonal benefits for individual family members' behaviors;
    - FFT Professional's Focus: Gathering and analyzing information pertaining to relational processes, and assess each dyad in the family using perception and understanding of relational processes; and
    - Activities: Observations, questionings, inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective.
  - Behavior Change
    - Goals: Reducing or eliminating referral problem(s) by improving family functioning and individual skill development;
    - FFT Professional's Focus: Focused on improving family communication and teaching new skills to achieve more positive interaction through domain-specific interventions (e.g., problem solving, anger management, depression, anxiety, substance use, etc.) that are tied to the relational assessment; and,
    - Activities: Introduction of tasks or skills to the family by providing the rationale for the exercise; coaching, modeling, and rehearsing techniques; and giving feedback along with homework for the family to practice outside of the session.
  - Generalization

        - Goals: Extending the improvements made during the Behavior Change phase into new situations or systems, relapse planning, and incorporating community systems into the treatment process;
        - FFT professional's focus: Maximizing a multisystemic/systems understanding and ability to establish links, maintain energy, and provider outreach into community systems; and
        - Activities: Accessing and maintaining connection to community supports, initiating clinical linkages, creating relapse planning, and helping the family to develop independence.
- It is not a requirement of the FFT model to offer 24/7 access to the FFT professional. Based on referral information and assessment of family risk and protective factors, the FFT provider may increase the frequency and length of sessions. If there is a crisis, the FFT provider may adjust the frequency and length to address the need. The FFT program intentionally includes development skills and interventions to reduce negativity and blame, factors that underlie crisis behavior.
- Booster sessions are a short term resumption of services initiated by the youth and/or family after successful discharge. Booster sessions may also be planned in advance as part of the discharge planning when the FFT professional is aware of transitional events.
- Covered services include:
    - Assessment,
    - Therapeutic interventions,
    - Crisis intervention, and
    - Care Coordination
- Required Activities
    - In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to FFT:
        - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria.
        - ISPs (see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The FFT Behavior Change Session Plan (as defined by FFT, LLC.) can be used as the ISP as long as it includes all of the requirements of an ISP. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. In cases where the FFT Professional is a QMHP-E, QMHP-C, CSAC or CSAC-supervisee, the FFT Supervisor directs and authorizes the treatment planning process as part of the FFT model.
        - The ISP must be reviewed and updated as necessary at a minimum of every 30-calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements. These 30 day reviews are consistent and comply with the routine activities required for fidelity in the FFT model and include treatment team meetings, consultations with FFT supervisors and consultants, meetings with individuals and natural supports and administration of fidelity measures.
        - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
- Provider Qualifications
    - FFT service providers shall be licensed by DBHDS as a provider of Mental Health Outpatient Services, be certified and maintain an active program certification with FFT, LLC., and be credentialed with Optum. FFT providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
    - FFT providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
    - New FFT Teams: Any team that is new to enrolling as a Medicaid provider with Optum. Teams are considered new from the date they are credentialed/contracted through an 18-month period.
    - Established FFT Teams: Any team that has been enrolled with Medicaid Optum past an 18-month period.
    - Bachelor's Established Team - 33% of team is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be (LMHP, LMHPR, LMHP-S, LMHP-RP).
    - Master's/Licensed Established Team - 33% of team is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be (LMHP, LMHPR, LMHP-S, LMHP-RP) or the entire team is a LMHP, LMHP-R, LMHP-S or LMHP-RP).
    - Bachelor's New Team - 33% of team is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be (LMHP, LMHPR, LMHP-S, LMHP-RP).

- Master's/Licensed New Team - 33% of team is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee. All other team members must be (LMHP, LMHPR, LMHP-S, LMHP-RP) or the entire team is a LMHP, LMHP-R, LMHP-S or LMHP-RP.

- Staff Requirements
  - FFT utilizes a mandatory group and individual consultation approach, meeting with a national consultant as required by FFT, LLC. The FFT team is required to complete ongoing trainings to maintain their certification.
  - In accordance with FFT fidelity, one FFT site supervisor may support a team of up to seven trained FFT Professionals. The site supervisor , carries a caseload while also attending FFT supervisor trainings, assuming supervision of the team, attending consultation with a FFT national consultant, completing FFT supervision paperwork and providing ongoing review of the client service system.
  - FFT supervisors and professionals maintain a caseload consistent with the FFT model and monitored by FFT, LLC.
  - FFT Professionals on a team may include LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees. FFT, LLC certifies by team, not by individual and thus individuals cannot deliver nor bill for FFT if they are operating outside of the team structure. If a certified team includes QMHP-Es, QMHP-Cs, CSACs and CSAC supervisees, they are limited to 33% of the team being a QMHP-E, QMHPCs, CSACs and CSAC-supervisee. CSACs and CSAC-supervisees may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2.
  - FFTs Supervisors must be a licensed mental health professional (LMHP), LMHP-Resident in Counseling (LMHP-R), LMHP-Resident in Psychology (LMHP-RP) or LMHP-Supervisee in Social Work (LMHP-S). All teams must follow Department of Health Professions (DHP) regulations for clinical supervision requirements of QMHP-Cs, QMHP-Es, CSACs and CSAC-supervisees and LMHP-Rs, LMHP-RPs or LMHP-Ss.
  - Assessments must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S.
  - Therapeutic interventions, crisis intervention and care coordination for FFT must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-E, QMHP-C, CSAC or CSAC-supervisee who meets the qualifications of this section.
- Service Authorization
  - This service requires prior authorization and can only be provided by a treatment provider who is licensed by FFT, LLC., and licensed by the Department of Behavioral Health and Developmental Services for Mental Health Outpatient Services.
  - Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time-frame, the begin date of authorization will be based on the date of receipt.
  - Service units are authorized based on medical necessity with a unit equaling fifteen minutes.
  - The following should be included with Continued Stay requests:
    - The continued stay service authorization form;
    - Updated ISP/FFT Behavior Change Plan that reflects the current goals and interventions;
    - Original Comprehensive Needs Assessment, and an addendum to this assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery.
  - The information provided for service authorization must be corroborated and, in the provider's, clinical record. An approved Service Authorization is required for any units of FFT to be reimbursed.
  - Additional information on service authorization is located in Appendix C of the manual.
- Service Limitations
  - In addition to the "Prohibited Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
    - The provision of FFT is limited to youth under the age of 21.
    - An individual can participate in FFT services with only one FFT team at a time.
    - FFT may not be authorized concurrently for a youth* with one or more of the following:
      - Group or Family Therapy,
      - ARTS ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7 and 4.0,
      - Community Stabilization,
      - Multi-Systemic Therapy,
      - Mental Health Partial Hospitalization Program,
      - Mental Health Intensive Outpatient,
      - Assertive Community Treatment,
      - Mental Health Skill Building,

- Intensive In-Home Services.

  *other family members may be receiving one of the above services and still participate in FFT as appropriate for the benefit of the youth receiving FFT services.
  - Other Mental Health and ARTS services, Inpatient Services, and Residential Treatment Services may be authorized and billed concurrently for no more than 14 consecutive calendar days, as the youth are being admitted or discharged from FFT to other behavioral health services.
  - If the individual continues to meet with an existing outpatient therapy provider, the FFT provider must coordinate the treatment plan with the provider.
  - Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with FFT, as are E/M outpatient services for the purposes of psychiatric medication evaluation and management.
- The following activities are not covered under FFT:
  - Inactive time or time spent waiting to respond to a behavioral situation;
  - Supervision hours of the staff;
  - Therapeutic interventions or collateral contacts that are not medically necessary;
  - Time spent doing, attending, or participating in recreational activities;
  - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor;
  - Childcare services or services provided as a substitute for the parent or others responsible for providing care and supervision;
  - Respite care;
  - Transportation for the youth or family. Additional medical transportation for service needs which are not considered part of FFT program services may be covered by the transportation service through Optum. Medical transportation to Medicaid providers may be billed to the transportation broker;
  - Services not in compliance with the FFT service manual and not in compliance with fidelity standards;
  - Any art, movement, dance, or drama therapies outside the scope of the FFT model fidelity. Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers, which are not part of the ISP;
  - Anything not included in the approved FFT service description;
  - Changes made to FFT that do not follow the requirements outlined in the provider contract, this appendix, or FFT fidelity standards;
  - Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.

Exclusions

- Youth who meet any one of the criteria below are not eligible to receive FFT:
  - The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of FFT.
  - The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
  - The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors.
  - The youth's functional impairment is solely a result of Developmental Disability, as defined in the Code of Virginia § 37.2-100.

Residential Crisis Stabilization

- Residential Crisis Stabilization Units (RCSUs) provide short-term, 24/7, residential psychiatric and substance related assessment crisis evaluation and brief intervention services.
  - Individuals experiencing changes in behavior noted by impairment or decompensation in functioning that may result in the need of a higher level of care.
  - Individuals stepping down from a higher level of care that need continued monitoring, stabilization and mobilization of resources.

- Individuals who need a safe environment for assessment, stabilization, and prevention of further escalation or decompensation.

RCSUs may also provide medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis; see provider qualifications and billing guidance for further details.

The goals of Residential Crisis Stabilization Unit services are as follows but are not limited to 1) stabilize the individual in a community-based setting and support the individual and natural support system; 2) Reduction of acute symptoms; and 3) Identification and mobilization of available resources including support networks.

This service occurs in a non-hospital, community-based crisis stabilization residential units with no more than 16 beds. RCSUs may co-locate with 23- Hour Crisis Stabilization.

Admission Criteria

- Individuals must meet all of the following criteria (1-5)*:
  - 1. One of the following must be present:
    - The individual must be experiencing an active behavioral health crisis; or
    - The individual is stepping down from a higher level of care after a recent behavioral health crisis and needs continued stabilization prior to returning to the community; and
  - 2. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with an International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates to a Diagnostic and Statistical Manual (DSM) diagnosis at the time of admission and is the focus of active treatment; and
  - 3. One of the following must be present:
    - Substantial changes in behavior noted by significant impairment or decompensation in functioning related to a behavioral health crisis; or
    - Actual or potential danger to self or others as evidenced by:
      - Suicidal thoughts or behaviors and/or recent self-injurious behavior with suicidal intent; or
      - Hopelessness and helplessness likely to lead to self-injury; or
      - Threatening harm to others or homicidal ideation; or
      - Command hallucinations or delusions; or
      - Acted in unpredictable, disruptive or bizarre ways that require further immediate observation and evaluation; or
    - Significant loss of impulse control that threatens the safety of the individual and/or others; or
    - Significant inability to maintain basic care for oneself and to keep oneself safe in the community in an age appropriate manner that is not associated with dementia; or
    - Intoxication that causes significant emotional, behavioral, medical, or thought process disturbance that interfere with judgment so as to seriously endanger the individual if not monitored and evaluated; or
    - Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment; or
    - Individual does not have the ability and/or the resources to support maintenance of safety and/or stability in the community until longer term services are available/accessible or mobilized; and
  - 4. The presenting clinical problem requires a safe, contained environment wherein assessment, evaluation and treatment can be conducted to determine next steps in the individual's care; and
  - 5. Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community.

  *The medical necessity for individuals admitted under a Temporary Detention Order (TDO) issued pursuant to section §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia is established and DMAS or its contractor cannot limit or deny services specified in a TDO (see the Temporary Detention Order Supplement to the Psychiatric Services Manual for additional details).

Continuing Stay Criteria

- All of the following criteria must be met (1-8):
  - 1. The individual continues to meet admission criteria;

- 2. Another less restrictive level of care would not be adequate to meet the individual's safety;
- 3. Treatment is still necessary to reduce symptoms and improve functioning so that the individual may participate in a less restrictive level of care;
- 4. There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care;
- 5. The individual's progress is monitored regularly, and the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;
- 6. Psychiatric medication monitoring is occurring as clinically indicated;
- 7. Individual/family/guardian/caregiver/natural support is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway;
- 8. Coordination of care and active discharge planning are ongoing, with goal of transitioning the individual to a less intensive level of care.

Discharge Criteria

- Any one of the following criteria must be met:
  - The individual no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive, and that level, and that level of care is available; or
  - The individual is not making progress toward goals, nor is there expectation of any progress and a different level of care is being recommended by the supervising LMHP; or
  - Functional status is restored as indicated by one or both of the following:
    - no essential function is significantly impaired; and/or
    - an essential function is impaired, but impairment is manageable at an available lower level of care.

Service Delivery

Critical Features

- Critical Features/Covered Service Components of RCSUs include:
  - Assessments; (medical, psychiatric evaluation, nursing assessment, etc.)
  - Care Coordination;
  - Crisis intervention;
  - Health literacy counseling;
  - Individual, group and/or family therapy;
  - Peer Recovery Support Services;
  - Skills Restoration;
  - Treatment Planning
- Required Activities
  - In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to RCSUs:
  - Assessment:
    - At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment for determining medical necessity criteria and the individual's appropriateness for the service. The assessment should be completed as soon as possible after admission but no later than 24 hours after admission. The assessment requirement can be met by one of the following:
      - Providers may choose to complete a Comprehensive Needs Assessment (see Chapter IV for requirements).
      - A prescreening assessment completed by the provider.
      - If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment.
      - A DBHDS approved assessment for residential crisis stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
      - For individuals admitted with a primary diagnosis of substance use disorder, providers may choose to complete a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual.
      - A psychiatric evaluation by a psychiatrist, or psychiatric nurse practitioner is required.
      - At a minimum, a brief psychiatric intake assessment completed by a psychiatrist or psychiatric nurse practitioner must be completed within four hours of admission to ensure that there are no medical or

psychiatric needs that warrant immediate referral to a higher level of care. This brief psychiatric intake assessment can be completed in person, via telehealth or RCSU staff telephonic consultation with the psychiatrist, nurse practitioner or physician assistant, to identify and address any potential immediate medical or psychiatric needs.
    - A comprehensive psychiatric evaluation must be completed within 24 hours of admission.
    - The RCSU provider may use a psychiatric evaluation completed within 24 hours prior to admission by a psychiatrist or psychiatric nurse practitioner to meet this requirement. Documentation that the RCSU psychiatrist or psychiatric nurse practitioner has reviewed and updated (as clinically necessary) the evaluation within four hours of admission, must be in the clinical record.
    - RCSU providers must have 24 hour in-person nursing. (RCSU providers have until 11/30/2022 to fully meet this requirement).
    - At a minimum, a nursing assessment must be completed at the time of admission to determine current medical needs. Nursing can be shared among co-located programs.
- Care Coordination
    - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
    - Appropriate transition to the next level of care shall be required. Documentation must include a demonstration of active transitioning from RCSU to an appropriate level of care for ongoing behavioral health services which includes care coordination and communication with the individual's MCO or FFS Contractor, service providers and other collateral contacts.
    - Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports.
- Crisis Intervention
    - Development of a plan to maintain safety in order to prevent the need for a higher level of care; or
    - Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; or
    - If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.
- Treatment Planning
    - Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S.
    - The following components must be available to individuals in the treatment program and provided in accordance with the individual's ISP:
        - Individualized treatment planning;
        - Individual, group and family therapies;
        - Nursing in-person 24/7*;
        - Skill restoration/development and health literacy counseling;
        - Assessment and psychiatric evaluation as well as additional clinically indicated psychiatric and medical consultation services must be available;
        - Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral;
        - Crisis intervention and safety planning support available 24/7;
        - Peer recovery support services, offered as an optional supplement for individuals;
        - Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:
            - The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;
            - The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;
            - The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers;
            - To bill the per diem on days other than the day of admission, providers must provide daily individual, group or family therapy unless the LMHP, LMHP-R, LMHP-RP or LMHP-S documents the reason why therapy is not clinically appropriate. In addition, providers must, at a minimum, provide at least two of the following daily:

        - Crisis Interventions
        - Health Literacy Counseling
        - Peer Recovery Support Services
        - Psychiatric Evaluation
        - Skill Restoration
    - Services must be provided in-person with the exception of the psychiatric evaluation and care coordination.
- Provider Qualifications
    - Residential Crisis Stabilization Unit service providers must be licensed by DBHDS as a provider of Residential Crisis Stabilization Programs, Group Home Service REACH or DD Group Home Service REACH, and be enrolled with DMAS. If RCSUs choose to provide ASAM 3.7- (medically monitored intensive inpatient) services, they must also be licensed by DBHDS for the ASAM 3.7 services.
    - If RCSUs provide services to an individual under a Temporary Detention Order, the provider must have a stipulation on their DBHDS license authoring the provider to serve individuals who are under a Temporary Detention Order in accordance with 12VAC35-105-580. This service must be provided in a DBHDS licensed location that meets the physical site requirements within DBHDS Licensing Regulations. The licensed location must be identified on the provider's DBHDS license. Services may not be provided in other locations outside of the licensed site.
    - Residential Crisis Stabilization Unit providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.
- Staff Requirements
    - Residential Crisis Stabilization Units must be staffed with a multidisciplinary team of physicians, nurses, LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHP-As, QMHP-Cs, QMHP-Es CSACs CSAC-Supervisees, CSAC-As, RNs, LPNs and a registered peer recovery specialist. Residential aide level staff can also provide services and support under the supervision of a QMHP-A or QMHP-C.
    - A LMHP (who is acting within the scope of their professional license and applicable State law) must supervise this program.
    - A licensed psychiatrist or psychiatric nurse practitioner (who is acting within the scope of their professional license and applicable State law) must be available to the program 24/7 either in person or via telemedicine to provide assessment, treatment recommendations and consultation meeting the licensing standards for residential crisis stabilization and medically monitored withdrawal services at ASAM level 3.7. A nurse practitioner or physician assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist.
    - Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP.
    - Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee*, or CSAC-A*.
    - Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
    - Health Literacy Counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management.
    - Individual, Group, and Family Therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
    - Nursing services must be provided by either a RN or an LPN who is present on the unit. The LPN must work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70.
    - Peer Recovery Support Services` must be provided by a Registered Peer Recovery Specialist.
    - Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a residential aide under the supervision of at least a QMHP-A or QMHP-C.
    - Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee*
      *CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2.
    - Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.
- Service Authorization

- Providers must submit a registration to the individual's MCO or FFS contractor within one business day of admission. The registration permits five calendar days/five units of service. Units billed must reflect the treatment needs of the individual and be based on the individual meeting medical necessity criteria.
- If additional activities beyond 5 calendar days/5 units are clinically required, the provider shall submit an authorization request to Optum through a continued stay service authorization request submitted no earlier than 48 hours before the requested start date of the continued stay and no later than the requested start date by the following items:
  - An assessment meeting one of the following:
    - A Comprehensive Needs Assessment (see Chapter IV for requirements);
    - A prescreening assessment completed by the provider;
    - An update or addendum to the prescreening assessment;
    - A DBHDS approved assessment for residential crisis stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S;
    - For individuals admitted with a primary diagnosis of substance use disorder, a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual; and
    - A current addendum to the above assessment, (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; and
    - Nursing Assessment; and
    - Psychiatric Evaluation; and
    - Individual Service Plan; and
    - A safety plan; and
- Documentation of care coordination.
  - Service authorization requests may require the submission of documentation of referrals to post-discharge services at the appropriate level of care based on the assessed needs of the individual.
- If a provider is licensed for both RCSU and for the provision of ASAM 3.7-WM, and an individual is admitted to the RCSU for withdrawal management services, the provider should bill for the Addiction and Recovery Treatment Services until withdrawal management is no longer needed. At that time, they may submit a registration for RCSU services.
- Consecutive registrations from the same or different provider are not allowed. A service authorization is required if additional service is required beyond the 5 calendar days/5 units.
- Additional information on service authorization is located in Appendix C of the manual.

- Residential Crisis Stabilization Billing Requirements
  - One unit of service equals one calendar day and is reimbursed as a per diem. The day of admission is billable regardless of the time of admission.
  - Day of discharge is billable if the minimum required activities to bill the RCSU per diem are met.
  - The same provider cannot bill multiple per diems in the same calendar day of 23-Hour Crisis Stabilization (S9485), RCSU (H2018) or ARTS services that are paid at a per diem rate.
  - Mobile Crisis Response, Community Stabilization, 23-Hour Crisis Stabilization may be billed on the same day as RCSU; however, services may not be delivered simultaneously.
  - Individuals who meet criteria for RCSU may transition from ASAM Level 3.7 to RCSU services.
  - Individuals likely to need greater than 23 hours of stabilization should be directly admitted to RCSU versus admitting to 23-Hour Crisis Stabilization.
  - A psychiatric evaluation may be provided through telemedicine. Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use telemedicine modifiers. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.
  - Billing Code: H2018; Unit – Per Diem; Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).
  - Billing Code: H2018; Modifier – 32; Unit – Per Diem; Description - Residential Crisis Stabilization Emergency Custody Order; Notes - Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service. Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).

- Billing Code: H2018; Modifier – HK; Unit – Per Diem; Description - Residential Crisis Stabilization Temporary Detention Order; Notes - Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service. Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).

Exclusions and Service Limitations

- Any one of the following criteria is sufficient for exclusion from this level of care:
  - The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting due to violent aggression or other anticipated need for physical restraint, seclusion or other involuntary control; or
  - The individual's medical condition is such that it can only be safely treated in a medical hospital as deemed by a physician
- In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:
  - RCSUs may not be billed concurrently with any other behavioral health service except when a service overlap with other community behavioral health services is needed as part of a safe discharge plan. Documented justification of the time needed for discharge planning and care coordination to other services is required. Overlap durations will vary depending on the documented needs of the individual and the intensity of the services but in no instances may exceed 48 hours.
  - Mobile Crisis Response, Community Stabilization, 23-Hour Crisis Stabilization may be billed on the same day as RCSU; however, services may not be delivered simultaneously.
  - Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010.

23-Hour Crisis Stabilization

23-Hour Crisis Stabilization provides ongoing assessment, crisis intervention and clinical determination for level of care to individuals experiencing a behavioral health crisis. Services are provided for a period of up to 23 hours in a community and center-based crisis stabilization setting including outpatient hospital settings that have an Outpatient Crisis Stabilization license. This service must be accessible 24/7 and is indicated for those situations wherein an individual is experiencing a behavioral health crisis and requires a safe environment for observation and assessment prior to determination of the next level of care. Although not required, 23-Hour Crisis Stabilization services typically co-locate with RCSUs as part of a continuum of crisis care.

23-Hour Crisis Stabilization is appropriate for individuals who have urgent behavioral health needs including but not limited to significant emotional dysregulation, disordered thought processes, substance use and intoxication resulting in behavioral crisis and environmentally de-stabilizing events that require multi-disciplinary crisis intervention and observation to stabilize the immediate crisis and determine the next appropriate step in the plan of care.

- The goals of this service include but are not limited to:
  - Opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full 23 hours of service to determine the best resources available for the individual to prevent unnecessary hospitalization.
  - Assessment:
    - Psychiatric evaluation
    - Further diagnostic testing (drug screens, lab tests and monitoring for emergent medical needs),
    - Level of care determination
  - Care Coordination
    - Screening and referral for appropriate behavioral health services and community resources.
  - Crisis Intervention:
    - Improvement of acute symptoms
    - Resolution of acute intoxication
    - Safety planning
  - Health Literacy Counseling:
    - Provision of medication (if clinically indicated) and monitoring of response

- Targeted education concerning diagnosis and treatments

Admission Criteria

- All of the following criteria must be met (1-5)*:
  - 1. The individual must be experiencing an active behavioral health crisis; and
  - 2. Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with an International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates to a Diagnostic and Statistical Manual (DSM) diagnosis at the time of admission and is the focus of active treatment and
  - 3. The individual or collateral contact reports at least one of the following:
    - a. suicidal/assaultive/destructive ideas, threats, plans or actions; or
    - b. an acute or increasing loss of control over thoughts, behavior and/or affect that could result in harm to self or others; or
    - c. functional impairment or escalation in mood/thought/behavior that is disruptive to home, school, or the community or impacting the individual's ability to function in these settings; or
    - d. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; or
    - e. Acute stress reaction that threatens to lead to significant emotional and/or behavioral deterioration without rapid intervention, evaluation, and treatment; and
  - 4. There is evidence of at least one of the following:
    - a. Indication that the symptoms will adequately resolve or stabilize within a 23 hour period at which time a less restrictive level of care will be appropriate; or
    - b. The presenting clinical problem requires a safe, contained environment wherein observation and assessment can be conducted to determine next steps in the individual's care; and
  - 5. Without urgent intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community.

  ** The medical necessity for individuals admitted under a Temporary Detention Order (TDO) issued pursuant to section §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia is established and DMAS or its contractor cannot limit or deny services specified in a TDO (see the Temporary Detention Order Supplement to the Psychiatric Services Manual for additional details).*

Continuing Stay Criteria

There is no continued stay for this service, the service is a total maximum of 23 hours per episode.

Discharge Criteria

- Regardless of the individual's clinical status, the service requires that individuals be discharged within 23 hours. The point at which that discharge occurs within that time frame may depend on:
  - Whether the individual no longer meets admission criteria or meet criteria for a less or more intensive level of care;
  - Determination and availability of the service or natural supports to which the individual is to be discharged into the care of.

Service Delivery

- Covered service components of 23-Hour Crisis Stabilization include:
  - Assessment
  - Care Coordination
  - Crisis Intervention
  - Health Literacy Counseling
  - Individual and Family Therapy
  - Peer Recovery Support Services
  - Skills Restoration
  - Treatment Planning
- Required Activities
  - The following required activities apply to 23-Hour Crisis Stabilization:
    - Assessment:

- At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment for determining medical necessity criteria and the individual's appropriateness for the service. The assessment requirement can be met by one of the following:
    - Providers may choose to complete a Comprehensive Needs Assessment (see Chapter IV for requirements).
    - A prescreening assessment completed by the provider.
    - If a prescreening assessment has been completed within 72 hours prior to admission by another provider, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment.
    - A DBHDS approved assessment for 23-Hour Crisis Stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
    - For individuals admitted with a primary diagnosis of substance use disorder, provides may choose to complete a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual.

- A psychiatric evaluation by a psychiatrist or psychiatric nurse practitioner
    - The 23-Hour Crisis Stabilization provider may use a psychiatric evaluation completed within 24 hours prior to admission by a psychiatrist or psychiatric nurse practitioner to meet this requirement. Documentation that the 23-Hour Crisis Stabilization psychiatrist or psychiatric nurse practitioner has reviewed and updated (as clinically necessary) the evaluation at admission must be in the clinical record.
    - 23-Hour Crisis Stabilization providers must have 24 hour in-person nursing. At a minimum, a nursing assessment must be completed at the time of admission to determine current medical needs. Nursing can be shared among co-located programs.
- Care Coordination
    - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
    - Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports.
    - Appropriate transition to the next level of care shall be required. Documentation must include a demonstration of active transitioning from 23-hour crisis stabilization to an appropriate level of care for ongoing behavioral health services which includes care coordination and communication with the individual's MCO or FFS Contractor, service providers and other collateral contacts.
- Crisis Intervention
    - Development of a plan to maintain safety in order to prevent the need for a higher level of care; or
    - Completion of a Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. The CEPP meets the safety plan requirement; or
    - If there is an existing Crisis Education and Prevention Plan (CEPP), the provider may review the CEPP and update as necessary with the individual. The CEPP meets the safety plan requirement.
- The following components must be available to individuals in the treatment program and provided in accordance with the individual's assessed needs:
    - Individualized treatment planning;
    - Individual, and family therapy;
    - Nursing on-site 24/7;
    - Skill restoration/development and health literacy counseling;
    - Assessment and evaluation as well as additional clinically indicated psychiatric and medical consultation services;
    - Medical, psychological, psychiatric, laboratory, and toxicology services available on-site or by consult or referral;
    - Crisis intervention and safety planning support available 24/7;
    - Peer recovery support services, offered as an optional supplement for individuals;
    - Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:
        - The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;
        - The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served;

        - The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.
    - At a minimum, required components of 23-Hour Crisis Stabilization include: assessment (psychiatric, nursing, and LMHP), crisis intervention and care coordination. Providers must have the capacity to provide any of the above components for up to 23 hours based on the individual's needs.
    - Services must be provided in-person with the exception of the psychiatric evaluation and care coordination.
    - Service delivery must be individualized. Group delivery of service components is not appropriate for this service.
- Provider Qualifications
    - 23-Hour Crisis Stabilization service providers must be appropriately licensed by DBHDS as an Outpatient Crisis Stabilization provider and enrolled with DMAS (see Chapter II).
    - This service must be provided in a licensed location that meet DBHDS physical site requirements within the Licensing Regulations. The licensed location must be identified on the provider's DBHDS license. Services may not be provided in other locations outside of a DBHDS licensed site.
    - 23-Hour Crisis Stabilization providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.
    - If the provider provides services to an individual under a Temporary Detention Order, the provider must have a stipulation on their DBHDS license authoring the provider to serve individuals who are under a Temporary Detention Order in accordance with 12VAC35-105-580.
- Staff Requirements
    - 23-Hour Stabilization services involve a multi-disciplinary team of physicians, nurses, LMHPs, LMHP-R, LMHP-RP, LMHP-S, QMHP-As, QMHP-Cs, QMHP-Es, CSACs, CSAC-Supervisees, CSAC-As, RNs, LPNs and/or registered peer recovery specialists within their scope of practice. Residential aide level staff can also provide supervision of the individual during the service under the supervision of an LMHP.
    - These programs must be supervised by a LMHP who is acting within the scope of their professional license and applicable State law.
    - A licensed psychiatrist or psychiatric nurse practitioner (who is acting within the scope of their professional license and applicable State law) must be available to the program 24/7 either in person or via telemedicine to provide assessment, treatment recommendations and consultation. A nurse practitioner or physician assistant working under the licensed psychiatrist may provide this coverage for the psychiatrist.
    - Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHPRP.
    - Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
    - Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
    - Health Literacy Counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management.
    - Individual and Family Therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S.
    - Nursing services must be provided by either a RN or a LPN who is present on the unit. The LPN must work directly under the supervision of an RN or licensed medical practitioner in accordance with 18VAC90-19-70.
    - Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.
    - Skills Restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a residential aide under the supervision of at least a QMHP-A or QMHP-C.
    - Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee*.
      *CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2.
    - Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. RNs and LPNs shall hold an active license issued by the Virginia Board of Nursing or hold a multistate licensure privilege pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.
- Service Authorization
    - 23-Hour Crisis Stabilization reimbursement is authorized through a registration process for one 23-hour episode/1 unit. Submission of registrations must be within 1 business day of admission.
    - Providers must submit a registration for one 23-hour episode/one unit to Optum within one business day of admission.

- Consecutive registrations from the same or different provider are not permitted.
- Additional information on service authorization is located in Appendix C of the manual.

- Documentation and Utilization Review
  - The individual's clinical record must reflect either resolution of the crisis which marks the end of the current episode or the discharge plan to an appropriate service to manage the ongoing symptoms associated with the crisis. Refer to Chapter VI of this manual for documentation and utilization review requirements.
- 23-Hour Crisis Stabilization Billing Requirements
  - One unit of service equals 23.00 hours and is reimbursed as a per diem.
  - The billing date is the day of admission and per diems cannot be billed on two consecutive calendar days.
  - If an individual is admitted to 23-Hour Crisis Stabilization and it is determined that RCSU services are needed, the provider should bill the first 23.00 hours with the 23-Hour Crisis Stabilization (S9485) procedure code and the Residential Crisis Stabilization Unit (H2018) procedure code for any subsequent 24-hour period. The provider should not bill multiple per diems for the first 24-hours of care and must request appropriate service registration for each service.
  - The same provider cannot bill multiple per diems in the same calendar day for 23-Hour Crisis Stabilization (S9485), RCSU (H2018) or ARTS services that are paid at a per diem rate.
  - Psychiatric evaluation may be provided through telemedicine. Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement", including the use of telemedicine modifiers. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.
  - Billing Code: S9485; Unit – Per Diem; Description - 23-Hour Crisis Stabilization; Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).
  - Billing Code: S9485; Modifier – 32; Unit – Per Diem; Description - 23-Hour Crisis Stabilization – Emergency Custody Order; Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).
  - Billing Code: S9485; Modifier – HK; Unit – Per Diem; Description - 23-Hour Crisis Stabilization – Temporary Detention Order; Provider Qualifications - Service components must be provided by a qualified provider (see Provider qualification and staff requirements section).

Exclusions and Service Limitations

- The individual is not appropriate for this service if there is a presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care.
- Temporary housing shall not be conditioned upon an individual receiving any crisis service and housing (including temporary housing) is not a reimbursable component of this service. If an individual meets admission criteria for this service and housing is an assessed need, this should be noted as a need on the registration to support coordination of resources for the individual. While loss or lack of housing may contribute to a behavioral health crisis, the solution to the housing need must be addressed through non-Medicaid funding or services related to housing. 23-hour Crisis Stabilization should address the behavioral health crisis triggered by the stressor of a housing problem using interventions and a plan directed explicitly at the behavioral health needs and symptoms. Providers are prohibited from using Medicaid reimbursement to cover housing costs for an individual and any funds used for this purpose will be retracted.
- Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010.

References

Commonwealth of Virginia. (2022). Mental Health Services Manual, Appendix G: Comprehensive Crisis Services.

Commonwealth of Virginia. (2021). Mental Health Services Manual, Chapter II: Provider Participation Requirements.

Commonwealth of Virginia. (2021). Mental Health Services Manual, Chapter IV: Covered Services and Limitations.

Commonwealth of Virginia. (2021). Mental Health Services Manual, Chapter VI: Utilization Review and Control.

Commonwealth of Virginia. (2018). Community Mental Health Rehabilitative Services Manual, Behavioral Therapy Program Supplement.

Commonwealth of Virginia. (2017). Community Mental Health Rehabilitative Services Manual, EPSDT Supplement B.

Commonwealth of Virginia. (2019). Community Mental Health Rehabilitative Services Manual, Peer Services Supplement.

The Council of Autism Service Providers. (2014, reaffirmed 2020). Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers. Second edition. Copyright © by The Council of Autism Service Providers (CASP), all rights reserved.

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

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

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

Virginia Medicaid (2021). Provider Manuals website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Revision History

Date	Summary of Changes
08/31/2017	Version 1 – Behavioral Therapy Services Under EPSDT
04/11/2018	• Version 2 – Added: ○ Day Treatment/Partial Hospitalization ○ Mental Health Case Management ○ Psychosocial Rehabilitation Therapeutic Day Treatment
05/09/2018	• Version 3 – Added: ○ Crisis Intervention Services ○ Crisis Stabilization Services ○ Intensive Community Treatment Services ○ Intensive In-Home (IIH) Services for Children and Adolescents ○ Mental Health Skills Building ○ Peer Support Services and Family Support Partners Consolidated all guidelines into one document on the new guideline template.
07/12/2019	• Version 4 ○ Added National LOCG language to sections: Common Criteria- Admission; Best Practices- Evaluation and Treatment planning ○ Updated per state specific language to sections: Behavioral Therapy Services- Continuation of Services; Crisis Stabilization Services- Admission Criteria; Day Treatment/Partial Hospitalization-Continuing Stay Criteria ○ Per state specific updates, removed language references to “At-Risk of Physical Injury” form Updated references
January 31, 2020	• Version 5: Added Evidence-Based Practice Criteria section, updated references, removed LOCUS/CASI/ECSII language for mental health and wraparound services.
June 21, 2021	• Version 6: Annual Review; Removed Evidence-Based Practice Criteria section.

Date	Summary of Changes
July 28, 2021	• Version 7: Added IOP, PHP, ACT services effective 07/01/2021
November 16, 2021	• Version 8: Added MST, FFT, Mobile Crisis, Community Stabilization, 23-hour Observation, Residential Crisis Stabilization, ABA services effective 12/01/2021
July 19, 2022	• Annual Review
October 18, 2022	• Version 9: Revisions to Community Stabilization, Mobile Crisis, Residential Crisis Stabilization, and 23-Hour Crisis Stabilization.

[i] At Risk of Hospitalization means one or more of the following:

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

[ii] Out of Home Placement means placement in one or more of the following:

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