CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV

Mental health services covered in this manual include: Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health Services (EBH), Mental Health Case Management (MHCM), and Treatment Foster Care Case Management (TFC-CM). This chapter describes general requirements for the provision of these mental health services. Providers should refer to the below Appendices and Supplement for information on definitions, service authorization and additional service specific requirements.

Appendix A: Definitions

Appendix C: Service Authorization

Appendix D: Intensive Community Based Support Youth
- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Applied Behavior Analysis (ABA)

Appendix E: Intensive Community Based Support
- Assertive Community Treatment (ACT)

Appendix F: Intensive Clinic Based Support
- Mental Health Intensive Outpatient (MH-IOP)
- Mental Health Partial Hospitalization Program (MH-PHP)

Appendix G: Comprehensive Crisis and Transition Services
- Mobile Crisis Response
- 23-Hour Crisis Stabilization
- Residential Crisis Stabilization Unit (RCSU)
- Community Stabilization

Appendix H: CMHRS
- Intensive In-Home (IIH)
- Therapeutic Day Treatment (TDT)
- Psychosocial Rehabilitation (PSR)
- Mental Health Skill-Building Services (MHSS)

Appendix I: Case Management
- Mental Health Case Management (MHCM)
- Treatment Foster Care – Case Management (TFC-CM)

Peer Recovery Support Services Supplement
- Mental Health Peer Support Services
- Mental Health Family Support Partners

Information on additional Behavioral Health services covered by the Department of Medical Assistance Services (DMAS) are located in the Addiction and Recovery Treatment Services (ARTS) Manual, Psychiatric Services Manual, and Residential Treatment Services Manual located on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

All providers of CMHRS, EBH, MHCM and TFC-CM are responsible for adhering to this manual, available on the DMAS website portal, their provider contract with the Managed Care Organizations (MCOs) and all DMAS policies and state and federal regulations.

FEE FOR SERIVCES (FFS) SERVICE AUTHORIZATION CONTRACTOR

Acentra serves as the current FFS service authorization contractor for medical and behavioral health services provided under Medicaid FFS. Acentra performs the following FFS behavioral health related functions: service registration and authorization of behavioral health services; maintains a behavioral health crisis hotline; provides training to providers and stakeholders; conducts member outreach and education; and, performs utilization management for members in FFS.

Providers may contact Acentra directly by phone at 1-888-827-2884 or via email at VAproviderissues@kepro.com. The Acentra website is located at: https://dmas.kepro.com

MEDICAID MANAGED CARE

For MCO members, most Medicaid services are provided through the member's MCO Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the contractual coverage, and reimbursement guidelines for services provided through the MCO.

Certain services, however, are carved out of managed care and will continue to be obtained through FFS (such as Dental Services, School Based Health Services and Residential Treatment Services). A complete list of carved out services are located in the MCO contracts posted online on the Cardinal Care Managed Care page at: https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/

Managed Care Coverage of Mental Health Services

The following services are included in the Cardinal Care Managed Care contract utilizing DMAS' current Mental Health coverage criteria and program requirements. :

- Assertive Community Treatment (H0040)
- Mental Health Intensive Outpatient (MH-IOP) (S9480)
- Mental Health Case Management (H0023)

- Therapeutic Day Treatment (TDT) / Assessment (H2016/H0032 U7)
- Mental Health Partial Hospitalization Program (MH-PHP) (H0035)
- Mental Health Skill-building Services (MHSS)/Assessment (H0046/H0032 U8)
- Intensive In-Home/Assessment (H2012/H0031)
- Psychosocial Rehab (H2017/H0032 U6)
- Mobile Crisis Response (H2011)
- Community Stabilization (S9482)
- 23-Hour Crisis Stabilization (S9485)
- Residential Crisis Stabilization Unit (H2018)
- Multisystemic Therapy (H2033)
- Functional Family Therapy (H0036)
- Applied Behavior Analysis (97151 – 97158, 0362T and 0373T)*
- Mental Health Peer Support Services or Family Support Partners – Individual (H0024)
- Mental Health Peer Support Services or Family Support Partners – Group (H0025)

For additional information, please refer to the "ARTS and MHS Doing Business with the MCOs Spreadsheet" available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/provider-resources/.

Carved Out Services

TFC-CM and Therapeutic Group Home Services (formerly known as Level A and Level B) are carved-out of Cardinal Care Managed Care at this time and remain covered through FFS. For additional information on Therapeutic Group Home Services, please see the Residential Treatment Services Manual.

FAMIS and FAMIS MOMS

FAMIS enrollees and FAMIS MOMS enrollees under age 21 who are covered by Cardinal Care Managed Care have limited mental health services benefits that include:

- Mental Health Partial Hospitalization Program (MH-PHP)
- Mental Health Intensive Outpatient (MH-IOP)
- Assertive Community Treatment (ACT)
- Mobile Crisis Response
- Community Stabilization
- 23-Hour Crisis Stabilization
- Residential Crisis Stabilization Unit
- Multisystemic Therapy
- Functional Family Therapy
- Applied Behavior Analysis
- Intensive In-Home Services
- Therapeutic Day Treatment
- Mental Health Case Management for Children at Risk of Serious Emotional

Disturbance Children with Serious Emotional Disturbance
- Peer Recovery Support Services

Cardinal Care Managed Care MCOs manage mental health services for their enrolled members.

Program of All-Inclusive Care for the Elderly (PACE)

Mental Health Services for individuals enrolled in PACE are provided by the individual's PACE Program. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/.

CARE COORDINATION

The purpose of care coordination is to ensure that the individual receives all needed services and supports in the most effective and efficient manner. Care coordination facilitates informed and congruent treatment planning, enables open communication among all treating providers, and ensures needed resources are integrated and well-coordinated. Care coordination is based on 1) an assessment conducted by a care coordinator and 2) a centralized plan of care. Care Management includes care coordination, but is primarily conducted telephonically and is typically performed by a benefits administrator or managed care company. This is in order to include network and claims data and trend analysis for enhanced care planning for individual cases.

Case Management is case specific; it is a covered service rendered by network providers in collaboration with a care coordinator or care manager. Case Managers partner with care coordinators or care managers to ensure needed services are covered for reimbursement and community resources are maximized to best support the individual's opportunity for recovery and treatment success.

Individuals enrolled in Cardinal Care Managed Care receive care management that integrates the medical and psychosocial models of care through a person centered approach through a MCO assigned care coordinator.

Coordination with Targeted Case Management

Targeted Case Management (TCM) is a covered service provided by contracted community providers. TCM includes case management for Addiction and Recovery Treatment Services (ARTS), mental health, developmental disabilities, treatment foster care, early intervention, and high risk prenatal and infant services. If an individual is receiving TCM, the assigned care coordinator or care manager will work collaboratively with the TCM provider to coordinate needed services in the community.

Care Coordination Requirements of Mental Health Providers

Mental Health providers provide care coordination in order to centralize comprehensive care planning efforts among various service types and providers. Care coordination is done in the spirit of collaboration with the treatment team and

is meant to support the youth on his or her path of recovery**.** Mental health providers are responsible for care coordination activities that include both behavioral health and medical needs as documented in the ISP.

These care coordination activities include:

- Assisting the individual access and appropriately utilize needed services and supports;
- Assisting the individual overcome barriers in order to maximize the use of these resources;
- Actively collaborating with all internal and external service providers to achieve open communication and integration of all needed services;
- Coordinating all services and supports, including all active treating service providers and the individual's family members and significant others involved in the individual's life;
- Assessing the effectiveness of these services/supports based on the individual's progress and unique circumstances;
- Preventing duplication of services or the provision of unnecessary interventions and supports; and
- Revising the ISP as clinically indicated and ensuring that service planning is inclusive of and consistent with other services being provided to the individual.

Care coordination between all service providers is required and must be documented in the ISP and Progress Notes. Coordination serves to help align services to prevent duplication is intended to complement the service planning and delivery efforts of each service. Providers must collaborate and openly communicate with other treating health care providers regarding active clinical care planning. Persons who routinely come in contact with the individual, or are involved in the individual's health care and recovery (i.e. PCPs, Case Managers, Probation Officers, Teachers, etc.), shall be included in the care coordination process to help support the individual and their overall wellbeing and care.

The provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of CMHRS or EBH services. Any additional care coordination with the individual's primary care provider or pediatrician shall also be documented and include efforts to schedule well visits for youth and as needed physician visits for adults. The documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

If an individual is receiving any mental health service and is also receiving TCM services, the mental health provider shall collaborate with the case manager by notifying the case manager of the provision of mental health services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the case manager within 30 calendar days of the discontinuation of services. Service providers and case managers who are using the same electronic health

record for the individual shall meet requirements for delivery of the notification, monthly updates, and discharge summary upon entry of this documentation into the electronic health record.

TELEHEALTH

Coverage of services delivered by telehealth are described in the "Telehealth Services Supplement". MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

ADVERSE OUTCOMES

Providers must follow notification and reporting processes for reporting adverse outcomes and critical incidents as required by applicable Local, State and Federal regulatory bodies and contracts with the MCOs and DMAS.

RECOVERY AND RESILIENCY

DMAS encourages the provider network to integrate principles into their practices and service delivery operations including providing high quality, consumer-focused, recovery- based behavioral health services for individuals enrolled in Virginia Medicaid. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential. Recovery is built on access to evidence- based clinical treatment and recovery support services for all populations (https://www.samhsa.gov/recovery).

A person's recovery is built on his or her strengths, talents, coping abilities, resources, and inherent values. It is holistic, addresses the whole person and their community, and is supported by peers, friends, and family members. Because recovery is a highly individualized process, recovery services and supports must be flexible to ensure cultural relevancy.

Resilience refers to an individual's ability to cope with adversity and adapt to challenges or change. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be better prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery.

A recovery focus is also a preventive approach that simultaneously supports building resiliency, wellness, measurable recovery and quality of life.

CULTURAL AND LINGUISTIC COMPETENCY

DMAS encourages providers to demonstrate an understanding and respect for each

individual's health-related beliefs and cultural values through the establishment of policies, practices and allocation of resources that support culturally and linguistically appropriate services. Culture has a significant impact on how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. It also affects every aspect of an individual's life, including how they experience, understand, and express, mental and emotional distress, illness and conditions.

Development of cultural and linguistic competency means that providers have the ability to value diversity, adapt to diverse populations, obtain any needed education and training in order to enhance cultural knowledge, work within values and beliefs that may be different from their own, and be capable of evolving over extended periods of time as cultures change.

Providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS) should refer to DBHDS for guidance in this area.

PROVIDER LICENSING AND CREDENTIALING REQUIREMENTS

All provider sites must be credentialed by the DMAS contractor, licensed by DBHDS as applicable and in compliance with all requirements as defined in DMAS, Department of Health Professions (DHP) and DBHDS regulations. Please refer to the service specific sections for specific licensing requirements. Payments shall not be permitted to health care entities that hold provisional DBHDS licenses. Providers must have the correct service license from DBHDS or DHP license as applicable in order to secure service authorizations and registrations, provide the service and be reimbursed for the service. Obtaining a license through DBHDS and/or DHP does not guarantee credentialing and contracting with DMAS or its contractors.

Please note that per 12VAC35-105:

- DBHDS requires the supervision of services that are intensive and clinical in nature such as IIH or TDT, must be provided by a LMHP or LMHP-S, LMHP-R, or LMHP-RP.

- DBHDS requires the supervision of services that are supportive in nature such as psychosocial rehabilitation or MHSS must be provided by a LMHP, LMHP-S, LMHP-R, LMHP-RP or QMHP-A.

PROVIDER STAFF REQUIREMENTS

Mental health providers are responsible for ensuring that employed or contracted staff meet the service-specific staff requirements of all services rendered by the service provider including licensure or registration, as appropriate, by a health regulatory board at the Department of Health Professions (DHP). Staff shall only work within the scope of practice as defined by the applicable DHP health regulatory

board.

Providers shall maintain documentation that demonstrates that individuals providing services have the required qualifications as defined in this chapter and the service specific appendices to this manual. Providers shall maintain copies of DHP licenses or registrations for staff required to be licensed or registered by DHP and documentation of qualifications for Qualified Paraprofessional in Mental Health (QPPMHs) and case managers to ensure that the assessments and services were provided by appropriately qualified individuals as defined in this chapter and in the service specific appendices of this manual.

Documentation must support that service components were provided by qualified staff that meet the minimum requirement for the service component being delivered as defined in the service specific appendices to this manual. For services where individual counseling/therapy is a required service component for reimbursement, services must be provided face-to-face and one-on-one by a LMHP, LMHP-R, LMHP-RP or LMHP-S.

Training and Supervision Requirements

Qualified Paraprofessional in Mental Health (QPPMH)

According to DBHDS regulations 12VAC35-105-20, individuals can complete 90 hours of classroom training to meet the QPPMH training qualification. An outline for a DMAS and DBHDS approved QPPMH training is included as an exhibit to this chapter.

Supervision of a QPPMH by a QMHP-C, QMHP-A, or LMHP, LMHP-R, LMHP-RP or LMHP-S is demonstrated by a review of progress notes, the individual's progress toward achieving ISP goals and objectives, and recommendations for change based on the individual's status. Supervision must occur monthly. Documentation that supervision occurred must be in the individual's clinical record and signed by the supervisor. Individual, group, or a combination of individual and group supervision is acceptable.

Certified Substance Abuse Counselors (CSACs), CSAC- Supervisees and CSAC-Assistants

Providers shall follow the Board of Counseling scope of practice for CSACs, CSAC-Supervisees and CSAC-Assistants which is defined in the Guidance Document 115-11. The Board of Counseling requires CSACs, CSAC-Supervisees and CSAC-Assistants to practice under supervision, also defined in the Guidance Document 115-11.

In addition, when Medicaid reimbursable services are provided by a CSAC-Supervisee or CSAC-Assistant, the supervising provider shall co-sign and date the progress note entry within three business days from the date the service was rendered indicating that they have reviewed the note. CSACs and CSAC Supervisees are allowed to do the ASAM multidimensional assessment to make recommendations for a level of care as well as develop the individual service plan and must be signed off by a licensed professional.

Supervision of QMHPs

The QMHP-E staff must have at least one hour of supervision per week by a LMHP, LMHP-R, LMHP-S or LMHP-RP which must be documented in the employee file. Evidence of compliance with the QMHP-E criteria must be in the staff file.

Department of Health Professions Registration

For reimbursement purposes, DMAS requires QMHP-A, QMHP-C and QMHP-Trainee (QMHP-E) staff to be registered with the Board of Counseling. Applicants may apply for QMHP registration by submitting an online application, fee and supplemental documentation with the Board of Counseling. For more information please visit the Board of Counseling website: https://www.dhp.virginia.gov/counseling/counseling_QMHP.html

Effective January 1, 2019, DMAS and its contractors will deny reimbursement for services rendered by QMHP-A, QMHP-C and QMHP-Trainee (QMHP-E) staff who are not registered with the Board of Counseling.

Variance for Staff Working with Adults and Children

Effective 1/1/2019, all QMHP staff must be registered with the Board of Counseling. DMAS no longer recognizes variance staff who have not registered with the Board of Counseling as approved providers of these services.

GENERAL SERVICE PROVISION REQUIREMENTS FOR ALL MENTAL HEALTH SERVICES

Mental health services are behavioral health interventions in nature and are intended to provide clinical treatment to those individuals with significant mental illness or children with, or at risk of developing, serious emotional disturbances. Mental health services include benefits available to individuals who meet the service specific medical necessity criteria based on diagnoses made by a Licensed Mental Health Professional (LMHP), LMHP-R, LMHP-S or LMHP-RP within the scope of their practice.

- LMHPs must adhere to the practice guidelines outlined by the ethical guidelines of the assigned professional board governing that license.

- Clinical services including assessments, Comprehensive Needs Assessments and individual, group and family therapy/counseling must be provided by a LMHP, LMHP-R, LMHP-RP or an LMHP-S. Refer to the Comprehensive Needs Assessment section of this chapter for exceptions to this requirement.

- Providers must adhere to DBHDS licensing rules as they relate to service

provision: http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/

- These services are intended to be delivered in a person-centered manner. The individuals who are receiving these services shall be included in all service planning activities.

- Providers shall discharge individuals if consent for treatment is withdrawn except during mandated assessments under the Code of Virginia §37.2-800 et. seq. for adults and §16.1-335 et seq. for youth under age eighteen.

The following elements are a clarification of Medicaid policy regarding documentation in addition to documentation requirements found throughout this chapter and the service specific appendices to this manual:

- Records shall fully disclose the extent of services provided to Medicaid members. This documentation must be written at the time the service is rendered, must be legible, and must clearly describe the services rendered

- The individual's medical record must demonstrate the appropriateness of the admission to service and for the level of care based upon the service definition, the provider assessment, and medical necessity criteria.

- The individual must be referenced on each page of the record by full name or Medicaid ID number.

- A document signed by the individual verifying freedom of choice of provider was offered and this provider was chosen must be present in the record.

- A document signed by the individual verifying that the individual was notified of their appeal rights must be present in the record.

- Any medications prescribed as a part of the treatment, including the prescribed quantities and the dosage, must be entered in the record.

- The record must contain a preliminary working DSM diagnosis or a primary International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates to a Diagnostic and Statistical Manual diagnosis and a Comprehensive Needs Assessment upon which the diagnosis and ISP is based.

- Services based upon missing, incomplete or outdated documentation shall result in denial of reimbursement.

- Services that are not provided on the date or for the time indicated on the claim shall result in denial of reimbursement.

COMPREHENSIVE NEEDS ASSESSMENT

The Comprehensive Needs Assessment is the initial face-to-face interaction encounter in which the provider obtains information from the individual, and parent, guardian or other family members as appropriate about the individual's mental health status and behaviors. The Comprehensive Needs Assessment serves to gather information to assess the needs, strengths and preferences of the individual.

For information on whether a service assessment is required in-person or is allowed through telemedicine, refer to the service specific sections located in Appendices to this manual. A provider cannot use a Comprehensive Needs Assessment conducted through telemedicine as a Comprehensive Needs Assessment for a service that requires an in-person assessment. If a provider has a valid Comprehensive Needs Assessment that was conducted through telemedicine and later wants to use the assessment as a Comprehensive Needs Assessment for another service that requires an in-person assessment, the assessment update completed to recommend the service must be conducted in-person.

The Comprehensive Needs Assessment must include the 15 elements outlined in this section and support medical necessity criteria as presented in the service authorization and the most current ISP.

Comprehensive Needs Assessments shall be required prior to developing an ISP and shall be required as a clinical foundation for the ISP during the entire duration of services. Services based upon incomplete, missing, or outdated assessments and ISPs as defined in this manual shall be denied reimbursement.

A valid Comprehensive Needs Assessment is required prior to initiating any of the following services:

- Assertive Community Treatment
- Intensive In-Home (IIH) Services
- Therapeutic Day Treatment (TDT)
- Mental Health Intensive Outpatient (MH-IOP)
- Mental Health Partial Hospitalization (MH-PHP)
- Psychosocial Rehabilitation (PSR)
- Mental Health Skill-building Services (MHSS)
- Applied Behavior Analysis (ABA)

A Comprehensive Needs Assessment that follows the guidelines in this manual shall be required for the EBH and CMHRS services listed above. A single Comprehensive Needs Assessment shall be used when recommending one or more of the above mental health services provided by the same DBHDS licensed agency except when written justification is provided.

The Comprehensive Needs Assessment must document the medical necessity for each recommended EBH and CMHRS service provided by the agency. The Comprehensive Needs Assessment for EBH and CMHRS shall be conducted face-

to-face by a LMHP, LMHP-R, LMHP-S or LMHP-RP. For services that allow a professional other than a LMHP, LMHP-R, LMHP-S or LMHP-RP to conduct an initial assessment, that assessment must include the required elements of a Comprehensive Needs Assessment but may be used for that service only and cannot be used as a Comprehensive Needs Assessment for other services.
Providers of Mobile Crisis Response, Community Stabilization, 23 Hour Crisis Stabilization and Residential Crisis Stabilization Unit services may choose to complete a Comprehensive Needs Assessment but a Comprehensive Needs Assessment is not required for these services.

Mental health case management may be included as a recommended service on a Comprehensive Needs Assessment completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S. A qualified mental health case manager who is also a LMHP, LMHP-S, LMHP-R or LMHP-RP may conduct a Comprehensive Needs Assessment to include CMHRS and EBH services in addition to mental health case management. Individuals receiving mental health case management may continue having their assessments and reassessments completed by a qualified mental health case manager who is not a LMHP, LMHP-S, LMHP-R or LMHP-RP. Mental health case management assessments completed by a qualified mental health case manager who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S shall be used only for mental health case management. Assessments completed by a qualified mental health case manager who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S may not be used as a Comprehensive Needs Assessment or updated by a LMHP, LMHP-R, LMHP-S, or LMHP-RP to be used as a Comprehensive Needs Assessment.

DBHDS licensed providers who are implementing the Daily Living Activities (DLA)-20 may use the DLA-20 as the Comprehensive Needs Assessment as long as the DLA-20 is performed by an LMHP, LMHP-R, LMHP-RP or LMHP-S, all 15 elements for the Comprehensive Needs Assessment are captured as well as all requirements are met as set forth in this manual. If not all 15 required elements are included in the DLA-20, a LMHP, LMHP-R, LMHP-RP or LMHP-S may create an addendum to a DLA-20 completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S to address any of the missing elements required for a Comprehensive Needs Assessment to recommend CMHRS and EBH services.

A DBHDS licensed agency may use a Psychiatric Diagnostic Interview (90791, 90792) completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S employed or contracted by the agency as the Comprehensive Needs Assessment as long as all 15 required elements for the Comprehensive Needs Assessment are included. If not all 15 required elements are included in the Psychiatric Diagnostic Interview, a LMHP, LMHP-R, LMHP-RP or LMHP-S may create an addendum to address any of the missing elements required for a Comprehensive Needs Assessment to recommend CMHRS and EBH services. Providers shall not bill for this addendum to the Psychiatric Diagnostic Interview under CMHRS assessment codes.

Assessments completed prior to January 1, 2019, Service Specific Provider Intakes (SSPIs) and Psychiatric Diagnostic Interviews, may not be used as a

Comprehensive Needs Assessment.

All providers shall ensure they meet the DMAS requirements as well as the DBHDS licensing requirements for completion of assessments.

Billing for the Comprehensive Needs Assessment

- Providers shall only bill for one Comprehensive Needs Assessment when these services are provided by the same agency. The provider shall bill the most appropriate assessment code, and if recommending more than one service, may choose the higher reimbursed assessment code of the services that are being recommended.
- Providers shall only bill under an assessment code for a service that they will be providing.
- For services with separate assessment codes, documentation must support that appropriate activities are billed under the assessment code, that all required data elements are met, and that the assessment code is otherwise being used appropriately. Psychological testing should be billed under outpatient psychiatric services and not under assessment billing.
- Service authorization is not required for billing the Comprehensive Needs Assessment.
- If the provider later reviews and updates the Comprehensive Needs Assessment due to the changing treatment needs of the individual, the addendum to the Comprehensive Needs Assessment is not billable under a service assessment code but face-to-face time necessary to conduct the review and update to the assessment may be billable under the service billing code.
- Required reviews and updates, including the annual review and update of the Comprehensive Needs Assessment and any other service specific review as described in this chapter are not billable under service assessment codes. Face-to-face assessment time required for any review and update may be billed as part of a service billing code.
- If a provider has a current, valid Comprehensive Needs Assessment but needs to conduct a full, new Comprehensive Needs Assessment based on the clinical needs of the individual, and bills under a service assessment code, the provider shall document the justification for the additional assessment billing.
- If the Comprehensive Needs Assessment becomes outdated as defined in this chapter, the provider may bill for the completion of a new Comprehensive Needs Assessment required to resume services under an assessment code, if available, for a service that they will be providing.

One or More Services Provided by the Same DBHDS Licensed Agency

When the initial Comprehensive Needs Assessment recommends several CMHRS and EBH services for an individual, the provider shall use this assessment for all CMHRS and EBH services recommended within the same DBHDS licensed agency.

If additional service needs are identified after the completion of the initial Comprehensive Needs Assessment and the Comprehensive Needs Assessment is not outdated as defined in this chapter, the provider shall review and update the initial Comprehensive Needs Assessment to include a description of how the individual meets medical necessity criteria for the additional service.

One or More Services Provided by different DBHDS Licensed Agencies

Providers should share assessments that recommend CMHRS and EBH services to be provided by a different DBHDS licensed agency, with appropriate consent from the member, to coordinate services. The agency receiving the referral shall complete a new Comprehensive Needs Assessment for the service they are to provide. For example, if Provider A is recommending Mental Health Skill Building and Psychosocial Rehabilitation in the initial Comprehensive Needs Assessment, but is only licensed to provide Mental Health Skill Building, Provider A shall bill the Mental Health Skill Building Assessment code/H0032 U8. Provider A would refer the individual to Provider B who is licensed for Psychosocial Rehabilitation. Provider B would conduct a new Comprehensive Needs Assessment documenting the medical necessity for services and bill for the Psychosocial Rehabilitation Assessment/H0032 U6.

Providers should only bill under the assessment code for a service that they will be providing. In the above example, if Provider A is licensed to provide both MHSS and PSR but will only be providing MHSS, the assessment shall be billed under the MHSS assessment code and not under the PSR assessment code.

Services Eligible for the Comprehensive Needs Assessment

Assessment Code	Service	Assessment Requirements Effective 1/1/19
H0031	IIH Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U6	PSR Assessment	Must meet Comprehensive Needs Assessment requirements
See Appendix F	Mental Health Intensive Outpatient (MH-IOP)	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP[1]
See Appendix F	Mental Health Partial Hospitalization (MH-PHP) Assessment	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP[1]
H0032 U7	TDT Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U8	MHSS Assessment	Must meet Comprehensive Needs Assessment requirements

See Appendix E	ACT Assessment	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP[1]
See Appendix D	Multisystemic Therapy	Providers may choose to complete a Comprehensive Needs Assessment
See Appendix D	Functional Family Therapy	Providers may choose to complete a Comprehensive Needs Assessment
See Appendix D	Applied Behavioral Analysis	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S.[2]
Billed as part of service component	Mobile Crisis Response, Community Stabilization, 23 Hour Crisis Stabilization, Residential Crisis Stabilization Unit	Providers may choose to complete a Comprehensive Needs Assessment
Billed as part of service component	Mental Health Case Management	Can be used as a Comprehensive Needs Assessment if completed by a qualified mental health case manager who is a LMHP, LMHP-R, LMHP-S or LMHP-RP and all 15 required elements are included.[3]
90791	Diagnostic Interview Exam	Can be used as a Comprehensive Needs Assessment if all 15 required elements are included. A LMHP, LMHP-R, LMHP-RP or LMHP-S may complete an addendum to address any missing elements and recommend additional services.
90792	Diagnostic Interview Exam Add on with Medical Services	Can be used as a Comprehensive Needs Assessment if all 15 required elements are included. A LMHP, LMHP-R, LMHP-RP or LMHP-S may complete an addendum to address any missing elements and recommend additional services.

[1]An assessment conducted by a physician assistant or nurse practitioner who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S can be used for that service only. The assessment cannot be used as a Comprehensive Needs Assessment for other services or updated by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

[2] An assessment conducted by a Licensed Assistant Behavioral Analyst (LABA) who

is not a LMHP, LMHP-R, LMHP-RP or LMHP-S can be used ABA only. The assessment cannot be used as a Comprehensive Needs Assessment for other services or updated by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

[3] The assessment for mental health case management does not need to be completed by a LMHP, LMHP-R, LMHP-RP or LMHP-S, however, a qualified mental health case manager who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S may conduct the assessment for mental health case management only. This assessment may not be used as a Comprehensive Needs Assessment or updated by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

Services Not Eligible for the Comprehensive Needs Assessment

Treatment Foster Care Case Management cannot be included in a Comprehensive Needs Assessment for other services. Providers should follow the assessment requirements in Appendix I of this manual.

Comprehensive Needs Assessment - 15 Required Elements

The Comprehensive Needs Assessment must contain a documented history of the severity, intensity, and duration of behavioral health care problems and behavioral and emotional issues and shall contain all of the following elements:

All fifteen elements must be addressed in the Comprehensive Needs Assessment to qualify for reimbursement.

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

2. **Behavioral Health History/Hospitalizations:** Give details of mental health history and any mental health related hospitalizations and diagnoses. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.

3. **Previous Interventions by providers and timeframes and response to treatment:** include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.

4. **Medical Profile:** Describe significant past and present medical problems, illnesses and injuries, known allergies, current physical complaints and medications. As needed, conduct an individualized fall risk assessment to

indicate whether the individual has any physical conditions or other impairments that put them at risk for falling. *All youth aged 10 years or younger should be assessed for fall risks based on age-specific norms*.

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

6. **Educational/Vocational Status:** School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.

7. **Current Living Situation, Family History and Relationships:** Describe the daily routine and structure, housing arrangements, financial resources and benefits. Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.

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

9. **Drug and Alcohol Profile:** Describe substance use by the individual and/or family members; specify the type of substance with frequency and duration of usage. Include any treatment or other recovery related efforts.

10. **Resources and Strengths:** Document individual's strengths, preferences, extracurricular, community and social activities, extended family; activities that the individual engages in or are meaningful to the individual. These elements are key to developing an ISP that supports the individual's recovery and resiliency efforts and goals.

11. **Mental Status Profile:** Include findings and clinical tools used.

12. **Diagnosis:** The documentation of a diagnosis must include the DSM diagnostic code & description as documented by the LMHP that provided the diagnosis.

13. **Professional Comprehensive Needs Assessment Summary and Clinical Formulation:** Includes a documentation of medically necessary services as defined by the service provider which:
    a. Identifies as much as possible, the causes of presenting treatment

issues, and
b. Identifies and discusses treatment options, outcomes, and potential barriers to progress, so that an individual specific service plan can be developed.

14. **Recommended Care and Treatment Goals**

15. **Dated signatures of the LMHP, LMHP-R, LMHP-RP or LMHP-S**

Definition of Valid and Outdated Comprehensive Needs Assessment

The Comprehensive Needs Assessment is considered to be valid as long as all of the following are met:

- The Comprehensive Needs Assessment is conducted face-to-face and completed, signed, and contemporaneously dated by the LMHP, LMHP-R, LMHP-RP or LMHP-S conducting the assessment;
- The Comprehensive Needs Assessment shall include the above 15 elements;
- The Comprehensive Needs Assessment shall describe how each recommended CMHRS and EBH service is medically necessary; and
- The Comprehensive Needs Assessment shall be appropriately reviewed and updated as necessary as described in the next section.

The Comprehensive Needs Assessment is considered to be outdated and no longer valid if any of the following occurs:

- A LMHP, LMHP-R, LMHP-RP, LMHP-S has not completed an annual, face-to-face review and update of the Comprehensive Needs Assessment as defined in the next section; or
- Within the past 31 calendar days, the provider has not provided any CMHRS or EBH service recommended by the Comprehensive Needs Assessment or a MHCM billable activity if MHCM is included in the Comprehensive Needs Assessment; or
- The Comprehensive Needs Assessment is not reflective of the individual's current level of functioning. If there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual, the Comprehensive Needs Assessment shall be updated within 31 calendar days of the change to remain valid.

If one of the above conditions occur, the Comprehensive Needs Assessment is outdated and a new Comprehensive Needs Assessment is required for any additional CMHRS or EBH services provided by the agency.

Review and Update of the Comprehensive Needs Assessment

<u>Review and Update - Annual requirements</u>

A LMHP, LMHP-R, LMHP-RP or LMHP-S shall conduct an annual face-to-face review and update that includes all of the following:

- A review of the Comprehensive Needs Assessment;
- Any necessary updates to the 15 elements of the Comprehensive Needs Assessment to reflect the individual's current level of functioning;
- An updated description of how the individual meets medical necessity criteria for all of the services recommended by the Comprehensive Needs Assessment; and
- A contemporaneously dated signature of the LMHP, LMHP-R, LMHP-RP or LMHP-S.

The annual review and update of the Comprehensive Needs Assessment must be conducted face-to-face and documented in an addendum to the Comprehensive Needs Assessment by the LMHP, LMHP-R, LMHP-RP or LMHP-S. A chart review by a LMHP, LMHP-R, LMHP-RP or LMHP-S to review the medical necessity criteria for CMHRS and EBH services is not sufficient to meet this requirement.

Review and Update – Clinical Indication

In addition, the Comprehensive Needs Assessment shall be reviewed and updated when there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual. The licensed practitioner shall make the clinical determination of how this review is completed to ensure the Comprehensive Needs Assessment is current. Any significant change in the medical, psychiatric or behavioral symptoms of the individual, to include any admissions to crisis or inpatient psychiatric services shall be included in the Comprehensive Needs Assessment. If there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual, the Comprehensive Needs Assessment shall be updated within 31 calendar days of the change to remain valid.

Services not initiated within 31 days

If the agency has a valid Comprehensive Needs Assessment as defined earlier in this section, and a CMHRS or EBH service included in the Comprehensive Needs Assessment was not initiated within 31 calendar days from the date the service was recommended by a LMHP, LMHP-R, LMHP-RP or LMHP-S, the Comprehensive Needs Assessment shall be reviewed and updated prior to initiating services. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the review and update shall complete an addendum to the Comprehensive Needs Assessment to include documentation of an updated description of how the individual meets medical necessity criteria for the service.

If a CMHRS or EBH service has not been initiated for more than 31 days and the Comprehensive Needs Assessment is outdated as defined above, a new Comprehensive Needs Assessment is required to initiate CMHRS or EBH services.

Lapse in services

If the agency has a valid Comprehensive Needs Assessment as defined earlier in this section, and there is lapse in a CMHRS or EBH service included in the

Comprehensive Needs Assessment for more than 31 calendar days, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall review and update the existing Comprehensive Needs Assessment. The LMHP, LMHP-R, LMHP-RP or LMHP-S completing the review and update shall complete an addendum to the Comprehensive Needs Assessment explaining the lapse and providing an updated description of how the individual meets medical necessity criteria for the service.

If a CMHRS or EBH service has lapsed for more than 31 days and the Comprehensive Needs Assessment is outdated as defined above, a new Comprehensive Needs Assessment is required to resume CMHRS or EBH services.

Comprehensive Needs Assessment After Discharge

If the agency has a valid Comprehensive Needs Assessment as defined earlier in this section, a LMHP, LMHP-R, LMHP-RP or LMHP-S shall review and update the Comprehensive Needs Assessment to continue providing a CMHRS or EBH service after an individual is discharged from the service. This update shall include a current description of how the individual meets medical necessity criteria for the service.

If an individual has been discharged from a CMHRS or EBH service and the Comprehensive Needs Assessment is outdated as defined above, a new Comprehensive Needs Assessment is required to resume services.

Providers must follow MCO and FFS service authorization contractor guidelines for initial service authorization or registration if individuals are readmitted to a service after the provider has discharged the individual from the particular service.

Additional Requirements for MHSS and PSR

An LMHP, LMHP-R, LMHP-RP or LMHP-S shall review MHSS and PSR services at a minimum of every six months to determine continued medical necessity for the service and update the assessment if necessary. The six month review may be conducted through a chart review or a face-to-face assessment. The review shall be documented in a progress note or as an addendum to the Comprehensive Needs Assessment. Providers of more than one of these services that require review every six months may complete the reviews together but shall include distinct documentation to support the medical necessity criteria for each service. Face-to-face time necessary to complete this review may be billed as part of the service component.

Additional Requirements for MH-PHP and MH-IOP

An updated assessment conducted by a LMHP LMHP-R, LMHP-RP, 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.

Review and Update - billing

Unless indicated in this section that a face to face is required, the LMHP, LMHP-R, LMHP-S or LMHP-RP may determine that the review and update can be appropriately conducted through chart review and information received from staff and family members. Time spent face-to-face with the individual to complete a necessary review to update the Comprehensive Needs Assessment may be billed under the service code. Providers should only bill under the assessment code for a CMHRS service if there is a documented need for a new Comprehensive Needs Assessment.

The FFS service authorization contractor and the MCOs have the discretion to request that providers submit the Comprehensive Needs Assessment for review. Providers shall follow up with the FFS service authorization contractor and/or MCO for specific requirements. MCO requirements are posted on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

INDIVIDUAL SERVICE PLAN (ISP) REQUIREMENTS

All services must be described with sufficient detail in an ISP based on the Comprehensive Needs Assessment and the most recent clinical supervision and review of the individual's treatment needs. The ISP is a comprehensive and regularly updated document that integrates both physical and behavioral health, service provider care coordination, and integrated care goals specific to the needs of the individual being treated and meeting the defined specific service requirements. Some CMHRS and EBH services, such as comprehensive crisis services, have different requirements for treatment planning, providers should refer to the service specific sections of this manual for details.

The ISP means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the comprehensive needs assessment. A comprehensive ISP is person-centered, includes all planned interventions, aligns with the individual's identified needs, care coordination needs, is regularly updated as the individual's needs and progress change, and shows progress throughout the course of treatment.

The ISP contains, but is not limited to the following:

- the individual's treatment or training needs;
- the individual's 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.

In addition, to the DMAS requirements above, providers shall follow the ISP requirements included in DBHDS licensing regulations (12VAC 35-105-665).

The provider shall include the individual and the family/caregiver, as may be appropriate, in the development of the ISP. To the extent that the individual's condition requires assistance for participation, assistance shall be provided. Documentation of the individual's involvement in the development of the ISP must be included in the record.

All ISPs shall be completed, signed, and contemporaneously dated by the LMHP, LMHP-S, LMHP-R, LMHP-RP, nurse practitioner, physician assistant, QMHP-A, QMHP-C, or QMHP-E as specified by the service preparing the ISP within 30 days of the date of initiation of services unless otherwise specified in the service specific appendices to this manual. The member's signature shall also be obtained. A youth's ISP shall also be signed by the parent/legal guardian as appropriate. If the member or guardian is unable or unwilling to sign the ISP, then the service provider shall document the reasons why the individual was not able or refuses to sign the ISP. Signatures shall be obtained unless there is a medical or clinical reason that renders the individual unable to sign the ISP

Providers must ensure that all interventions and the anticipated and allowable settings of the interventions are defined in the Individual Service Plan. Documentation shall include how all identified intervention and settings meet the treatment needs of the individual. Any ISP deviation as well as the reason for the deviation shall be documented in the individual's medical record.

The ISP shall be reviewed quarterly (90 calendar days), updated annually, and as the needs, goals and progress of the individual changes. Review of ISP means that the service provider reviews the ISP, evaluates and updates the member's progress toward meeting the ISP objectives, and documents the outcome of this review. For DMAS to determine that these reviews are satisfactory and complete, the reviews shall:

- Update the goals, objectives, and strategies of the ISP, as clinically appropriate, to reflect any change in the individual's progress and treatment needs as well as any newly identified problems;
- Be conducted in a manner that enables the individual to participate in the process; and
- The review shall be documented and placed in 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 qualified staff as specified by the service, and the individual and/or guardian, as appropriate, when a minor child is the recipient of services.

Some mental health services require that ISP reviews occur more frequently than

every 90 calendar days. Providers should refer to the service specific sections of this manual for additional ISP requirements. For services that require a 30 calendar day ISP review, the 30 calendar day ISP review requirements can be met through a progress note that clearly documents the following:

- the ISP, including goals and progress towards them has been discussed with the team and the individual;
- any alterations to the ISP;
- the review and any necessary changes have been discussed with the individual and the individual's response. The individual's signature is not required. During months where a quarterly review or annual ISP update is conducted, no additional documentation is necessary to meet 30 day ISP review requirements.

An ISP that is not updated either annually or as the needs and progress of the individual change shall be considered outdated. An ISP that does not include all required elements specified in 12VAC30-50-226 shall be considered incomplete. Services based upon incomplete, missing, or outdated ISPs shall be denied reimbursement

If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed as long as the treatment for the substance use condition is intended to positively impact the mental health condition and providers are appropriately licensed and acting within the scope of their expertise. The impact of the substance use condition on the mental health condition must be documented in the provider's assessment, ISP and the progress notes.

DBHDS licensed providers must follow all DBHDS regulations including staffing requirements related to supervision and approval of ISPs (12VAC35-105-590).

Individual Specific Treatment Goals and Objectives

Goals, Objectives and Intervention/Strategies should be based on the individuals presenting areas of needs as identified in the provider's assessment.

Goals:

- Should reflect an individualized specific overview of the objectives and will address the larger presenting needs. Goals are longer term than objectives.

Objectives:

- Should demonstrate shorter term, measurable, achievable, action-oriented, strength-based activities that the individual/family will engage in toward completion of the goal.

Intervention/Strategies:

- Should define specific steps that the provider and individual will engage in toward the attainment/achievement of each objective.
- Interventions are developed based on the individual's specific strengths and needs (i.e. developmental level, level of functioning, academic/literacy ability, interests, etc.).

- Interventions should clearly reflect care coordination.
- Parent and Caregiver objectives must be related to increasing functional and appropriate interpersonal interactions with the individual authorized to receive services and must include the individual-specific program purpose of the goals to be achieved within the authorized time period.

Frequency:

- The ISPs must include the recommended service frequency needed to accomplish the goals, objectives and interventions/strategies that will meet the needs identified in the provider's assessment.

- The ISP must be reviewed, at a minimum, every 3 months (every 90 calendar days) to determine if the goals and objectives continue to meet the needs of the individual or require revision.

- The ISP shall be updated annually and as the needs, goals and progress of the individual changes.

Discharge Goal:

- All ISPs shall include an individualized discharge plan. Describe the discharge planning to summarize an estimated timetable to achieving the goals and objectives in the service plan, include discharge plans that are specific to need of the individual at the time the service needs are reviewed.

Service Provider Care Coordination and Continuity of Care:

- All ISPs should clearly include care coordination as necessary to improve the care.
- All ISPs should clearly identify all current professionals involved in the individual's care and with whom is actively coordinated during the duration of the service (i.e. educational, psychiatric, medical, case management, probation, etc.)
- Care coordination activities must be defined related to the specific treatment needs and the related service goals and objectives and describe any psychoeducation or care coordination strategies as they relate to other care providers and persons (other CMHRS services, Outpatient/Clinic Services, Foster Care, Judicial or Educational related staff, Relatives, etc.) who routinely come in contact with the individual.

PROGRESS NOTES

Providers shall be required to maintain progress notes detailing all relevant information related to service provision. Such documentation shall fully disclose the extent of services provided in order to support providers' claims for reimbursement for services rendered. Progress notes shall support the medical necessity criteria and how the individual's needs for the service match the level of care criteria. **This**

documentation shall be written, signed, and dated at the time the services are rendered or within one business day from the time the services were rendered.

Progress notes must contain individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress. Each progress note shall be signed and contemporaneously dated by the provider's professional staff who have prepared the notes and delivered the service. Progress shall convey staff interventions, and the provider's and the individual's assessed progress towards achieving mutually identified goals and objectives in the ISP.

Progress notes shall be documented for each service unit billed. The content of each progress note shall corroborate the time billed and specifically document the service provided to support each of the units billed. At a minimum, progress notes shall include:

- the name of the service rendered,
- the date of the service rendered,
- the dated signature and credentials of the person who rendered the service,
- the setting in which the service was rendered, and
- the amount of time spent in delivering a covered service including the start and end times of the service.

Progress notes for services provided in group settings must indicate the number of participants in the group. For services where group psychotherapy is allowed, reimbursement is not allowed for more than 10 individuals regardless of Medicaid eligibility unless the LMHP, LMHP-R, LMHP-RP or LMHP-S documents clinical justification for exceeding 10 individuals.

DMAS shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services when documentation does not demonstrate unique differences particular to the individual or support the time/units billed.

SERVICE AUTHORIZATION

All services which do not require service authorization require registration. This registration shall transmit to DMAS or its contractor (i) the individual's name and Medicaid identification number; (ii) the specific service to be provided, the relevant procedure code and begin date of the service; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

For information on services that require service authorization and services that do

not require service authorization but require registration, please refer to the FFS service authorization contractor or the individual's MCO. Additional information is also available in Appendix C of this manual and in the service specific appendices to this manual.

For mental health services requiring service authorization, the medical record content must corroborate information provided to DMAS or its contractor.

NON-REIMBURSABLE ACTIVITIES FOR ALL MENTAL HEALTH SERVICES

The following activities are not reimbursable and shall not be included for billable time for reimbursement.

- Staff travel time;
- Staff time spent completing documentation without the individual present;
- Services that have not been rendered;
- Services rendered that are not in accordance with an approved service authorization or required registration;
- Services based upon an incomplete, missing or outdated assessment or ISP;
- Services not identified on the individual's authorized ISP or treatment plan;
- Services that are not documented;
- Services provided to children, spouse, parents, or siblings of the eligible individual under treatment or others in the individual's life to address problems not directly related to the individual's issues and not listed on the individual's ISP or treatment plan;
- Services provided that are not within the provider's scope of practice;
- Time spent when the individual is employed and performing the tasks of their job;
- Time spent in any activity that is not a covered service component (examples include, but are not limited to: child care, respite care, housing, time spent in snacks and meals, time spent in transportation);
- Contacts that are not medically necessary;
- Time when the individual is participating in recreational activities;
- Services provided by one staff member to two or more individuals at the same time when group delivery of either the service or the service component is not allowed;
- Time when the individual is participating in educational instruction;

- Inactive time or time spent waiting to respond to a behavioral situation. Inactive time is defined as time when the provider is not providing a covered service component.

Marketing Requirements

Providers shall comply with marketing requirements as required by state regulations (12VAC30-130-2000). Violations of marketing requirements could result in provider contract termination.

1. Marketing and promotional activities (including but not limited to provider promotional activities, written materials, television, radio, websites, and social media) shall comply with all applicable federal and state laws.

2. Marketing and promotional materials must include the following: Clear, written descriptions of the Medicaid or FAMIS behavioral health service; eligibility requirements for the service; application fees and other changes; and all other necessary information for beneficiaries and their families to make an informed decision about enrollment into the service.

3. Provider marketing and promotional materials shall be distributed only in the service locations listed on the Department of Behavioral Health and Developmental Services (DBHDS) license addendum.

Marketing Limits and Prohibitions

1. Providers shall not offer cash or noncash incentives to their enrolled or prospective members for the purposes of marketing, retaining beneficiaries within the providers' services, or rewarding behavior changes in compliance with goals and objectives stated in members' ISPs.

2. While engaging in marketing activities, providers shall not:

    a. Engage in any marketing activities that could misrepresent the service, or DMAS or its contractors;

    b. Assert or state that the member must enroll with the provider in order to prevent the loss of Medicaid or FAMIS benefits;

    c. Conduct door-to-door, telephone, unsolicited school presentations, or other cold call marketing directed at potential or current members;

    d. Conduct any marketing activities or use marketing materials that are in violation of marketing requirements;

    e. Make home visits for direct or indirect marketing or enrollment activities except when specifically requested by the member or family;

f. Collect or use Medicaid or FAMIS confidential information or Medicaid or FAMIS protected health information (PHI), as that term is defined in Health Insurance Portability and Accountability Act of 1996 (HIPAA), that may be either provided by another entity or obtained by marketing provider, to identify and market services to prospective members;

g. Violate the confidential information or confidentiality of PHI by sharing or selling or sharing lists of information about members for any purposes other than the performance of the provider's obligations relative to its DMAS provider agreement;

h. Contact, after the effective date of disenrollment, members who choose to disenroll from the provider except as may be specifically required by DMAS;

i. Conduct service assessment or enrollment activities at any marketing or community event; or

j. Assert or state (either orally or in writing) that the provider is endorsed either by the Centers for Medicare and Medicaid Services, DMAS, or any other federal or state governmental entities.

Termination of Providers for Violating Marketing Requirements
Providers that violate any of the prohibitions in this section, shall be subject to termination of their provider agreements for the services affected by the marketing activity. See Chapter II of this provider manual for any applicable appeal rights for providers.

TRANSPORTATION BENEFITS

- Provider transportation of the individual receiving services is not reimbursable.

- FFS members with transportation benefits receive services through the Non-Emergency Medical Transportation (NEMT) broker. The NEMT program serves members going to Medicaid covered services, including psychiatric appointments. Transportation services must be “preauthorized” by the FFS NEMT broker.

- For members assigned to a Managed Care Organization (MCO), please contact the MCO for transportation services. Individual providers and agencies may seek mileage reimbursement through the FFS transportation broker or MCO for services under which transportation is covered should they transport individuals to appointments. Reimbursement for transportation is for mileage only. In order to bill for other covered services please refer to the specific service requirements located in Appendices to this manual.

- If you have any FFS transportation questions, need to check transportation eligibility, want to make transportation arrangements or discuss the mileage reimbursement process please contact LogistiCare at (866) 386-8331. For more additional information regarding the NEMT program please refer to the DMAS NEMT website http://transportation.dmas.virginia.gov. Individuals enrolled in an MCO must contact the individual's MCO directly in order to arrange transportation.

EXHIBITS

Virginia Pre-Admission Screening Report:
https://www.virginiamedicaid.dmas.virginia.gov/wps/PA_VAPiderFormsSearch/DMAS-P98.xls