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Final Text

Action: Mental Health Skill-building Services

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12VAC30-50-226. Community mental health services.

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Affiliated" means any entity or property in which a provider or facility has a direct or indirect ownership interest of 5.0% or more, or any management, partnership, or control of an entity.

"Behavioral health services administrator" or "BHSA" means an entity that manages or directs a behavioral health benefits program under contract with DMAS. DMAS' designated BHSA shall be authorized to constitute, oversee, enroll, and train a provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Such authority shall include entering into or terminating contracts with providers in accordance with DMAS authority pursuant to 42 CFR Part 1002 and § 32.1-325 D and E of the Code of Virginia. DMAS shall retain authority for and oversight of the BHSA entity or entities.

"Certified prescreener" means an employee of either the local community services board/behavioral health authority or its designee who is skilled in the assessment and treatment of mental illness and who has completed a certification program approved by DBHDS.

"Clinical experience" means ~~practical experience in providing direct services on a full-time basis (or the equivalent part-time experience as determined by DBHDS in the document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12,2013, revised May 3, 2013) to individuals with medically-documented diagnoses of mental illness or intellectual/developmental disability or the provision of direct geriatric services or full-time (or the equivalent part-time experience) special education services~~, for the purpose of rendering (i) mental health day treatment/partial hospitalization, (ii) intensive community treatment, (iii) psychosocial rehabilitation, (iv) mental health ~~support~~ skill building, (v) crisis stabilization, or (vi) crisis intervention services, practical experience in providing direct services to individuals with diagnoses of mental illness or intellectual disability or the provision of direct geriatric services or

special education services. Experience shall include supervised internships, supervised practicums, or supervised field experience. Experience shall not include unsupervised internships, unsupervised practicums, and unsupervised field experience. ~~This required clinical experience shall be calculated as set forth in DBHDS document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.~~ The equivalency of part-time hours to full-time hours for the purpose of this requirement shall be established by DBHDS in the document titled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Code" means the Code of Virginia.

"DBHDS" means the Department of Behavioral Health and Developmental Services consistent with Chapter 3 (§ 37.2-300 et seq.) of Title 37.2 of the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services and its contractor or contractors consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSM-5" means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, copyright 2013, American Psychiatric Association.

"Human services field" means the same as the term is defined by DBHDS in the guidance document entitled Human Services and Related Fields Approved Degrees/Experience, issued March 12, 2013, revised May 3, 2013.

"Individual" means the patient, client, or recipient of services described in this section.

"Individual service plan" or "ISP" means a comprehensive and regularly updated treatment plan specific to the individual's unique treatment needs as identified in the ~~clinical assessment~~ service-specific provider intake. The ISP contains, but is not limited to, ~~his~~ the individual's treatment or training needs, ~~his~~ 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. 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 minor child, the ISP shall also be signed by the individual's parent/legal guardian. Documentation shall be provided if the individual, who is a minor child or an adult who lacks legal capacity, is unable or unwilling ~~-~~ to sign the ISP.

"Individualized training" means ~~training~~ instruction and practice in functional skills and appropriate behavior related to the individual's health and safety, instrumental activities of daily living skills, and use of community resources; assistance with medical management; and monitoring health, nutrition, and physical condition. The training shall be rehabilitative and based on a variety of incremental (or cumulative) approaches or tools to organize and guide the individual's life planning and shall ~~be rooted in~~ reflect what is important to the individual ~~while taking into account~~ in addition to all other factors that affect his ~~life~~ functioning, including effects of the disability and issues of health and safety.

"Licensed mental health professional" or "LMHP" means ~~a licensed physician, licensed clinical psychologist, licensed professional counselor, licensed clinical~~

~~social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, or certified psychiatric clinical nurse specialist~~ the same as defined in 12VAC35-105-20.

"LMHP-resident" or "LMHP-R" means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling. For purposes of Medicaid reimbursement to their supervisors for services provided by such residents, they shall use the title "Resident" in connection with the applicable profession after their signatures to indicate such status.

"LMHP-resident in psychology" or "LMHP-RP" means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology. For purposes of Medicaid reimbursement by supervisors for services provided by such residents, they shall use the title "Resident in Psychology" after their signatures to indicate such status.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as "supervisee" is defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work. For purposes of Medicaid reimbursement to their supervisors for services provided by supervisees, these persons shall use the title "Supervisee in Social Work" after their signatures to indicate such status.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in 12VAC35-105-20.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC35-105-20.

"Qualified paraprofessional in mental health" or "QPPMH" means the same as defined in 12VAC35-105-20.

"Register" or "registration" means notifying DMAS or its contractor that an individual will be receiving services that do not require service authorization.

"Review of ISP" means that the provider evaluates and updates the individual's progress toward meeting the individualized service plan objectives and documents the outcome of this review. For DMAS to determine that these reviews are

satisfactory and complete, the reviews shall (i) update the goals, objectives, and strategies of the ISP to reflect any change in the individual's progress and treatment needs as well as any newly identified problems; (ii) be conducted in a manner that enables the individual to participate in the process; and (iii) be documented in the individual's medical record no later than 15 calendar days from the date of the review.

"Service authorization" means the process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by a DMAS service authorization contractor prior to service delivery and reimbursement in order to validate that the service requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

"Service-specific provider intake" means the same as defined in 12VAC30-50-130 and also includes individuals who are older than 21 years of age.

B. Mental health services. The following services, with their definitions, shall be covered: day treatment/partial hospitalization, psychosocial rehabilitation, crisis services, intensive community treatment (ICT), and mental health ~~supports~~ skill building. Staff travel time shall not be included in billable time for reimbursement. ~~1.~~ These services, in order to be covered, shall meet medical necessity criteria based upon diagnoses made by LMHPs who are practicing within the scope of their licenses and are reflected in provider records and on providers' claims for services by recognized diagnosis codes that support and are consistent with the requested professional services. ~~2.~~ 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. All services which do not require service authorization require registration. This registration shall transmit service-specific information to DMAS or its contractor in accordance with service authorization requirements ~~(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~~.

~~3.~~ 1. Day treatment/partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services, limited annually to 780 units, include the major diagnostic, medical, psychiatric, psychosocial, and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment. One unit of service shall be defined as a minimum of two but less than four hours on a given day. Two units of service shall be defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement.

a. Day treatment/partial hospitalization services shall be time limited interventions that are more intensive than outpatient services and are required to stabilize an individual's psychiatric condition. The services are delivered when the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community.

b. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that the individual requires repeated interventions or monitoring by the mental health, social services, or judicial system that have been documented; or

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

c. Individuals shall be discharged from this service when they are no longer in an acute psychiatric state and other less intensive services may achieve psychiatric stabilization.

d. Admission and services for time periods longer than 90 calendar days must be authorized based upon a face-to-face evaluation by a physician, psychiatrist, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, or psychiatric clinical nurse specialist.

e. These services may only be rendered by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH.

~~4.~~ 2. Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services, limited annually to 936 units, include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. One unit of service is defined as a minimum of two but less than four hours on a given day. Two units are defined as at least four but less than seven hours in a given day. Three units of service shall be defined as seven or more hours in a given day. Authorization is required for Medicaid reimbursement. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals: (i) who without these services would be unable to remain in the community or (ii) who meet at least two of the following criteria on a continuing or intermittent basis:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal

hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or

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

b. These services may only be rendered by either an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a QPPMH.

~~5.~~ 3. Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention activities shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one business day or the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

a. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by mental health, social services, or the judicial system are or have been necessary; or

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

b. The annual limit for crisis intervention is 720 units per year. A unit shall equal 15 minutes.

c. These services may only be rendered by an LMHP, an LMHP-supervisee, LMHP-resident, LMHP-RP, or a certified prescreener.

~~6.~~ 4. Intensive community treatment (ICT), initially covered for a maximum of 26

weeks based on an initial service-specific provider intake and may be reauthorized for up to an additional 26 weeks annually based on written intake and certification of need by a licensed mental health provider (LMHP), shall be defined by 12VAC35-105-20 or LMHP-S, LMHP-R, and LMHP-RP and shall include medical psychotherapy, psychiatric assessment, medication management, and care coordination activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community. Authorization is required for Medicaid reimbursement.

a. To qualify for ICT, the individual must meet at least one of the following criteria:

(1) The individual must be at high risk for psychiatric hospitalization or becoming or remaining homeless due to mental illness or require intervention by the mental health or criminal justice system due to inappropriate social behavior.

(2) The individual has a history (three months or more) of a need for intensive mental health treatment or treatment for co-occurring serious mental illness and substance use disorder and demonstrates a resistance to seek out and utilize appropriate treatment options.

b. A written, service-specific provider intake, as defined at 12VAC30-50-130, that documents the individual's eligibility and the need for this service must be completed prior to the initiation of services. This intake must be maintained in the individual's records.

c. An individual service plan shall be initiated at the time of admission and must be fully developed, as defined in this section, within 30 days of the initiation of services.

d. The annual unit limit shall be 130 units with a unit equaling one hour.

e. These services may only be rendered by a team that meets the requirements of 12VAC35-105-1370.

~~7.~~ 5. Crisis stabilization services for nonhospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation. Services may be ~~authorized~~ provided for up to a 15-day period per crisis episode following a face-to-face service-specific provider intake by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. Only one unit of service shall be reimbursed for this intake. The provision of this service to an individual shall be registered with either DMAS, DMAS contractors, or the BHSA within one ~~calendar~~ business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination. ~~See 12VAC30-50-226-B for registration requirements.~~

a. The goals of crisis stabilization programs shall be to avert hospitalization or rehospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. The services must be documented in the individual's records as having been provided consistent with the ISP in order to receive Medicaid reimbursement.

b. The crisis stabilization program shall provide to individuals, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

c. This service may be provided in any of the following settings, but shall not be limited to: (i) the home of an individual who lives with family or other primary caregiver; (ii) the home of an individual who lives independently; or (iii) community-based programs licensed by DBHDS to provide residential services but which are not institutions for mental disease (IMDs).

d. This service shall not be reimbursed for (i) individuals with medical conditions that require hospital care; (ii) individuals with primary diagnosis of substance abuse; or (iii) individuals with psychiatric conditions that cannot be managed in the community (i.e., individuals who are of imminent danger to themselves or others).

e. The maximum limit on this service is 60 days annually.

f. Services must be documented through daily progress notes and a daily log of times spent in the delivery of services. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from an acute crisis of a psychiatric nature that puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service:

(1) Experience difficulty in establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports;

(2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized;

(3) Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; or

(4) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

g. These services may only be rendered by an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E or a certified prescreener.

~~8.~~ 6. Mental health ~~support~~ skill-building services (MHSS) shall be defined as goal-directed training ~~and supports~~ to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. Services that are rendered before the date of service authorization shall not be reimbursed. These services may be authorized up to six consecutive months as long as the individual meets the coverage criteria for this service. The service-specific provider intake, as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service. ~~This program~~ These services shall provide goal-directed training in the following ~~services~~ areas in order to be reimbursed by Medicaid or the BHSA: ~~training in or reinforcement of~~ (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 of health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. 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 this section. A review of MHSS services by an LMHP, LMHP-R, LMHP-RP, or LMHP-S shall be repeated for all individuals who have received at least six months of MHSS to determine the continued need for this service.

a. Individuals qualifying for this service ~~must~~ shall 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 without these services would be unable to remain in the community. The individual must meet at least two of the following criteria on a continuing or intermittent basis:~~ Services are provided to individuals who require individualized goal-directed training in order to achieve or maintain stability and independence in the community.

~~(1) Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization or homelessness or isolation from social supports;~~

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

~~(3) Exhibit such inappropriate behavior that repeated interventions documented by the mental health, social services, or judicial system are or have been necessary; or~~

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

b. ~~The individual must demonstrate functional impairments in major life activities. This may include individuals with a dual diagnosis of either mental illness and intellectual disability, or mental illness and substance abuse disorder.~~ Individuals ages 21 and older shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall have one of the following as a primary mental health diagnosis:

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and 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) requires individualized training for the individual in order to achieve or maintain independent living in the community.

(2) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills, such as symptom management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(3) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation, pursuant to § 37.2-809 B of the Code of Virginia. 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 the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(4) 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 antipsychotic, 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 shall not be required 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 the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

c. Individuals aged 18 to 21 years shall meet all of the following criteria in order to be eligible to receive mental health skill-building services:

(1) The individual shall not be living in a supervised setting as defined in §63.2-905 and §63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, MHSS shall only be authorized for up to six months prior to the date of transition;

(2) The individual shall have at least one of the following as a primary mental health diagnosis:

(a) Schizophrenia or other psychotic disorder as set out in the DSM-5;

(b) Major depressive disorder;

(c) Recurrent Bipolar-I or Bipolar II; or

(d) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year and that includes all of the following: (i) is a serious mental illness or serious emotional disturbance; (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) requires individualized training for the individual in order to achieve or maintain independent living in the community;

(3) The individual shall require individualized goal-directed training in order to acquire or maintain self-regulation of basic living skills such as symptom

management; adherence to psychiatric and physical health medication treatment plans; appropriate use of social skills and personal support systems; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

(4) The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) either residential or nonresidential crisis stabilization; (iii) intensive community treatment (ICT) or program of assertive community treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility (RTC-Level C) as a result of decompensation related to the individual's serious mental illness; or (v) temporary detention order (TDO) evaluation pursuant to § 37.2-809 B of the Code of Virginia,. 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 the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(5) The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications, within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that antipsychotic, 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 of medication management shall be maintained in the individual's mental health skill-building services record. For individuals not prescribed antipsychotic, mood stabilizing, or antidepressant medications, the provider shall have documentation from the medication management physician describing how the individual will be able to actively participate in and benefit from services without the assistance of medication. 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 the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

(6) An independent clinical assessment, established in 12VAC30-130-3020, shall be completed for the individual.

~~c.~~ d. Service-specific provider intakes shall be required at the onset of services and 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. Requirements for ~~provider-specific~~ service-specific provider intakes and ISPs are set out in 12VAC30-50-130.

~~d.~~ e. The yearly limit for mental health ~~support~~ skill-building services is ~~372~~ 520 units. Only direct face-to-face contacts and services to the individual shall be reimbursable. One unit is ~~at least one hour but less than three hours.~~ 1 to 2.99 hours per day, two units is 3 to 4.99 hours per day.

~~e.~~ f. These services may only be rendered by an LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH.

g. The provider shall clearly document details of the services provided during the entire amount of time billed.

h. 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 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.

i. Limits and exclusions.

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

(2) Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.

(3) Mental health skill-building services shall not be reimbursed for individuals who are also receiving services under the Department of Social Services independent living program (22VAC40-151), independent living services (22VAC40-151 and 22VAC40-131), or independent living arrangement (22VAC40-131) or any Comprehensive Services Act-funded independent living skills programs.

(4) Mental health skill-building services shall not be available to individuals who are receiving treatment foster care (12VAC30-130-900 et seq.).

(5) Mental health skill-building services shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities or hospitals.

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

(7) Mental health skill-building services shall not be available for residents of residential treatment centers (Level C facilities) except for the intake code H0032 (modifier U8) in the seven days immediately prior to discharge.

(8) Mental health skill-building services shall not be reimbursed if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability Waiver (12VAC30-120-1000 et seq.), Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.), the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.),

and EPSDT services (12VAC30-50-130).

(9) Mental health skill-building services shall not be duplicative of other services. Providers shall be required to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or QPPMH to avoid duplication of services.

(10) Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving mental health skill-building services unless their physicians issue signed and dated statements indicating that the individuals can benefit from this service.

(11) Individuals who are not diagnosed with a serious mental health disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability shall not be excluded from the mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in subdivision B 8 b (1) or B 8 c (2) of this section and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health skill-building services.

DOCUMENTS INCORPORATED BY REFERENCE (12VAC30-50)

~~Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition DSM-IV-TR, copyright 2000, American Psychiatric Association~~

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, DSM-5, 2013, American Psychiatric Association

Length of Stay by Diagnosis and Operation, Southern Region, 1996, HCIA, Inc.

Guidelines for Perinatal Care, 4th Edition, August 1997, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists

Virginia Supplemental Drug Rebate Agreement Contract and Addenda

Office Reference Manual (Smiles for Children), prepared by DMAS' Dental Benefits Administrator, copyright 2005 (www.dmas.virginia.gov/downloads/pdfs/dental-office_reference_manual_06-09-05.pdf)

Patient Placement Criteria for the Treatment of Substance-Related Disorders ASAM PPC-2R, Second Edition, copyright 2001, American Society of Addiction Medicine

~~**Virginia Medicaid Durable Medical Equipment and Supplies Provider Manual, Appendix B (rev. 1/11), Department of Medical Assistance Services**~~

Human Services and Related Fields Approved Degrees/Experience, Department of Behavioral Health and Developmental Services (rev. 5/13)

12VAC30-60-143. Mental health services utilization criteria; definitions.

A. ~~This section sets out the utilization criteria and standards relative to the community mental health services set out in 12VAC30-50-226.~~ Definitions. The following words and terms when used in this section shall have the following meanings unless the context indicates otherwise:

"Child or adolescent" means the same as "adolescent or child" defined in

12VAC30-50-130.

"Licensed mental health professional" or "LMHP" means the same as defined in 12VAC30-50-130.

"LMHP-resident" or "LMHP-R" means the same as defined in 12VAC30-50-130.

"LMHP-resident in psychology" or "LMHP-RP" means the same as defined in 12VAC30-50-130.

"LMHP-supervisee in social work," "LMHP-supervisee," or "LMHP-S" means the same as defined in 12VAC30-50-130.

"Qualified mental health professional-adult" or "QMHP-A" means the same as defined in 12VAC30-50-130.

"Qualified mental health professional-child" or "QMHP-C" means the same as defined in 12VAC30-50-130.

"Qualified mental health professional-eligible" or "QMHP-E" means the same as defined in 12VAC30-50-130.

B. Utilization reviews shall include determinations that providers meet the following requirements:

1. The provider shall meet the federal and state requirements for administrative and financial management capacity. The provider shall obtain, prior to the delivery of services, and shall maintain and update periodically as the Department of Medical Assistance Services (DMAS) or its contractor requires, a current provider enrollment agreement for each Medicaid service that the provider offers. DMAS shall not reimburse providers who do not enter into a provider enrollment agreement for a service prior to offering that service.

2. The provider shall document and maintain individual case records in accordance with state and federal requirements.

3. The provider shall ensure eligible individuals have free choice of providers of mental health services and other medical care under the Individual Service Plan.

4. Providers shall comply with DMAS marketing requirements as set out in 12VAC30-130-2000. Providers that DMAS determines have violated these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E. Providers whose contracts are terminated shall be afforded the right of appeal pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

5. If an individual receiving community mental health rehabilitative services is also receiving case management services pursuant to 12VAC30-50-420 or 12VAC30-50-430, the provider shall collaborate with the case manager by notifying the case manager of the provision of community mental health rehabilitative services and sending monthly updates on the individual's treatment status. A discharge summary shall be sent to the care coordinator/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.

6. The provider shall determine who the primary care provider is and inform him of the individual's receipt of community mental health rehabilitative services. The

documentation shall include who was contacted, when the contact occurred, and what information was transmitted.

7. 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. The ISP shall be updated annually or as the needs and progress of the individual changes. An ISP that is not updated either annually or as the treatment interventions based on 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. All ISPs shall be completed, signed, and contemporaneously dated by the LMHP, ~~LMHP-supervisee, LMHP-resident~~, ~~LMHP-R,~~ LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E preparing the ISP within a maximum of 30 days of the date of the completed intake unless otherwise specified. The child's or adolescent's ISP shall also be signed by the parent/legal guardian and the adult individual shall sign his own. If the individual, whether a child, adolescent, or an adult, is unwilling to sign the ISP, then the service provider shall document the clinical or other reasons why the individual was not able or willing to sign the ISP. Signatures shall be obtained unless there is a clinical reason that renders the individual unable to sign the ISP.

(a) Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review the ISP, modify as appropriate, and update the ISP, and all of these activities shall occur with the individual in a manner in which the individual may participate in the process. The ISP shall be rewritten at least annually.

(b) 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 problems.

(c) Documentation of ISP review shall be added to the individual's medical record no later than 15 days from the calendar 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.

C. Day treatment/partial hospitalization services shall be provided following a service-specific provider intake and be authorized by the LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S. An ISP, as defined in 12VAC30-50-226, shall be fully completed, signed, and dated by either the LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, the QMHP-A, QMHP-E, or QMHP-C and reviewed/approved by the LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S within 30 days of service initiation.

1. The enrolled provider of day treatment/partial hospitalization shall be licensed by DBHDS as providers of day treatment services.

2. Services shall only be provided by an LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, QMHP-C, QMHP-E, or an LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S as defined at 12VAC35-105-20, except for LMHP-R, LMHP-RP, and LMHP-S, which are defined in 12VAC30-50-226.

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

4. Individuals shall be discharged from this service when other less intensive services may achieve or maintain psychiatric stabilization.

D. Psychosocial rehabilitation services shall be provided to those individuals who have experienced long-term or repeated psychiatric hospitalization, or who experience difficulty in activities of daily living and interpersonal skills, or whose support system is limited or nonexistent, or who are unable to function in the community without intensive intervention or when long-term services are needed to maintain the individual in the community.

1. Psychosocial rehabilitation services shall be provided following a service-specific provider intake that clearly documents the need for services. This intake ~~that~~ shall be completed by either an LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S. An ISP shall be completed by either the LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, LMHP-S, or the QMHP-A, QMHP-E, or QMHP-C and be reviewed/approved by either an LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, ~~-~~LMHP-RP, or LMHP-S within 30 calendar days of service initiation. At least every three months, the LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, the QMHP-A, QMHP-C, or QMHP-E must review, modify as appropriate, and update the ISP.

2. Psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S who shall document the continued need for the service. The ISP shall be rewritten at least annually.

3. The enrolled provider of psychosocial rehabilitation services shall be licensed by DBHDS as a provider of psychosocial rehabilitation ~~or clubhouse~~ services.

4. Psychosocial rehabilitation services may be provided by an LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or a qualified paraprofessional under the supervision of a QMHP-A, a QMHP-C, a QMHP-E, or an LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S.

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

6. 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.

E. ~~Crisis~~ Initiation of crisis intervention services shall be indicated following a service-specific provider intake that documents a marked reduction in the individual's psychiatric, adaptive or behavioral functioning or an extreme increase in personal distress. In order to receive reimbursement, providers shall register this service with DMAS, DMAS contractors, or the BHSA within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

1. The crisis intervention services provider shall be licensed as a provider of emergency services by DBHDS ~~pursuant to 12VAC35-105-30~~.

2. Client-related activities provided in association with a face-to-face contact are reimbursable.

3. An individual service plan (ISP) shall not be required for newly admitted individuals to receive this service. Inclusion of crisis intervention as a service on

the ISP shall not be required for the service to be provided on an emergency basis.

4. For individuals receiving scheduled, short-term counseling as part of the crisis intervention service, an ISP shall be developed or revised ~~by the fourth face-to-face contact~~ to reflect the short-term counseling goals by the fourth face-to-face contact.

5. Reimbursement shall be provided for short-term crisis counseling contacts occurring within a 30-day period from the time of the first face-to-face crisis contact. Other than the annual service limits, there are no restrictions (regarding number of contacts or a given time period to be covered) for reimbursement for unscheduled crisis contacts.

6. Crisis intervention services may be provided to eligible individuals outside of the clinic and ~~billed,~~ reimbursed, provided the provision of out-of-clinic services is clinically/programmatically appropriate. Travel by staff to provide out-of-clinic services shall not be reimbursable. Crisis intervention may involve contacts with the family or significant others. If other clinic services are billed at the same time as crisis intervention, documentation must clearly support the separation of the services with distinct treatment goals.

7. An LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener~~, as defined in 12VAC30-50-226,~~ shall conduct a face-to-face service-specific provider intake. The intake shall document the need for and the anticipated duration of the crisis service.

8. Crisis intervention shall be provided by either an LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener.

9. For an admission to a freestanding inpatient psychiatric facility for individuals younger than age 21, federal regulations (42 CFR 441.152) require certification of the admission by an independent team. The independent team must include mental health professionals, including a physician. These preadmission screenings cannot be billed unless the requirement for an independent team certification, with a physician's signature, is met.

10. Services shall be documented through daily notes and a daily log of time spent in the delivery of services.

F. Case management services pursuant to 12VAC30-50-420 (seriously mentally ill adults and emotionally disturbed children) or 12VAC30-50-430 (youth at risk of serious emotional disturbance).

1. Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is an ISP in effect that requires regular direct or client-related contacts or activity or communication with the individuals or families, significant others, service providers, and others including a minimum of one face-to-face individual contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for case management services. Case management shall not be billed for persons in institutions for mental disease.

4. The ISP shall document the need for case management and be fully completed within 30 calendar days of initiation of the service. The case manager shall review the ISP at least 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.

5. The ISP shall also be updated at least annually.

6. The provider of case management services shall be licensed by DBHDS as a provider of case management services.

G. Intensive community treatment (ICT).

1. A service-specific provider intake that documents eligibility and the need for this service shall be completed by either the LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S prior to the initiation of services. This intake documentation shall be maintained in the individual's records. ~~Proper completion of the service-specific provider intake shall comport with the requirements of 12VAC30-50-130.~~

2. An individual service plan, based on the needs as determined by the service-specific provider intake, must be initiated at the time of admission and must be fully developed by either the LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and approved by the LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP, or LMHP-S within 30 days of the initiation of services.

3. ICT may be billed if the individual is brought to the facility by ICT staff to see the psychiatrist. Documentation must be present in the individual's record to support this intervention.

4. The enrolled ICT provider shall be licensed by the DBHDS as a provider of intensive community services or as a program of assertive community treatment, and must provide and make available emergency services 24-hours per day, seven days per week, 365 days per year, either directly or on call.

5. ICT services must be documented through a daily log of time spent in the delivery of services and a description of the activities/services provided. There must also be at least a weekly note documenting progress or lack of progress toward goals and objectives as outlined on the ISP.

H. Crisis stabilization services.

1. This service shall be ~~authorized~~ initiated following a face-to-face service-specific provider intake by either an LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, or a certified prescreener, as defined in 12VAC30-50-226.

2. In order to receive reimbursement, providers shall register this service with DMAS, DMAS contractors, or the BHSA within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination.

~~2.~~ 3. The service-specific provider intake must document the need for crisis stabilization services.

~~3.~~ 4. The Individual Service Plan (ISP) must be developed or revised within three

calendar days of admission to this service. The LMHP, ~~LMHP-supervisee, LMHP-resident,~~ LMHP-R, LMHP-RP, LMHP-S, certified prescreener, QMHP-A, QMHP-C, or QMHP-E shall develop the ISP.

~~4.~~ 5. Room and board, custodial care, and general supervision are not components of this service.

~~5.~~ 6. Clinic option services are not billable at the same time crisis stabilization services are provided with the exception of clinic visits for medication management. Medication management visits may be billed at the same time that crisis stabilization services are provided but documentation must clearly support the separation of the services with distinct treatment goals.

~~6.~~ 7. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization.

~~7.~~ 8. Providers of residential crisis stabilization shall be licensed by DBHDS as providers of ~~mental health~~ residential or nonresidential crisis stabilization services. Providers of community-based crisis stabilization shall be licensed by DBHDS as providers of mental health nonresidential crisis stabilization.

I. Mental health ~~support~~ skill-building services as defined in 12VAC30-50-226 B 8. ~~Refer to 12VAC30-50-226 for criteria, service authorization requirements, and service-specific provider intakes that shall apply for individuals in order to qualify for this service.~~

1. ~~Prior to~~ At admission, an appropriate face-to-face service-specific provider intake must be ~~completed,~~ conducted, documented, signed, and dated~~, and documented~~ by the LMHP, ~~LMHP-supervisee, LMHP-resident, or~~ LMHP-R, LMHP-RP ~~indicating that service needs can best be met through mental health support services~~. Providers shall be reimbursed one unit for each intake utilizing the appropriate billing code. Service-specific provider intakes 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.

~~2. The ISP, as defined in 12VAC30-50-226, shall be completed, signed, and dated by either a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E within 30 calendar days of service initiation, and shall indicate the specific supports and services to be provided and the goals and objectives to be accomplished. The LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP or QMHP-A, QMHP-C, or QMHP-E shall supervise the care if delivered by the qualified paraprofessional. If the care is supervised by the QMHP-A, QMHP-E, or QMHP-C, then the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP shall review and approve the supervision of the care delivered by the qualified paraprofessional.~~

~~3. Every three months, the LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, or QMHP-E shall review, modify as appropriate, and update the ISP showing a new signature and date of each revision. If the ISP review is conducted by the QMHP-A, QMHP-C, or QMHP-E, then it shall be reviewed/approved/signed/dated by the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP. The ISP shall be rewritten, signed, and dated by either a QMHP-A, QMHP-C, QMHP-E, an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP at least annually.~~

~~4. Only direct face-to-face contacts and services to individuals shall be reimbursable.~~

~~5. Any services provided to the individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or the individual's work towards obtaining a GED.~~

~~6. 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.~~

~~7. Room and board, custodial care, and general supervision are not components of this service.~~

~~8. This service is not billable for individuals who reside in facilities where staff are expected to provide such services under facility licensure requirements.~~

~~9. Provider qualifications. The enrolled provider of mental health support services shall be licensed by DBHDS as a provider of supportive in-home services, intensive community treatment, or as a program of assertive community treatment. Individuals employed or contracted by the provider to provide mental health support services shall have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations.~~

~~10. Mental health support services, which continue for six consecutive months, shall be reviewed and renewed at the end of the six-month period of authorization by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP who shall document the continued need for the services.~~

~~11. Mental health support services shall 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.~~

2. The primary psychiatric diagnosis shall be documented as part of the intake. The LMHP, LMHP-R, LMHP-RP, or LMHP-S performing the intake shall document the primary mental health diagnosis on the intake form.

3. 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 how many days per week and how many hours per week are required to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. The ISP shall indicate 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.

4. Every three months, the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in a manner in which he may participate with the process, modify as appropriate, and update the ISP. The ISP must be rewritten at least annually.

a. 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.

b. 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.

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

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

7. If the provider knows or has reason to know of the individual's nonadherence to a regimen of prescribed medication, medication adherence shall be a goal in the individual's ISP. If the care is delivered by the qualified paraprofessional, the supervising LMHP, LMHP-R, 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 concerns about medication nonadherence (provided that the individual has consented to such sharing of information). 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:

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the prescribing professional works for;

d. Date and time of call;

e. Reason for the care coordination call;

f. Description of medication regimen issue or issues to be discussed; and

g. Whether or not there was a resolution of medication regimen issue or issues.

8. Discharge summaries shall be prepared by providers for all of the individuals in their care. Documentation of prior psychiatric services history shall be maintained in the individual's mental health skill-building services medical record.

9. 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 by 12VAC30-50-226 B 8 b (3) and 12VAC30-50-226 B 8 c (4), by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Documentation of telephone contacts with the prior provider shall include the following minimum elements:

a. Name and title of caller;

b. Name and title of professional who was called;

c. Name of organization that the professional works for;

d. Date and time of call;

e. Specific placement provided;

f. Type of treatment previously provided;

g. Name of treatment provider; and

h. Dates of previous treatment.

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 the treatment provider shall be sufficient to meet this requirement. Family member statements shall not suffice to meet this requirement.

10. The provider shall document evidence of the psychiatric medication history, as required by 12VAC30-50-226 B 8 b (4) and 12VAC30-50-226 B 8 c (5), by maintaining a photocopy of prescription information from a prescription bottle or by contacting the current or previous prescribing 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 (i) the name of the prescribing physician, (ii) the name of the medication with dosage and frequency, and (iii) the date of the prescription shall be sufficient to meet these criteria. Family member statements shall not suffice to meet this requirement.

11. 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: (i) name and title of caller, (ii) name and title of prior professional who was called, (iii) name of organization that the professional works for, (iv) date and time of call, (v) specific prescription confirmed, (vi) name of prescribing physician, (vii) name of medication, and (viii) date of prescription.

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

13. Any services provided to the individual that are strictly academic in nature shall not be billable. These include, but are not limited to, such basic educational programs as instruction or tutoring in reading, science, mathematics, or GED.

14. 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.

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

16. Provider qualifications. The enrolled provider of mental health skill-building services must be licensed by DBHDS as a provider of mental health community support (defined in 12VAC35-105-20). 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. Mental health skill-building services shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the mental health skill-building services record.

17. Mental health skill-building services shall 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.

18. If mental health skill-building services are provided in a group home (Level A or B) or assisted living facility, effective July 1, 2014, there shall be a yearly limit of up to 4160 units per fiscal year and a weekly limit of up to 80 units per week, with at least half of each week's services provided outside of the group home or assisted living facility. There shall be a daily limit of a maximum of 20 units. Prior to July 1, 2014, the previous limits shall apply. 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.

19. Limits and exclusions.

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

b. Mental health skill-building services shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability Waiver or Individual and Family Developmental Disabilities Support Waiver.

c. Mental health skill-building services shall not be reimbursed for individuals who are also receiving independent living skills services, the Department of Social Services independent living program (22VAC40-151), independent living services (22VAC40-151 and 22VAC40-131), or independent living arrangement (22VAC40-131) or any Comprehensive Services Act-funded independent living skills programs.

d. Mental health skill-building services shall not be available to individuals who are receiving treatment foster care (12VAC30-130-900 et seq.).

e. Mental health skill-building services shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities or hospitals.

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

necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 days of mental health skill-building services.

g. Mental health skill-building services shall not be available for residents of residential treatment centers (Level C facilities) except for the intake code H0032 (modifier U8) in the seven days immediately prior to discharge.

h. Mental health skill-building services shall not be reimbursed if personal care services or attendant care services are being received simultaneously, unless justification is provided why this is necessary in the individual's mental health skill-building services record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through the Intellectual Disability Waiver (12VAC30-120-1000 et seq.), Individual and Family Developmental Disabilities Support Waiver (12VAC30-120-700 et seq.), the Elderly or Disabled with Consumer Direction Waiver (12VAC30-120-900 et seq.), and EPSDT services (12VAC30-50-130).

i. Mental health skill-building services shall not be duplicative of other services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E to avoid duplication of services.

j. Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving mental health skill-building services unless their physicians issue a signed and dated statement indicating that the individuals can benefit from this service.

k. Individuals who are not diagnosed with a serious mental health disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the mental health skill-building services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 B 8 b (1) or 12VAC30-50-226 B 8 c (2) and that the provider can document and describe how the individual is expected to actively participate in and benefit from mental health support services.

J. Except as noted in subdivision I 18 of this section and in 12VAC30-50-226 B 6 e, the limits described in this regulation and all others identified in 12VAC30-50-226 shall apply to all service authorization requests submitted to either DMAS or the BHSA as of [the effective date of this regulation]. As of [the effective date of these regulations], all annual limits, weekly limits, daily limits, and reimbursement for services shall apply to all services described in 12VAC30-50-226 regardless of the date upon which service authorization was obtained.