Community Mental Health and Rehabilitative Services

Changes in the Virginia Department of Medical Assistance Services Regulations

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DMAS Regulation Changes

Regulation changes went into effect as of January 30, 2015 for DMAS Community Mental Health and Rehabilitative Services.

This presentation will review the changes.

**DISCLAIMER:**

THIS PRESENTATION IS NOT MEANT TO SUBSTITUTE FOR THE COMPREHENSIVE PROVIDER MANUAL OR STATE AND FEDERAL REGULATIONS.

The Community Mental-Health Rehabilitation Services manual is located at: [https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual](https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)

Final regulations are located on the Virginia Regulatory Town Hall at: [http://townhall.virginia.gov/L/ViewXML.cfm?textid=9322](http://townhall.virginia.gov/L/ViewXML.cfm?textid=9322)
Regulation Sections in Administrative Code

Some cross references are present that refer to the children’s regulation sections for definitions used in adult services. Ex: “Service Specific Provider Intake” is defined in the children’s section but referenced in the adult services as a requirement. Individual Service Plan is defined in the Adult section but referenced in children’s service sections.

Covered Services Children
• [http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section130](http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section130)

Covered Service Adult

UR criteria and MNC criteria in general:
• [http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section5/](http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section5/)

UR and MNC children’s

UR and MNC Adult
• [http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section143/](http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section143/)

Marketing:
“BHSA” as Defined in the MHSS Emergency Regulations

Magellan Health serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the behavioral health benefits program under contract with DMAS. Magellan is 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. Magellan’s authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and the designated BHSA. DMAS shall retain authority for and oversight of the BHSA entity or entities.

Providers under contract with Magellan of Virginia should consult Magellan’s National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.
Changes in Service Authorization Processing at Magellan: June 1, 2015

As of January 30, 2015 the new regulations are in effect.

Case Management Registrations may be processed right now.

Staff requirements, licensing requirements, service plan requirements, service specific provider intake and procedural changes must be in compliance with the regulations.

Magellan will implement the new program requirements and verify that new requirements are met by providers on all new service requests and continued stay/concurrent review requests beginning on June 1, 2015.

Providers are expected to adhere to all new regulatory changes as of January 30, 2015.
Services NOT Impacted by Rule Changes and the LMHP Requirement for Service Specific Provider Intakes

Mental Health Skill-building Services* (MHSS rules are defined by currently effective Emergency Regulations)
MH Case Management* (no changes to service model or requirements)
Substance Abuse Crisis Intervention
Substance Abuse Intensive Outpatient Treatment
Substance Abuse Day Treatment
Opioid Treatment
Residential Substance Abuse Treatment for Pregnant and Post Partum Women
Substance Abuse Day Treatment for Pregnant and Post Partum Women
Substance Abuse Case Management
Provider Impacts

Are the staff qualifications in the regulations currently in effect?

ANSWER: Yes. The staff qualifications went into effect on January 30, 2015. DMAS worked closely with the Department of Behavioral Health and Developmental Services and the Department of Health Professions to ensure that DMAS requirements align with the provider and practitioner licensing requirements issued by these agencies. These changes were subject to public comment. In addition, DMAS discussed LMHP and QMHP staff qualification issues with providers regularly as these regulations were being developed and promulgated. (As a result, additional types of LMHPs and QMHPs are permitted to provide services.)

Will the new regulations affect documentation requirements?

ANSWER: Yes. Documentation in the clinical record must be in compliance with and reflect the new regulatory language, consistent with the effective date of these regulations. Additionally, documentation submitted for service authorization will be validated within the clinical record upon post payment review. Inconsistencies may be subject to retraction and/or referral to the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General.
LMHP Role and Definitions

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.

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

Professional clinical services must be provided by a LMHP or a LMHP Supervisee or Resident, unless otherwise noted.

As Defined in 12VAC35-105-20 (DBHDS Regulations)
"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.
New Definition for LMHP “Types”

As defined in 12VAC30-50-130:

"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.
New Definition for LMHP “Types”

As defined in 12VAC30-50-130:

"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.
New Definition for LMHP “Types”

As defined in 12VAC30-50-130:

"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.
Marketing Requirements

Providers shall comply with DMAS marketing requirements at 12VAC30-130-2000. Providers that DMAS determines violate these marketing requirements shall be terminated as a Medicaid provider pursuant to 12VAC30-130-2000 E.
Magellan Care Coordination, Provider Service Coordination and Coordination with CSB and TFC Case Managers
Case Management vs. Service Coordination

Case Management is a stand alone service that supports the global needs of the individual in any or all realms of life related to level of functioning.

Example: assisting a client/family in obtaining resources based on input from the member or other service providers involved in the care.

Service Coordination is activity that enhances the benefit of the specific service for the member/family.

Example: exchanging information with a psychiatrist about observations of a child’s behavior during sessions to optimize interventions defined in the Individual Service Plan.
Care Coordination

Care Coordination is provided by Magellan employed clinical staff who are licensed behavioral health clinicians. The central purpose of Care Management is to help individuals receive quality services in the most cost-effective manner. The primary activities of care management include utilization management, triage and referral, opening communication between identified providers, aligning care plans, discharge planning following 24 hours levels of care, continuity of care, care transition, quality management, and independent review.

"Care coordination" means collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

DMAS and Magellan of Virginia agree that care coordination has two (2) main goals:

1) to improve the health and wellness of individuals with complex and special needs; and
2) to integrate services around the needs of the individual at the local level by working

Examples when Magellan may provide care coordination to assist individuals and families include:
Ambulatory follow-up and discharge planning (including follow-up appointments) for all individuals in inpatient and/or residential settings under their management.
An MCO liaison at Magellan will work with MCOs to develop strategies for identification of individuals with co-morbid behavioral health and medical needs and facilitate referrals into respective systems of care.
Care coordination with Primary Care Physicians (PCPs).
Assistance with transferring cases from one provider to another
Care Coordination

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• Care coordination with Primary Care Physicians (PCPs).

• Assistance with transferring cases from one provider to another
"Care coordination" in the regulations defined in 12VAC30-50-130 means the same as Service Coordination defined in the DMAS manual as collaboration and sharing of information among health care providers, who are involved with an individual's health care, to improve the care.

The purpose of Service Coordination is to ensure that the individual receives all needed services and supports; that these resources are well-coordinated and integrated; and that they are provided in the most effective and efficient manner possible.

For an individual receiving CMHR services, this activity is meant to ensure an optimal Individual Service Plan be developed based on as much information as possible related to both the member's physical and behavioral clinical picture.

Service Coordination is done in the spirit of collaboration with the treatment team and is meant to support the member on his or her path of recovery.
Provider Service Coordination

Service Coordination includes:

• Assisting the individual to access and appropriately utilize needed services and supports;
• Assisting them to overcome barriers to being able to maximize the use of these resources;
• Actively collaborating with all internal and external service providers;
• Coordinating the services and supports provided by these individuals (including family members and significant others involved in the consumer’s life);
• Assessing the effectiveness of these services/supports;
• Preventing duplication of services or the provision of unnecessary interventions and supports; and
• Revising the service plan as clinically indicated.
Provider Service Coordination

Service coordination between different providers is required and must be documented in the ISP and Progress Notes.

- Service Coordination serves to help align services to prevent duplication and is intended to complement the service planning and delivery efforts of each service.
- Providers must collaborate and share information among other health care providers and individuals who routinely come in contact with the individual, i.e. PCPs, Case Managers, Probation Officers, Teachers, etc. and who are involved with the individual’s health care and overall wellbeing in order to improve care.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual’s receipt of community mental health rehabilitative services including efforts to schedule well visits for kids and as needed physician visits for adults.
Provider and Case Management Coordination

Should the individual receiving CMHRS (*except ICT*) be enrolled in Case Management Services, it is **required** that the service provider have a minimum of the following contact with the Community Services Board or Behavioral Health Authority case manager:

1. Notify the CSB/BHA case manager that the individual is enrolled with the service provided.

2. Send monthly updates of the individual’s status to the CSB Case Manager.

3. Send a discharge summary to the case manager within 30 days of the service discontinuation date.
Service Specific Provider Intake & Individual Service Plan
All Mental Health Services:
Service Specific Provider Intakes

Service-specific provider intake (SSPI) means the evaluation that is conducted according to the Department of Medical Assistance Services as defined in 12VAC30-50-130. The SSPI defines the medical necessity of the service and defines the treatment needs to be addressed by the service plan.

Unless otherwise specified, service-specific provider intakes shall be conducted by:

- A licensed mental health professional (LMHP);
- LMHP “Types”:
  - LMHP-supervisee in social work or LMHP-S;
    - *Supervisee is defined in 18VAC140-20-10*
  - LMHP-resident or LMHP-R; or
    - *Resident is defined in 18VAC140-20-10*
  - LMHP-resident in psychology or LMHP-RP*
    - *Individual in residency is defined in 18VAC140-20-10*
Which Service Requires a Specific Intake Using an LMHP Type?

A service specific provider intake must be completed prior to initiating each of the following services:

Intensive In-home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Mental Health Crisis Intervention* (only if an ISP is developed-refer to service details)
Mental Health Crisis Stabilization
Mental Health Day Treatment/Partial Hospitalization Services
Psychosocial Rehabilitation
Intensive Community Treatment
Mental Health Skill-building Services
Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)

For services that require a service authorization, the service specific provider intake must be used to determine the medically necessity for each service requested on behalf of the individual.
Which Service Requires a Specific Intake Using Unchanged Provider Rules?

*MH and SA Case Management intakes do not require the same credentials as the direct MH services. MH Case Management intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services.

Refer to licensing rules for all services:

http://law.lis.virginia.gov/admincode/title12/agency35/chapter105/section650/

A service specific provider intake must be completed prior to initiating each of the following services:

- Substance Abuse Residential Treatment for Pregnant Women
- Substance Abuse Day Treatment for Pregnant Women
- Mental Health Case Management
- Substance Abuse Case Management
- Substance Abuse Crisis Intervention
- Substance Abuse Intensive Outpatient
- Substance Abuse Day Treatment
- Opioid Treatment
Service Specific Provider Intake Required Elements

Service-specific provider intake includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements:

(i) the presenting issue/reason for referral,
(ii) mental health history/hospitalizations,
(iii) previous interventions by providers and timeframes and response to treatment,
(iv) medical profile,
(v) developmental history including history of abuse, if appropriate,
(vi) educational/vocational status,
(vii) current living situation and family history and relationships,
(viii) legal status,
(ix) drug and alcohol profile,
(x) resources and strengths,
(xi) mental status exam and profile, NEW
(xii) diagnosis,
(xiii) professional summary and clinical formulation,
(xiv) recommended care and treatment goals, and
(xv) the dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.
All Services: Service Specific Provider Intake Frequency

All services* require a Service Specific Provider Intake to be completed at the onset of services. The Service Specific Provider Intake must be completed face to face by an LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP for all services except Crisis Intervention and Crisis Stabilization which allow the use of an LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP and a Certified Pre-Screener.

*All fifteen Service Specific Intake elements are required to be documented by providers of Substance Abuse Treatment Services and Case Management services. The 15 required service specific provider intake elements must be completed by staff as defined in the Department of Behavioral Health and Developmental Services licensing requirements for assessments as described in 12VAC35-105-650. Intakes for substance abuse treatment services and case management must be conducted by staff who meet the licensing requirements defined by DBHDS and defined in the DMAS CMHRS provider manual.

For services that continue for 12 months or more, the provider must complete an intake every 12 months. (must be reimbursed to qualify for ongoing service reimbursement)

*Missing Intake claims are a leading cause of claims denials for services

If there is a lapse in services that is greater than 31 consecutive calendar days without any communications from family members/legal guardian or the individual with the service provider, the provider shall discharge the individual. If the individual continues to need services, then a new service specific provider intake shall be completed and a new service authorization shall be required.
All Services: Individual Service Plan Requirements

As defined in 12VAC30-50-226, the ISP is 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, as defined in 12VAC30-50-226, shall be updated as the individual's needs and progress changes and signed by either the parent or legal guardian and the individual. Documentation shall be provided if the individual is unable or unwilling to sign the ISP.

The ISP must include the estimated timetable for achieving the goals and objectives, describe how progress will be measured and include discharge plans that are specific to needs of the individual at the time the service needs are reviewed.

Service plans shall incorporate an individualized discharge plan that describes transition from current services to other appropriate less intensive services. The discharge plan must describe the methods that will be used to facilitate a successful transition to services.
All Individual Service Plans should be completed in a **Person Centered Manner**

The Person Centered ISP:
- is based on the understanding of the individual gained during the intake.
- is the road map for the work done by the client and provider.
- addresses the Strengths, Needs, Abilities, and Preferences of the individual.
- balances strengths with barriers.
- focuses on the client’s life vision by incorporating his/her hopes, dreams, and goals.
- is a “living” or “working” document.

• Magellan presentation on **Effective Assessment and Service Planning: The Basics** can be found on the MagellanofVirgina.com (for providers-trainings)
ISP Changes

An ISP that does not include all required elements shall be considered incomplete and not meeting the reimbursement requirements.

- **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.

- **Interventions/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 service coordination
  - Parent and Caregiver objectives *included in IIH services* must be related to increasing functional and appropriate interpersonal interactions and must include the individual-specific program purpose of the goals to be achieved within the authorized time period;
ISP Changes

• **Frequency:**
  - The ISPs should include the frequency with which the overall service will be provided
  - The ISP must be reviewed, at a minimum, on a quarterly basis (every 3 months) to determine if the goals and objectives meet the needs of the individual based on the most recent clinical review of the service documentation and assessment of functioning.
  - The review of progress as well as any changes to the ISP must be documented in the quarterly report. All revised service plans must be signed by the individual and/or family.

• **Discharge Goal:** All ISPs should include an individualized discharge plan that includes an estimated timetable to achieving the goals and objectives in the service plan. The discharge plan must describe the methods that will be used to facilitate a successful transition to services.
ISP Changes

• **Service Coordination:**
  - All ISPs should clearly include service coordination as necessary
  - Service coordination activities must be defined related to the specific treatment needs and the related service goals and objectives and describe any psycho-educational or service 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.

• **Continuity of Care:** All ISPs should clearly identify all current professionals involved in the individual’s care and all who will be involved in service coordination (i.e. educational, psychiatric, medical, case management, probation, etc.)
Service Changes, “At Risk” Process, & SRA Forms
Changes:

- New definitions for At Risk and Out of Home Placement impact the medical necessity criteria
- Medical necessity criteria has been re-organized to better clarify eligibility for the service.
- New VICAP Processing requirements for those deemed at risk
- Service Coordination is required to coordinate the service with other service providers and persons involved in the individuals care
Discharge Criteria:

- Medicaid reimbursement is not available when other less intensive services may achieve stabilization.
  - Reimbursement shall not be made for this level of care if the following applies:
    - The individual no longer meets the at risk criteria; or
    - The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.

- Discharge is required when the individual has achieved maximal benefit from this level of care and their level of functioning has not improved despite the length of time in treatment and interventions attempted and the individual meets all of the discharge criteria:
Children’s Services: Intensive In-Home Services

Changes:

• Revised Service Definition
• New definitions for At Risk and Out of Home Placement
• New VICAP Processing requirements for those deemed at risk
• Must adhere to new ISP definition (All Services)
  • *Strictly defined in IIH.*
  • *All interventions and settings of interventions should be defined in the ISP*
• TFC and IIH may be covered at the same time
Children’s Services: Intensive In-Home Services

Case management is removed from IIH due to a federal requirement in 42 CFR § 441.18. The service definition is revised to provide for care coordination which can be referred to as “service coordination” and will include activities designed to implement treatment goals by the service provider.

Important points to remember!

• Individuals enrolled in IIH and who are in need of Case Management Services may receive these services from their local Community Services Board or Behavioral Health Authority.

• It is not required for the individual enrolled in IIH to receive Case Management.

• Should an IIH provider recognize the need for Case Management Services the individual should be referred to the local CSB to be assessed for this service. If providers need assistance with the referral, Magellan is available to assist them.
Children’s Services: Intensive In-Home Services

Revised Service Definition:
Intensive in-home services (IIH) to children and adolescents under age 21

• shall be time-limited interventions provided in the individual's residence and when clinically necessary in community settings
• All interventions and the settings of the intervention shall be defined in the Individual Service Plan
• IIH services shall be designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home
• designed to promote psychoeducational benefits in the home setting of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the individual
• These services provide crisis treatment; individual and family counseling; communication skills (e.g., counseling to assist the individual and his parents or guardians, as appropriate, to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); care coordination with other required services; and 24-hour emergency response
Children’s Services: Intensive In-Home Services

Covered services and limitations

• It is expected that the pattern of service provision may show more intensive services and more frequent contact with the individual and family initially with a lessening or tapering off of intensity toward the latter weeks of service.

• Activities outside the home, such as trips to the library, restaurants, museums, health clubs, shopping centers, and the like, are not considered a part of the scope of services. There must be a clinical rationale documented for any activity provided outside the home. Services may be provided in the community instead of the home if this is supported by the service specific provider intake and the ISP.
Discharge Criteria

• Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

• Reimbursement shall not be made for this level of care if the following applies:
  a. The individual is no longer at risk of being moved into an out-of-home placement related to behavioral health symptoms; and
  b. The level of functioning has improved with respect to the goals outlined in the ISP, and the individual can reasonably be expected to maintain these gains at a lower level of treatment.
  c. The child is no longer in the home.
  d. There is no parent or responsible adult actively participating in the service.

• Discharges shall also be warranted when the service documentation does not demonstrate that services meet the IIH service definition or when the services progress meets the “failed services” definition:
Children’s Services: “Failed Services”

For IIH and TDT

- “Failed services” will not be authorized for payment
  - "Failed services" or "unsuccessful services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.
"At risk” means one or more of the following:

• (i) within the two weeks before the intake, the individual shall be screened by an LMHP type for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis intervention, crisis stabilization, hospitalization or other high intensity interventions are or have been warranted; REFER to Emergency Services for Assessment if necessary.

• (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement;

• (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, and who is neither an employee of or consultant to the IIH services or therapeutic day treatment (TDT) provider, has recommended an out of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident;
"At risk” means one or more of the following:

• (iv) the individual has a history of unsuccessful services (either crisis intervention, crisis stabilization, outpatient psychotherapy, outpatient substance abuse services, or mental health skill building) within the past 30 days.

• (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who is either:
  • (a) transitioning (within the last 30 days) out of residential treatment facility Level C services,
  • (b) transitioning (within the last 30 days) out of a group home Level A or B services,
  • (c) transitioning (within the last 30 days) out of acute psychiatric hospitalization, or
  • transitioning (within the last 30 days) between foster homes, mental health case management, crisis intervention, crisis stabilization, outpatient psychotherapy, or outpatient substance abuse services.
"Out-of-home placement" means placement in one or more of the following:

- (i) either a Level A or Level B group home;
- (ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services;
- (iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care;
- (iv) Level C residential facility
- (v) emergency shelter for the individual only due either to his mental health or behavior or both;
- (vi) psychiatric hospitalization; or
- (vii) juvenile justice system or incarceration.
Children’s Services: At Risk Criteria and Case Processing

For all individuals that have been screened by an LMHP type and meet criteria “i” of the “At Risk Criteria” they are deemed “at risk for physical injury” and the service-specific intake and service authorization process must be managed by the provider according to the following requirements:

- Within the two weeks prior to the SSPI, the individual shall be screened by an LMHP* for escalating behaviors that have put either the individual or others at immediate risk of physical injury.
  *The LMHP screening can occur in the community but it will also occur during the VICAP.
- For individuals who meet the criteria “i”, the VICAP assessor will arrange for an immediate emergency services evaluation at the CSB to determine the most appropriate level of service.

The following must happen when individuals are referred for IIH or TDT when the individual is deemed safe to initiate services in the community by the VICAP assessor or emergency services provider:

- The SSPI must take place within 14 calendar days of the screening (VICAP or other *LMHP)
- If the SSPI is not completed within 14 calendar days of the screening, a risk screening must be done by the LMHP, this may be the LMHP doing the SSPI, to determine if the delay in treatment poses any threats or concerns to the individual or others.
- The risk screening must be submitted along with the service authorization request to Magellan. If an authorization request is submitted with either an incomplete SSPI or a risk screening, the authorization request will be pended for up to three business days.
- Please note, the VICAP assessment is valid for 30 days only.
At Risk Criteria and Case Processing

VICAP Assessment (good for 30 days) → Individual meets “at risk for physical injury criteria” → Referred to IIH/TDT

- NO (bet. 15-30 days)
  - Complete Risk Screening Tool → Submit SRA & Risk Tool

- SSPI w/in 14 days
  - YES → Submit SRA
VICAP Process when a member is “At Risk”

• The VICAP assessor has the ethical and clinical responsibility to ensure that any member who is “at risk” receives the appropriate level of care.
  • If the individual is deemed at risk of physical injury or the risk assessment determines there is a need for immediate intervention, the provider will work with the appropriate entities (parents, local CSB, local hospital) to come up with a safety plan and conduct an emergency services assessment to assess for the most appropriate level of care.

• If the individual is deemed safe to initiate services in the community by the VICAP assessor or emergency service provider the assessor should:
  • direct the parent/legal guardian to MagellanofVirginia.com – “Find a Provider”
  • call Magellan with the parent/legal guardian to get help with finding a provider search
  • Provide the parent/legal guardian with the Magellan Customer Service number 800-424-4046

• The parent and legal guardian should be told that the member was determined to be at risk and that a service specific provider intake should be completed within 14 days.
DMAS Risk Screening Tool

• The DMAS Risk Screening Tool should be used:
  • By the LMHP when the SSPI is not completed within 14 calendar days of the screening
  • The Risk Screening Tool must be submitted with the SRA.
  • Handout – DMAS Risk Screening Tool
Community-based services for children and adolescents under 21 (Level A and B).

Service Specific Provider Intake Required for all cases

Care coordination is now a part of Group Home Level A services.

Should the individual receiving Group Home Level A or B services be enrolled in Case Management Services, it is required that the Level A or B service provider have a minimum of the following contact with the Community Services Board or Behavioral Health Authority case manager:

1. Notify the CSB/BHA case manager that the individual is enrolled services.
2. Send monthly updates of the individual’s status to the CSB Case Manager.
3. Send a discharge summary to the case manager within 30 days of the service discontinuation date.
Crisis Intervention

Changes:

• Effective Immediately-Services must be registered with Magellan within one business day of the provision of the service-specific intake.

• The service-specific provider intake (face to face), as defined at 12VAC30-50-130, shall document the individual's behavior and describe how the individual meets criteria for this service.
  • If the intake is completed by the pre-screener it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within one business day.
  
  • During Emergency Custody Order (ECO) related Crisis Intervention services CSB’s may use the DMAS 224-Preadmission Screening form to document the required elements of the service specific provider intake as defined in Chapter 6 of this manual.

• Provision of services shall be provided by a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, or certified pre-screener.

• Providers shall be licensed as a provider of emergency services.
Crisis Stabilization

Changes:

• Effective Immediately-Services must be registered with Magellan within one business day of the provision of the service-specific intake. *(An authorization is required for any GAP recipient receiving this service. Soon when the MHSS regulations are finalized the service will require authorization just like GAP)*

• A face to face service-specific intake must be completed by an LMHP, LMHP-supervisee, LMHP Resident, or LMHP-RP.
  • If the intake is completed by the pre-screener it must be signed off by an LMHP, LMHP-supervisee, LMHP-resident or LMHP-RP within one business day.

• Provision of services shall be provided by a LMHP, LMHP-supervisee, LMHP-resident, LMHP-RP, QMHP-A, QMHP-C, QMHP-E, or a certified pre-screener.
  • Crisis stabilization may be provided up to **15 consecutive days in each episode**, up to 60 days annually. Daily service provision is limited to the times when the individual meets the clinical necessity and service definition requirements.

• Residential Crisis Stabilization providers shall be licensed as providers of mental health residential crisis stabilization services.

• Providers of community-based crisis stabilization shall be licensed as providers of mental health nonresidential crisis stabilization.
Intensive Community Treatment

Changes:
• Case Management may be allowed*
• Revised Medical Necessity Criteria

*For ICT and PACT services this unbundling may only serve to be a technicality since the service model includes case management and service coordination as an included part of the service. DMAS is working with provider associations to define the scope of ICT as it relates to the provision of service coordination.

*DMAS is consulting with CMS on this rule: stay tuned for more details
Intensive Community Treatment

Case management is being removed from ICT due to a federal requirement in 42 CFR § 441.18. The service definition is revised to provide for care coordination which DMAS defines in the manual as “service coordination” and will include activities designed to implement treatment goals by the service provider.

• Individuals enrolled in ICT may receive Case Management Services from their local Community Services Board or Behavioral Health Authority.
• It is not required for the individual enrolled in ICT to receive Case Management.
• In the ICT/PACT model the individual accepts a holistic service delivery system when they choose to receive ICT
• Should an ICT provider recognize the need for Case Management Services, the individual should be referred to the local CSB to be assessed for this service and decide which service model is in their best interest.
Day Treatment/Partial Hospitalization

Changes:

• Revised Medical Necessity Criteria

• 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.
  • This requirement is in addition to the SSPI and must be provided by an LMHP
Day Treatment/Partial Hospitalization

Revised Medical Necessity Criteria

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.

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.
 Revised Medical Necessity Criteria:
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 SSPI must be performed by an LMHP type

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.

b. 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.
The Service Request Application (SRA)

- The clinical information received by Magellan is crucial.

- The Magellan clinical staff rely on this information to develop an understanding of what is happening with the member at the time the SRA is submitted.

- Care managers also use supporting documentation submitted to inform the case conceptualization they develop to make the decision about the service being requested.

- Without key information leading to a clear understanding of the needs of the member, an authorization is unable to be granted.
Update to Current SRA’s

Questions related to the SSPI

• Initial forms ask: Was the Intake completed by an LMHP type? Yes  No

• VICAP/Intake questions for TDT and IIH:
  • Was an Independent Clinical Assessment completed through the Community Service Board (CSB) /Behavioral Health Authority (BHA)? Yes  No
    – If yes, what was the date of the assessment?
    – If yes, please explain why:
  • Did the VICAP indicate the child is demonstrating behaviors that have put either the individual or others at immediate risk of physical injury? Yes  No
  • If yes, to question 4, was the Intensive In-Home Intake done within 14 days of the VICAP? Yes  No
    – If no to question 5, was a specific suicide/homicide risk assessment done? Yes  No
    – If the VICAP is older than 14 business days, the specific suicide/homicide risk assessment must be submitted with this SRA.
    – What was the date of the Intensive In-Home Intake for this individual? Date:
Update to Current SRA’s

Questions related to the ISP

• Examples of ISP questions from some initial and continued stay forms
  • List initial treatment goals identified at intake for the individual and parent/guardian related to the behaviors listed in 18a – If immediate physical threat to self or others is indicated in the VICAP or intake, include safety goals included in the ISP:
  • Was an ISP developed with the individual by an LMHP or QMHP within 30 days? Yes  No
    - Please submit the current, signed ISP.
  • Was an Individualized Service Plan (ISP) developed within 30 days of the beginning of services for this individual by an LMHP or QMHP: Yes  No
    - If yes, has this ISP been reviewed and updated at least every 3 months: Yes  No  Not Applicable
  • Are services provided in accordance with an Individual Service Plan (ISP) which was fully completed by an LMHP type or QMHP type within 30 days of initiation of the service and signed by individual as well as parent or guardian? Yes  No
    - Please describe summary of individual’s progress during previous authorization period:
Update to current SRA’s

Questions related to Service Coordination

• Examples of Service/Care Coordination questions
  • Has the local CSB been contacted to determine if Mental Health Case Management services are being provided? Yes No
    - Date of Contact: Name of CSB:
  
  • Is the individual receiving Mental Health Case Management? Yes No
    - If yes, what is the name of the Mental Health Case Manager?
    - If no, was a referral made to the CSB for Mental Health Case Management with the consent of the parent or guardian? Yes If yes, date of referral: No - If no, why not?
Update to current SRA’s

Questions related to Service Coordination

• Examples of Service/Care Coordination questions
  • Does the individual have a primary care physician (PCP)? Yes  No
    - If yes, has there been communication with the PCP to provide updates regarding treatment and service coordination? Yes  No
    - If yes, name of Physician:
    - If no, have there been efforts to connect the individual with a PCP? Yes  No
  • Have Health, Safety and Welfare issues been identified with this Individual? Yes  No
    - If yes, has a Child Protective Services (CPS) referral been made? Yes  No
    - If no, what intervention(s) have been taken to address this concern?

**on IIH and TDT forms**
Update to current SRA’s

Questions related to Medical Necessity

Does the individual have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization or homelessness or isolation from social supports?  Yes  No

• If yes, please explain using specific behaviors including frequency and intensity of these behaviors, and avoiding vague words such as ‘aggressive’:

Does individual exhibit behaviors that require repeated interventions by the mental health, social services or judicial system?  Yes  No

• If yes, please explain using specific behaviors including frequency and intensity of these behaviors, and avoiding vague words such as ‘aggressive’. Also explain the interventions being required by the community systems:
Progress Notes and Documentation Requirements
Progress Notes and General Documentation
Requirements

• "Progress notes" means individual-specific documentation that contains the unique differences particular to the individual's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes.

• Individualized and member-specific progress notes are part of the minimum documentation requirements and shall convey the following:
  • individual's status,
  • staff interventions, and, as appropriate,
  • the individual's progress, or
  • lack of progress, toward goals and objectives in the ISP.
Progress Notes and General Documentation

Requirements

The content of each progress note shall corroborate the time and specifically document the service provided to support each of the units billed.

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 that are supported by documentation that does not demonstrate unique differences particular to the individual.
Progress Notes and General Documentation Requirements

The progress notes shall also include, at a minimum:

- Name of the service rendered,
- Date of the service rendered,
- Signature and credentials of the person who rendered the service,
- Setting in which the service was rendered, AND
- The amount of time or units/hours required to deliver the service.

- **The content of each progress note shall corroborate the time/units billed.**
- **Progress notes shall be documented for each unit of service that is billed.**
Progress Notes and General Documentation
Requirements

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 the information in the electronic health records.

The provider must maintain a copy of the entire fully completed Independent Clinical Assessment in each individual’s file.

After the Independent Clinical Assessment is completed and prior to admission, a face-to-face service specific provider intake must be conducted and documented.
Confidentiality Statement for Providers

The information presented in this presentation is confidential and expected to be used solely in support of the delivery of services to Magellan members. By receipt of this presentation, each recipient agrees that the information contained herein will be kept confidential and that the information will not be photocopied, reproduced, or distributed to or disclosed to others at any time without the prior written consent of Magellan Health, Inc.

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Thank You