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MEDICAID MEMO

TO: All Community Mental Health and Rehabilitation Service Providers and Managed Care Organizations

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 11/20/18

SUBJECT: Updates to Community Mental Health Rehabilitative Services (CMHRS)

The purpose of this memorandum is to detail changes related to Community Mental Health Rehabilitative Services (CMHRS). The Department of Medical Assistance Services (DMAS) will be updating the *CMHRS* provider manual with the following changes: 1) Implementing the Comprehensive Needs Assessment (effective January 1, 2019); 2) Clarifying the recommendation for a psychiatric evaluation in Crisis Stabilization services; and 3) Removing the *At Risk of Physical Injury* form (P502) requirement in Therapeutic Day Treatment (TDT) and Intensive In-Home (IIH) Services.

Comprehensive Needs Assessment

Effective January 1, 2019, DMAS is implementing the Comprehensive Needs Assessment in CMHRS to allow for a single assessment to be used when recommending one or more CMHRS services provided by the same Department of Behavioral Health and Developmental Services (DBHDS) licensed agency. Allowing one Comprehensive Needs Assessment in place of multiple Service-Specific Provider Intakes (SSPIs) is intended to support member access to care and efficiency by reducing the time and administrative burden on providers and members they serve. Licensed agencies include providers with a specific DBHDS license to provide one or more of the following services: IIH, psychosocial rehabilitation (PSR), TDT, day treatment/partial hospitalization, mental health skill-building (MHSS), intensive community treatment (ICT), crisis stabilization, crisis intervention and mental health case management. SSPIs and Psychiatric Diagnostic Interviews completed prior to January 1, 2019 will not apply to the Comprehensive Needs Assessment criteria. Effective January 1, 2019, a Comprehensive Needs Assessment that follows the guidelines in this memorandum is required for new requests for CMHRS services and CMHRS services previously recommended by a SSPI that is outdated (greater than 12 months old).

The Comprehensive Needs Assessment must document the medical necessity for each recommended CMHRS service including mental health case management. The Comprehensive Needs Assessment for CMHRS shall be conducted by a Licensed Mental Health Professional (LMHP), LMHP-Resident (LMHP-R), LMHP-Supervisee (LMHP-S) or LMHP Resident in Psychology (LMHP-RP).

The Comprehensive Needs Assessment requires a face-to-face assessment by a LMHP, LMHP-R, LMHP-S or LMHP-RP to gather information about the individual's mental health status and symptoms from the individual and parent, guardian or other family members as appropriate. The Comprehensive Needs Assessment must include the same 15 elements previously required by the SSPI and as described in Chapter 4 of the *CMHRS* provider manual. The Comprehensive Needs Assessment is required prior to the development of the Individual Service Plan (ISP) for each service and is used as the basis for the ISP for the entire duration of services.

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

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

Comprehensive Needs Assessment Recommending CMHRS Services Provided by the Same DBHDS Licensed Agency

When the initial Comprehensive Needs Assessment recommends several CMHRS services for an individual, the provider shall use this assessment for all CMHRS services recommended within the same DBHDS licensed agency. If additional service needs are identified after the completion of the initial Comprehensive Needs Assessment, the provider shall amend the initial Comprehensive Needs Assessment. The initial Comprehensive Needs Assessment is valid for one year from the date of the assessment. If CMHRS services are not initiated within 31 calendar days from the date they are recommended by a LMHP, LMHP-R, LMHP-RP or LMHP-S, the Comprehensive Needs Assessment shall be amended or updated prior to initiating services. Please see the reassessment section of this memo for additional details. Please note that services should start as soon as possible after the initial assessment. Crisis intervention and crisis stabilization services require immediate service delivery and it is not appropriate to have a delay of up to 31 days to initiate the service.

Providers shall only bill for one Comprehensive Needs Assessment when these services are provided by the same agency. The provider shall bill the most appropriate assessment code, and if recommending more than one service, may choose the higher reimbursed assessment code of the services that are being recommended as long as they are licensed by DBHDS to provide the service and contracted with Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs). If the provider later amends the Comprehensive Needs Assessment due to the changing treatment needs of the individual, the amendment to the Comprehensive Needs Assessment is not billable.

For example, if the provider is recommending IIH and TDT in the initial Comprehensive Needs Assessment, the provider may bill only one assessment code and may choose the higher reimbursement of the two: IIH Assessment/H0031 at $60.00. The billing code and reimbursement rate must follow what is currently posted on the DMAS Fee File Schedule. Another example, if the provider performs the initial Comprehensive Needs Assessment and recommends TDT only, the provider would bill TDT Assessment/H0032 U7 at $36.53. If the same DBHDS licensed provider amends the Comprehensive Needs Assessment at a later date (within one year from date of original assessment) to support the need for an additional service, the provider would not bill for an additional assessment and shall submit the service authorization to request the additional service as required.

Comprehensive Needs Assessment for CMHRS Services Provided by Multiple DBHDS Licensed Agencies

When coordinating services with another DBDHS licensed agency, providers should share assessments with appropriate consent from the member; however, the agency receiving the referral shall complete a new Comprehensive Needs Assessment for the service they are to provide. For example, if Provider A is recommending MHSS and PSR in the initial Comprehensive Needs Assessment, but is only licensed to provide MHSS, Provider A shall bill the MHSS Assessment code/H0032 U8. Provider A would refer the individual to Provider B who is licensed to provide PSR. Provider B would conduct a new Comprehensive Needs Assessment documenting the medical necessity for services and bill for the PSR Assessment/H0032 U6.

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

Please see the CMHRS and Psychiatric Services chart below for detailed information on whether a service can be included in a Comprehensive Needs Assessment.

Services Eligible for the Comprehensive Needs Assessment

Assessment Code	Service	Assessment Requirements Effective 1/1/19
H0031	IIH Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U6	PSR Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U7 (adult)	Day Treatment/Partial Hospitalization Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U7	TDT Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U8	MHSS Assessment	Must meet Comprehensive Needs Assessment requirements
H0032 U9	ICT Assessment	Must meet Comprehensive Needs Assessment requirements

Billed as part of service component	Crisis Stabilization	Can be used as a Comprehensive Needs Assessment if completed by a LMHP, LMHP-R, LMHP-S or LMHP-RP.*
Billed as part of service component	Crisis Intervention	Can be used as a Comprehensive Needs Assessment if completed LMHP, LMHP-R, LMHP-S or LMHP-RP.*
Billed as part of service component	Mental Health Case Management	Can be used as a Comprehensive Needs Assessment if completed by a qualified mental health case manager who is a LMHP, LMHP-R, LMHP-S or LMHP-RP and all 15 required elements are included.**
90791	Diagnostic Interview Exam	Can be used as a Comprehensive Needs Assessment if all fifteen required elements are included. A LMHP, LMHP-R, LMHP-RP or LMHP-S may complete an addendum to address any missing elements and recommend additional services.
90792	Diagnostic Interview Exam Add on with Medical Services	Can be used as a Comprehensive Needs Assessment if all fifteen required elements are included. A LMHP, LMHP-R, LMHP-RP or LMHP-S may complete an addendum to address any missing elements and recommend additional services.

* An assessment conducted by a Certified Pre-screener who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S may be used as the assessment for crisis stabilization or crisis intervention only. This assessment cannot be used as a Comprehensive Needs Assessment or amended by a LMHP, LMHP-R, LMHP-RP or LMHP-S to be used as a Comprehensive Needs Assessment.

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

Services Not Eligible for the Comprehensive Needs Assessment

The services listed below require program specific assessments. Assessments for Substance Use Case Management, Treatment Foster Care Case Management, Governor's Access Pan (GAP) Case Management or Behavioral Therapy services do not apply to the Comprehensive Needs Assessment.

Service	**Assessment Requirements**
Behavioral Therapy	No change. Follow the assessment requirements in Behavioral Therapy Supplement. May not be included as part of Comprehensive Needs Assessment.
Substance Use Case Management	No change. Follow the assessment requirements in the Addiction and Recovery Treatment Services (ARTS) Manual. May not be included as part of Comprehensive Needs Assessment.
Treatment Foster Care Case Management	No change. Follow the assessment requirements in the CMHRS Manual. May not be included as part of Comprehensive Needs Assessment.
GAP Case Management	No change. Follow the assessment requirements in the GAP Supplement to the CMHRS Manual. May not be included as part of Comprehensive Needs Assessment. Additional information is available at http://www.dmas.virginia.gov/#/gap.

Reassessments

At a minimum, the Comprehensive Needs Assessment must be reviewed annually by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Reviews must be documented in a progress note or on the assessment by the LMHP, LMHP-R, LMHP-RP or LMHP-S and are not billable.

The Comprehensive Needs Assessment must be updated when there is a clinical indication based on the medical, psychiatric or behavioral symptoms of the individual. The Comprehensive Needs Assessment must also be updated when there is a lapse in all CMHRS services provided by the same agency for greater than 31 consecutive calendar days. These reassessments are billable using the same guidelines as the above section.

If there is a lapse of greater than 31 days in one but not all CMHRS services that an agency provides to an individual, the LMHP, LMHP-R, LMHP-RP or LMHP-S may make an addendum to the current Comprehensive Needs Assessment explaining the lapse and providing justification for continued services. The addendum is not billable. An example would be a child who receives IIH and school based TDT from the same provider. If the child's TDT services lapse for greater than 31 days in the summer but the provider continues to provide IIH, the provider may complete an addendum to the Comprehensive Needs Assessment prior to resuming TDT in the fall, which justifies the need for TDT during the school year based on the individual's current needs.

The reassessment guidelines for lapse in services do not apply to mental health case management. Providers of mental health case management should follow DBHDS guidelines for lapse in services.

Psychiatric Evaluation in Crisis Stabilization Services
DMAS will be updating the Crisis Stabilization section of the *CHMRS* provider manual with the following clarifications to the Psychiatric Evaluation:

- DMAS recommends that an individual eligible for crisis stabilization services receive a psychiatric/medical evaluation within 72 hours of admission to the service. The purpose of a psychiatric/medical evaluation during initiation of crisis stabilization services is to address medical and pharmacological interventions that may help to support the individual with managing their acute symptoms in the least restrictive environment.

- DMAS is expanding the practitioner type to allow for physicians, nurse practitioners and physician assistants acting within the scope of their practice in accordance with the applicable Virginia Health Regulatory Board.

- The evaluation does not have to be performed by the Crisis Stabilization provider and may be coordinated with a private provider.

- DMAS does not require the evaluation to be billed nor does the provider have to be enrolled as a Medicaid provider, including an ordering, prescribing or referring (ORP) practitioner.

- A face-to-face evaluation is recommended, however, if coordinated with an outpatient provider, the evaluation may be conducted through telemedicine as allowed in physician and outpatient psychiatric services. See the DMAS *Physician-Practitioner* provider manual and *Psychiatric Services* provider manual for additional details. Telemedicine is not allowed for services billed under Crisis Stabilization.

- If the evaluation is to be billed and reimbursed through a Medicaid MCO or Magellan of Virginia under physician or outpatient psychiatric services, the provider must either be credentialed with the appropriate MCO or Magellan of Virginia or be employed by an agency credentialed with the appropriate MCO or Magellan of Virginia. Magellan of Virginia only credentials providers of behavioral health services. Providers shall consult with the MCO or Magellan of Virginia for credentialing questions prior to providing services to ensure they meet qualifications for reimbursement.

- Crisis Stabilization providers do not need to discharge individuals if they are not seen by a psychiatrist, nurse practitioner or physician assistant within 72 hours of service admission. Providers should document attempts and any barriers to coordinating a psychiatric/medical evaluation for the individual, or the reasons why it would not be in the individual's best interest to meet with a psychiatrist, nurse practitioner or physician assistant during this treatment period.

At Risk of Physical Injury Form

DMAS has removed the *At Risk of Physical Injury* form (P502) requirement in TDT and IIH. The *At Risk of Physical Injury* form was used as part of the Virginia Independent Assessment Program (VICAP), which was terminated on November 30, 2016.

Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0) or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627