Regulation Changes: Crisis Services and Mental Health Skill-building Services (MHSS)

July 12, 2016
Disclaimer

These slides are not meant to substitute for the comprehensive information available in the Virginia Administrative Code, Code of Federal Regulations, or the Department of Medical Assistance Services (DMAS) provider manual.

Providers may find the final regulations (including the changes) on the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/I/ViewStage.cfm?stageid=7391.
Training Objectives

At the conclusion of this training, you will be able to:

- Identify the newest regulatory changes for Crisis Stabilization, Crisis Intervention and Mental Health Skill-building (MHSS) services.
- Understand the MHSS service definition, eligibility criteria, and service limitations.
- Adhere to MHSS documentation requirements.
Regulatory Change Highlights
Regulatory Change Highlights

Crisis Stabilization

Effective 8/1/2016, the following regulatory changes will apply to Crisis Stabilization:

- The timeframe for crisis stabilization registrations will change from 1 calendar day to 1 business day.
- The daily limit of eight (8) units will no longer apply.

As a reminder, only direct hours of service can be billed. The Magellan clinical care management team reviews and monitors trends in utilization for providers billing more than eight hours per day.
Regulatory Change Highlights

Crisis Intervention

Effective 8/1/2016, the following regulatory change will apply to Crisis Intervention:

• The maximum duration for Crisis Intervention registrations will change from 30 days to 7 days.
Utilization Limit Increase

The new regulations increased the unit utilization limit to 520 units per fiscal year based on a Sunday to Saturday billing period.

Only direct, face-to-face contacts and services to the individual will be reimbursed.

- 1 unit = 1 to 2.99 hours per day
- 2 units = 3 to 4.99 hours per day

Providers must clearly document the details of the services provided for the entire amount of time billed.

Utilization Weekly Limit

There will be a utilization limit of 10 units per week. This change will be reflected in upcoming revisions to the DMAS Community Mental Health and Rehabilitative Services (CMHRS) Manual.
Regulation Changes-Townhall

Townhall Comment Period

The comment period for this regulatory package will remain open from 6/27/2016 through 7/27/2016.

Individuals who wish participate in the public comment forum, may visit the Townhall website at:
Regulatory Change Details: MHSS
Service Definition

Mental Health Skill-building Services (MHSS) means:

“Goal-directed training to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment.”

*12VAC30-50-226
MHSS Eligibility Criteria

To qualify for MHSS, individuals 21 and older must meet the criteria for each of the following items:
- Clinical necessity
- Qualifying mental health diagnosis
- Need for goal-directed training
- Prior history of a qualifying higher level of care
- Prior history of a qualifying prescription within the past 12 months

Individuals younger than 21 years of age must meet the criteria for the following items in addition to the above items:
- Living situation- cannot be living in a supervised setting as defined in § 63.2-905.1 of the Code of Virginia
- Must be transitioning into an independent living situation
- Independent Clinical Assessment (ICA)
MHSS Eligibility Criteria

☑️ Qualifying primary mental health diagnosis:

- Schizophrenia or other psychotic disorder as set out in the DSM-5.
- Major Depressive Disorder
- Bipolar I or Bipolar II

Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year 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.
MHSS Eligibility Criteria

☑ Requires individualized, goal-directed training

MHSS must be rehabilitative and based on a variety of incremental or cumulative approaches and tools that will:

- Address other barriers to independent life functioning:
  - Effects of the individual’s disability
  - Issues of health and safety

Reflect what is important to the individual

Organize and guide the individual’s life planning
MHSS Eligibility Criteria

☑️ Need for goal-directed training

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
- **Use of community resources**
MHSS- Goal-directed Training

What kind of goal-directed training is reimbursable through MHSS?

1. Training Instruction and practice in functional skills and appropriate behavior related to individual’s:
   - Health and safety
   - Instrumental (contributory or purposeful toward independence) Activities of Daily Living (ADL), which means personal care tasks i.e. dressing, bathing, eating, etc.
   - Use of community resources

2. Assistance with medication management

3. Monitoring of health, nutrition, and physical condition

Training must be in one of the 3 areas above and must include goals toward self-monitoring and self-regulation of these activities.
MHSS Eligibility Criteria

☑ History of Qualifying Higher Level of Care

- Psychiatric hospitalization
- Residential or **Nonresidential** crisis stabilization
- PACT or ICT services
- RTC-Level C placement
- TDO evaluation due to decompensation related to serious mental illness (SMI).

This documentation requirement may be met by keeping the prior provider’s **discharge summary** in the record. It must include **all** of this information:

☑ Treatment type ☑ Treatment dates ☑ Treatment provider name

**PLEASE NOTE**
☒ Documentation of family member statements will NOT meet this requirement.
MHSS Eligibility Criteria

- **History of Qualifying prescription in the past 12 months**

For individuals who are **not prescribed** antipsychotic, mood stabilizing, or antidepressant medications in the past 12 months due to a contraindication:

- The provider must obtain medical records signed by the licensed prescriber detailing the **contraindication**.
- Documentation must be maintained in the member’s MHSS record how the member is expected to benefit from the training without medication.
MHSS: Limits and Exclusions
MHSS Limits and Exclusions

MHSS must not be duplicative of other services.

Other services include, but are not limited to, those provided through:
• Medicaid waiver services
• Group homes
• Assisted living facilities
• Residential treatment facilities
• Independent living skills services
• Skilled nursing facilities
• Personal / attendant care

The MHSS provider must coordinate services to avoid duplication. When services conflict, the provider must document support for any coverage exceptions described in the regulations, and must document the coordination of care.
**MHSS Limits and Exclusions**

If the individual resides in a group home (Level A or B) or assisted living facility (ALF):

- The individual’s residential provider may not serve as the MHSS provider.
- The individual may receive MHSS from another MHSS agency **not affiliated** with the owner of the facility in which they reside.
- The ISP **must not duplicate/contradict** the residential treatment plan.
- The provider **must coordinate** with the residential treatment plan and document coordination.

"**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.
MHSS: Provider Qualifications
MHSS Provider Qualifications

Provider Qualifications

The new regulations indicate that **MHSS may only be rendered by individuals with these qualifications** as defined in 12VAC35-105-20:

- Licensed Mental Health Professional (LMHP)
- Qualified Mental Health Professional-adult (QMHP-A)
- Qualified Mental Health Professional-child (QMHP-C)
- Qualified Mental Health Professional-eligible (QMHP-E)
- Qualified Paraprofessional in Mental Health (QPPMH)

**Or these qualifications** as defined in 12VAC30-50-226:

- Licensed Mental Health Professional-resident (LMHP-R)
- Licensed Mental Health Professional-resident in psychology (LMHP-RP)
- Licensed Mental Health Professional-supervisee in social work (LMHP-S)
MHSS: Documentation Requirements
MHSS Documentation Requirements

Assessment (Service-specific provider intake or SSPI)

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

The LMHP type must document the primary mental health diagnosis in the SSPI.

SSPI Frequency Requirements

SSPIs are required at the onset of services

• At admission, an appropriate face-to-face SSPI must be conducted, documented, signed, and dated by the LMHP type.
• Providers shall be reimbursed one unit for each intake.

SSPIs must be repeated upon any lapse in services of more than 30 calendar days.

Service Review

Every 6 months, the LMHP type must review services and document the continued need for the service in the individual’s medical record.

The LMHP may conduct the service review as part of an SSPI at the 6 month interval.
MHSS Documentation Requirements

Individual Service Plan (ISP)

The ISP is a comprehensive and regularly updated treatment plan.

The ISP must:

- be completed, signed, and contemporaneously dated by the LMHP type or QMHP type preparing the ISP within a maximum of 30 days of the date of the completed intake (SSPI)
- contain an Individualized Discharge Plan
- be updated either annually or as the treatment interventions change, based on the needs and progress of the individual

Services based upon incomplete, missing, or outdated SSPIs or ISPs will be denied reimbursement.

Time billed may not exceed the frequency established in the ISP.
Individual Service Plan (ISP)- Review of ISP

Every three months, the LMHP type or QMHP type must review, modify, and update the ISP.

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 ISP reviews are satisfactory and complete, the reviews must:

• 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
• be conducted in a manner that enables the individual to participate in the process
• be documented in the individual's medical record no later than 15 calendar days from the date of the review as evidenced by the dated signatures of the LMHP type or QMHP type and the individual.
MHSS Documentation Requirements

Documentation

Discharge Summaries
Providers must complete discharge summaries when individuals leave services.

Discharge summaries from prior psychiatric services must also be kept in the individual’s medical record.

Medication History
The medical record must contain evidence of the individual’s psychiatric medication history. Family member statements will not meet this requirement.
Resources

The resources below offer many more details to support this training.

Permanent Regulation Text
http://www.townhall.virginia.gov/l/ViewStage.cfm?stageid=7391

DMAS CMHRS Provider Manual:
DMAS VA Medicaid Web Portal ➔ Provider Resources ➔ Provider Manuals ➔ Provider Manuals ➔ Community Mental – Health Rehabilitation Services ➔ Chapter (Chapters II, IV, and VI will be affected by the regulation changes).

Please send additional questions to VAProviderQuestions@MagellanHealth.com.

Friday Provider Call:
Providers are encouraged to send questions in via the e-mail address above and call in to hear responses.
When: Every Friday at 1:00 PM
Call In: 1-888-850-4523 (no RSVP required)
Passcode: 743713