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Clinical	Psychosocial Rehab Services that continue more than six months are suppose to be reviewed to determine if the individual continues to meet medical necessity. Does this have to be a face to face with the consumer if an SSPI is not being performed and does the review have to be billed?	On page 55 of Chapter Four of the Community Mental Health and Rehabilitation Services Manual, it states that psychosocial rehabilitation services of any individual that continue more than six months shall be reviewed by an LMHP, LMHP-supervisee, LMHP-resident, or LMHPRP to determine if the individual continues to meet the medical necessity criteria." They are not required to be done face to face but it may be good clinical practice to do the review face to face. Providers can bill the review when it is done as part of an SSPI but it is not required. Please keep in mind service specific provider intakes are required to be done at least annually.
Clinical	In a mental health clinic, can a psychiatric nurse practitioner provide the oversight of a psychiatrist, specifically for treatment plan reviews for outpatient counseling services?	Federal law requires that each mental health clinic be physician-directed. On page 1 and 2 of chapter 4 of the Mental Health Clinic manual it states, "The physician must have a face-to-face visit with the recipient, prescribe the type of care provided, and if services are not limited by the prescription, periodically review the need for continued care. The patient's medical records must document that the physician personally reviewed the patient's medical history, conducted a thorough assessment, confirmed or revised the diagnosis, saw the patient face-to-face, reviewed and signed the plan of care, and is periodically reviewing the need for continued care." The physician does not have to be a psychiatrist, but a psychiatric nurse practitioner would not meet this requirement.
Clinical	How do we handle assessments and ISP's that were completed prior to Oct 1 with old ICD-10 codes? Do we need to update them or just utilize the new codes moving forward?	Best Practice would be to do an addendum to an assessment or Service Specific Provider Intake to update it with the new diagnosis code and the reason for the change with the effective date. As the ISP is a working document and is supposed to be updated as the needs, goals and progress of the individual changes, it would also be best practice to update these documents as well to reflect changes to the diagnosis.

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Clinical	Is there a time frame on when a higher level of care should have occurred under Mental Health Skill-Building Services for service eligibility?	On page 62 of the Community Mental Health and Rehabilitative Services Manual Chapter 4, it states "The individual shall have a prior history of any of the following: psychiatric hospitalization; crisis stabilization, ICT or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC Level C); or TDO evaluation as a result of decompensation related to serious mental illness." Although there is no specific time frame requirements identified in the DMAS manual or regulation under Mental Health Skill Building, best practice is to assess whether the member needs this level of care if they have not required a higher level of care in a long time.
Clinical	Can outpatient therapy be provided by the Intensive In-home provider? If so, what are the qualifications of staff?	In the Community Mental Health Rehabilitative Services Manual, Chapter 4, Page 29, it states that regarding IIH, "outpatient therapy must be either provided by the IIH provider or coordinated with another provider to align the service with ISP goals and objectives. The ISP and progress notes must reflect the need and coordination of services." Outpatient therapy can be provided by the IIH provider as part of the service or can be billed separately by the IIH provider. If you are providing the outpatient therapy as part of the service, you would still want to make sure that the provider meets the qualifications outlined in the Psychiatric Services Chapter 2 pages 7-8. The outpatient therapist does NOT have to be from an outside agency to be reimbursed for IIH.
Clinical	How will claims be processed for existing TDT authorizations that end after 12/1 but do not contain the new modifiers?	Effective December 1, 2016, Providers are expected to identify on the claim the appropriate modifier for the service for the time frame in which they are billing, either school-based (H0035 HA), after-school (H0035 HA UG) or summer (H0035 HA U7). Providers are responsible for submitting claims with the appropriate modifier.
Clinical	When does the SSPI have to be completed for Intensive Community Treatment services?	Page 57 of Chapter IV of the Community Mental Health Rehabilitative Services Manual, states prior to admission, an appropriate service –specific provider intake shall be conducted by the licensed mental health professional (LMHP), LMHP supervisee, LMHP- resident, or LMHP-RP. Therefore, service specific provider intakes are required prior to admission.

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Clinical	Is a six month assessment required for Mental Health Skill-Building Services?	On page 63 of Chapter IV of the Community Mental Health Services Manual it states every six months, the LMHP, LMHP-R, LMHP-S or LMHP-RP must review the individual ISP and services being received in order to determine if continuation of services is necessary. Clinically it may be helpful for the LMHP, LMHP-R, LMHP-S or LMHP-RP to complete a new service specific provider intake to review clinical progress and assess the medical necessity of continuing Mental Health Skill-Building Services. However, DMAS Regulations do not specifically require the provider to complete a service specific provider intake every six months when providing mental health skill building services. The service specific provider intake must be updated annually, however.
Clinical	On page 60 of the Community Mental Health and Rehabilitative Services Manual Chapter 4 it states that crisis stabilization services are not appropriate and cannot be reimbursed for individuals with psychiatric conditions which cannot be managed in the community, such as individuals who are in imminent danger to themselves or others. Does this apply to residential crisis stabilization?	Yes, this also applies to residential crisis stabilization. If the member's symptoms and behaviors require that they be in an inpatient psychiatric hospital and not in the community, then from a clinical perspective it would not be appropriate for them to be in residential or non-residential crisis stabilization.
Clinical	How does DMAS Regulations address ICT member receiving MHSS?	A member can have PACT/ICT and MHSS at the same time. Providers would need to thoroughly document how the services are not duplicative in nature. On page 59 of Community Mental Health Services Revision 11-1-2016, it states under Service Requirements that ICT "Service Coordination to ensure there is no duplication in services or billing and to ensure continuity of care .The purpose of ICT 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".
Clinical	The "30 day lapse in service" language has changed for TDT and MHSS. As now written, it appears that the "without communication or contact" qualifier has been removed from TDT and MHSS lapses, and individuals in these two services must be discharged after 30 days regardless of whether there has been any continued contact or communication with the	Correct. Chapter 6, Page 9 of the Community Mental Health and Rehabilitation Services states "If there is a lapse in TDT services for more than 31 consecutive calendar days without any communications from family members/legal guardian or the individuals with the service provider, the provider shall discharge the individual. If the individual continues to need services, then a new intake/admission shall be documented and a new service authorization required". This also holds true for IIH services.

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	individual and/or family during that time. Is that correct?	"Service-specific provider intakes shall be repeated upon any lapse in MHSS services of more than 30 calendar days." Best practice would be to evaluate whether the service continues to be medically necessary and review the ISP to ensure that it continues to be accurate and meets the member's current needs.
Clinical	Chapter 6, pg. 9 now reads: If there is a lapse in TDT services that is greater than 31 consecutive calendar days, the provider shall discharge the individual." It does NOT include "without any communication from the family members/legal guardian or individuals". Chapter 4, pg. 34 now reads: "If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the individual". Again, it does NOT include "without any communication from the family members/legal guardian or individuals". So this implies that all TDT students who have a lapse in service due to the summer break will have to be discharged regardless of the provider's continued communication with the family/individual during the summer break.	*C*orrect. Each TDT member that will not be participating in the summer program (if there is a lapse for more than 31 consecutive calendar days) should be discharged from TDT services. Chapter 6, Page 9 of the Community Mental Health and Rehabilitation Services states "If there is a lapse in TDT services for more than 31 consecutive calendar days, the provider shall discharge the individual. If the individual continues to need services, then a new SSPI shall be completed and a new service authorization shall be required." Best practice would be to evaluate whether the service continues to be medically necessary and review the ISP to ensure that it continues to be accurate and meets the member's current needs.
Clinical	Can a physician or a psychiatric nurse practitioner provide documentation regarding any other Axis I mental health disorder specific to the identified individual within the past year addressing the four identified areas?	Chapter 4, Page 62 of the Community Mental Health and Rehabilitation Services Manual states: "Any other Axis I mental health disorder that a physician has documented specific to the identified individual within the past year to include all of the following: (i) that is a serious mental illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities that are documented in the individual's medical record, AND; (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community." Magellan would encourage you as a Magellan provider to speak with your Licensing Specialist and contact the Department of Behavioral Health and Developmental Services (DBHDS) Office of Licensing about any further clarification the regarding the definition of a physician.

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Clinical	Are services provided by MHSS such as linking and referring, planning billable?	In the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapter 4 on page 79 (Mental Health Case Management H0023). It states that case management includes activities that are intended to positively impact a member's mental health condition. Those activities include linking the individual to needed services and supports specific to the Individual Service Plan (ISP). Case Management activities include coordinating services and treatment planning with other agencies and providers. Case Management is defined as problem-solving activities designed to promote community adjustment and improve functional capacity (page 80). If a case manager is taking a member to a doctor's appointment and is present throughout the appointment, this activity should be tied to the individual's ISP and aimed at improving the member's functioning or mental health condition. Documentation should include interventions or problem solving activities that are taking place to help this member and demonstrate how the case manager is needed in this appointment to link the member to this provider or coordinate care. While service authorization for this service is not required, registration of this service with Magellan is required. In the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapter 4 on page 68 (Mental Health Skill Building Services H0046). It states "only direct face-to-face contacts and services to the individual members are reimbursable". Best clinical practice is to review page 67 and 68 of the Community Mental Health Services Manual Chapter IV In regards to limitations and exclusions for Mental Health Skill-Building Services. A member can have Mental Health Case management (H0023) and MHSS (H0046) at the same time. Providers would need to thoroughly document in the notes that the services are not duplicative in nature.
Clinical	Chapter 6, page 9 of the CMHRS manual speaks to a lapse of service in IIH, TDT and MHSS. Chapter 4 also addresses lapses for these specific services. Does the same requirement exist that if PSR lapses in service for 30+ days that the individual must be discharged and a new SSPI completed if services are still warranted/desired? If a non-billable contact is	Chapter 4, page 54 of the CMHRS manual states" service-specific provider intakes shall be required at the onset of services and 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". Chapter 6, page 10 of the CMHS manual states "the SSPI and ISP must be up to date based on the clinical and service needs of the individual." Please keep in mind, however, that Service

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	made with the individual within those 30 days, does a lapse still occur if a PSR service was not delivered during that time?	Specific Provider Intakes are required to be done at least annually. It would be best clinical practice for a PSR case that has a lapse in services beyond *30* days to discharge the member and a complete a new service specific intake to initiate services. If providers have maintained contact with the member or their family member, you would not need to discharge the member. However, best practice would be to evaluate whether the service continues to be medically necessary and review the ISP to ensure that it continues to be accurate and meets the member's current needs.
Clinical	What is the interpretation regarding delivery service time must be added "consecutively" to reach a billable unit of service for MHSS services?	The new changes for Mental Health Skill Building went into effect 8/1/16. Per the new regulations, there is a daily maximum of 2 units with a weekly maximum of 10 units. One unit is 1 to 2.99 hours per day and two units is 3-4.99 hours per day. Due to adding this weekly max, providers should be reminded that a week is Sunday-Saturday. Anything billed outside of this weekly time span will deny (exceed weekly unit max for procedure). For example, an organization provided MHSS services to a member today in the amount 6 hours. This organization can only submit 2 units of billing for the member today. A provider may not rollover the extra 1 hour for another day due to the maximum daily unit limitation. As a reminder, providers must clearly document the details of the services provided for the entire amount of time billed. For additional training in regards to MHSS, there was a provider training posted on July 12, 2016 to go over all the regulation changes. The recorded training is on www.magellanofvirginia.com under For Providers and 2016 Training. It is titled "Regulation Changes".
Clinical	Regarding the DMAS Psychiatric Services manual requirements for outpatient services where it states that "service must be medically prescribed treatment". Does "medically prescribed treatment" mean that a physician must prescribe outpatient therapy serviced in writing? If so, how is the written order or prescription to be written?	Magellan encourages providers to refer to the documentation requirements for outpatient psychiatric and substance abuse services in the Psychiatric Services Manual, Chapter 4 pages 26-28. The section you are referring to: "Services shall be medically prescribed treatment, which is documented in an active written treatment plan designed, signed, and dated by the professionally licensed, Medicaid enrolled qualified provider. Psychiatric and substance abuse medication management requires a plan

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		of care" please see page 24. You do not have to have a physician prescribed treatment.
Clinical	How can a MHSS provider document proof of member's higher level of care history in order to meet medical necessity criteria if the provider is unsuccessful with obtaining confirmation of member's history in member's medical record?	On page 65, Chapter of the Community Mental Health Rehabilitative Services manual it states "The provider shall document evidence of the individual's prior psychiatric services history, as required above under eligibility requirements, by contacting the prior provider or providers of such health care services after obtaining written consent from the individual. Family member statements shall not suffice to meet this requirement. The provider shall document 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 f. dates of previous treatment. If a provider attests that a member has a higher level of care history then it is expected to be part of the member's record. A provider is always welcomed to submit a request for service authorization and Magellan will review the request against medical necessity. For additional training in regards to MHSS, please go to www.magellanofvirginia.com under For Providers and 2016 Training. It is titled "Regulation Changes".
GAP	How can we get paid for a case management registration when the member transitioned to regular Medicaid from GAP in the middle of the registration?	If the member's coverage (transition from GAP to Medicaid or vice versa) changes during the case management service registration, the provider should call 1-800-424-4046 as soon as the coverage change has occurred. This will allow Magellan to update the registration to reflect member's current coverage to allow payment of claims.
Network	Is there a place on the Magellan website that lists the ICD-10 codes that are eligible?	Yes. If you go to Magellanprovider.com and click on the "Getting Paid" tab, there is an option for DSM5/ICD10. You will click ICD10, then you will see a couple of links – click on ICD10 Mixed Services Protocol that will bring up a PDF of the code list for submission. This is a reference document for other lines of business, so it is still recommended to use the DMAS manuals and Magellan provider communications for specific guidance for Virginia Medicaid.

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Quality	Regarding adverse outcome reporting, specifically how is “an incident of violence initiated by the member” defined? And how does this criteria apply to children (such as in a Therapeutic Day Treatment program)?	For incidents of violence, providers should report any act of violence that is initiated by a member that requires medical attention for either the member or other person involved more than basic first aid or required a significant intervention such as being arrested or charged for the incident as a result of the act. This would be the same regardless of age of the member whether it is an adult or child or the level of care the member is receiving. Some examples: An altercation between two members such as 2 children. Neither required significant medical attention nor were criminal charges filed. It was handled within the services. This is not something that we would need. However, if an altercation did occur where an ambulance was needed to be called or medical attention was sought or legal charges were filed we would need to be notified.

As a reminder, Magellan of Virginia hosts a weekly call each Friday beginning at 1 p.m. The call is open to all providers to address questions and issues. We encourage providers to visit the Friday Provider Call page on Magellan of Virginia's website to review weekly agendas with program announcements, questions to be covered during the call and quarterly FAQs. Providers may submit questions using the contact us link feature on the Magellan of Virginia homepage. Questions should be submitted by the close of business each Wednesday for discussion on Friday. Any questions that require more research will be held over and answered on a subsequent call. We look forward to your participation.