Sentara Health Plans

Medicaid

Mental Health Intensive Outpatient Services (MH-IOP), BH 29

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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual *.

Description & Definitions:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p.3 (5/28/2025)

Mental Health Intensive Outpatient Services (MH-IOP)

Mental Health Intensive Outpatient (MH-IOP) is a structured program of skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. MH-IOP is based on a comprehensive, coordinated and individual service plan (ISP) that involves the use of multiple, concurrent service components and treatment modalities. Treatment focuses on symptom reduction, crisis and safety planning, promoting stability and independent living in the community, recovery and relapse prevention and reducing the need for a more acute level of care.

MH-IOP is provided to individuals who do not require the intensive level of care of inpatient, residential or partial hospitalization services, but require more intensive services than outpatient services and would benefit from the structure and safety available in the MHIOP setting. MH-IOP can also serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program.

Critical features of MH-IOP include:

- MH-IOP services include structured schedules for participants. Treatment goals should be measurable, person-centered, recovery oriented, trauma-informed, time-limited, developmentally appropriate, medically necessary, and directly related to the reason(s) for admission.

- Tapers in intensity as an individual's symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care.
- Services are provided in groups or on a one-to-one basis as clinically indicated.
- The integration and documentation of evidence-based practices to address family, social and community risk factors and provide coping skills to improve symptoms and functioning; and
- The promotion of behavior change in the individual's natural environment, with the overriding goal of empowering the individuals, their identified family natural supports to promote improved functioning
- The inclusion of ~~rigorous~~ quality assurance mechanisms that focus on achieving individual outcomes through monitoring treatment fidelity and progress and adjusting treatment goals and plans to address individual needs and barriers as they arise.

In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MH-IOP:

Treatment Program:

- The MH-IOP treatment program must be available: 9-19 hours a week for individuals 18 years old and above or 6-19 hours a week for youth under age 18.
- The MH-IOP treatment program must be available at least 3 days of services weekly (Sunday-Saturday).

Covered service components include:

- Assessment
- Care Coordination
- Crisis Intervention
- Health Literacy Counseling
- Individual, Family and Group therapy
- Medication Management
- Occupational Therapy
- Peer Recovery Support Services
- Psychological assessment and testing
- Skills Restoration
- Treatment Planning

- The individual must participate in a minimum of 2 distinct service components daily. If the session involves a Comprehensive Needs Assessment no other service component is required to bill the per diem.
- If the minimum service components are not met, providers must document the reason in the individual's medical record.
- MH-IOP providers must be able to provide any of the above listed service components if the need is identified in the individual's assessment.
- The requirement that peer recovery support services, psychological testing and occupational therapy be available may be met through MH-IOP program staff or by referral to a qualified provider.
- If an individual does not participate in the minimum clinical service hours per week (9 for adults and 6 for youth), the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record. Documentation of any ISP deviation as well as reason for the deviation should be submitted with the next service authorization request.
- If the individual consistently deviates from the required services in the ISP, the provider should reassess for another level or care to better meet the individual's needs.

Assessment:

- At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant must conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment

(see Chapter IV for requirements), documenting the individual's diagnosis/es and describing how service needs match the level of care criteria. If a nurse practitioner who is not a psychiatric/mental health nurse practitioner or a physician assistant conducts the initial assessment it can only be used as the assessment for MH-IOP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details). An assessment completed by the provider within the 30 days prior to admission can meet the above initial assessment requirements if the required components are included and there is a documented review and update at admission by the LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant.

- A psychiatric evaluation must be conducted by a physician, nurse practitioner or physician assistant within 72 hours of admission into the service either in-person or through telemedicine. The psychiatric provider must coordinate medication management with existing medical and psychiatric providers.
  A psychiatric evaluation completed within the 30 days prior to admission can meet the above initial psychiatric evaluation requirement if there is a documented review and update at admission by the physician, nurse practitioner or physician assistant.
- An updated assessment conducted by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant is required every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued stay.

Medication Management:

- Ongoing medication management by the psychiatric provider must occur at a minimum of monthly or more frequently as clinically indicated in the ISP.

Treatment Planning:

- ISPs (see Chapter IV for requirements) shall be required during the entire duration of services and must be current. Other staff may assist with treatment planning through collaborative behavioral health services but the treatment plan must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant.
- ISPs must be reviewed as necessary at a minimum of every 30 calendar days or more frequently depending on the individual's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 calendar day review as well as additional quarterly review requirements.

Individual, Family and Group Therapy:

- The individual must participate in a minimum of 2 hours of therapy (individual, group or family) per week. See Chapter IV for information on group sizes.

Crisis Intervention:

- The provider must have an individualized crisis intervention plan that is accessible to the individual 24/7.

Care Coordination:

- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). Care coordination should include a focus on identification of additional needs to support recovery (e.g. housing, employment, food stability, mentoring, and parenting supports) and connecting the individual and natural supports to appropriate referrals to meet these needs.
- If the individual continues to also meet with an existing outpatient therapy provider, the MH-IOP provider must coordinate the ISP with the provider.
- Care coordination through referrals to higher and lower levels of care, as well as community and social supports, must include the following:
  - The provider must collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care;
  - The provider must collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers.

Admission Criteria:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services, App. F - Intensive Clinic Based Support p. 11 (5/28/2025)

Mental Health Intensive Outpatient Services (MH-IOP) is considered medically necessary for **1 or more** of the **following**:

- Admission with **ALL** of the following:
  - Documentation indicates evidence that the individual currently meets criteria for a primary diagnosis consistent with the most recent version of the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates with the Diagnostic and Statistical Manual that requires and can reasonably be expected to respond to treatment interventions.
  - Within the past 30 days, with **ALL** of the following:
    - the individual has experienced persistent or increasing symptoms associated with their primary DSM disorder which has contributed to decreased functioning in home, school, occupational or community settings relationships with Others. And
    - The individual is transitioning from a higher level of care or interventions at lower levels of care or in alternative, community-based rehabilitation services have been attempted but have been unsuccessful in adequately addressing the symptoms
  - The individual is at risk for admission to inpatient hospitalization, residential treatment services, residential crisis stabilization or partial hospitalization as evidenced by acute intensification of symptoms, but has not exhibited evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision; **or** the individual is stepping down from one of these settings and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision;
  - The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours
  - The individual requires an intensive structured treatment program with a multidisciplinary team;
  - The individual can reliably attend, and actively participate in, all phases of the treatment program;
  - The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and
  - For youth under age 18, there is a family/caregiver resource that is available to engage with treatment providers and support and reinforce the tenets of the MH-IOP services.
- Continued Stay – Individuals must meet **ALL** of the following:
  - Must meet **1 or more** of the following:
    - The individual continues to meet admission criteria
    - Another less intensive level of care would not be adequate to address the individual's needs;
    - Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care
    - The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and (ISP) has been revised to incorporate new goals
  - Must meet **ALL** of the following:
    - The ISP contains evidence symptoms and functional capacity are likely to respond to treatment
    - Documentation indicates that the individual is making progress towards goals, or the ISP is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals;
    - A psychiatric medical evaluation documents that medication options have been considered or initiated
    - 8. The provider is engaging the individual's natural supports in treatment as clinically indicated; and
    - Documentation demonstrates that coordination of care and discharge planning has been ongoing from the day of admission with the goal of transitioning the individual to a less intensive level of

care. These efforts should be documented to include communication with potential future service providers, community partners, and resources related to school, occupational or other community functioning.

- If the above continued stay criteria are not met, service authorizations may be extended for up to 10 calendar days to give additional time to ensure successful transition to the after-care plan. Providers must submit a service authorization request and documentation supporting the need for the extension to the MCO or FFS Service Authorization Contractor

NOTE: Individuals may be authorized to participate in less than nine hours a week for adults and six hours a week for youth as a transitional step down to lower level services for one to two weeks prior to transitioning to promote recovery. Providers should seek approval for such a transition from the MCO or the FFS contractor and the provider shall document the rationale in the individual's ISP.

Discharge Guidelines:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services, App. F - Intensive Clinic Based Support p. 10 (5/28/2025)

The individual meets discharge criteria if **1 or more of** the following:

- The individual no longer meets medical necessity criteria;
- The individual has met ISP goals and an appropriate aftercare plan has been established;
- The individual does not appear to be participating in treatment program and has not benefited from MH-IOP despite documented efforts to engage the individual.

Exclusions and Service Limitations:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services, App. F - Intensive Clinic Based Support p.10 (05/28/2025)

Individuals meeting **ANY 1 or more** of the following are ineligible for MH-IOP:

- Functional impairment is solely a result of a personality disorder or Developmental Disability and/or Intellectual Disability, as defined in the Code of Virginia § 37.2-100
- Presenting issues are primarily due to Substance Use Disorder; in this case, the individual should be evaluated for Addiction Recovery Treatment Services.

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services, App. F - Intensive Clinic Based Support p.10 (05/28/2025)

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV of the DMAS manual, the following service limitations apply:

- MH-IOP may not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0 (with the exception of ASAM level 3.1), Mental Health Partial Hospitalization Programs, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or inpatient admission. A seven day overlap is allowed for care coordination and continuity of care.
- If an individual has an authorization for a behavioral health service prior to admission to MH-IOP that is not allowed to be authorized concurrently with MH-IOP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-IOP within 31 days. Contact the individual's MCO or FFS contractor for authorization requirements.
- MH-IOP may be billed only within 7 days prior to discharge from Residential Levels of Care, as the individual is transitioning to a lower level of care.
- Providers shall not bill the MH-IOP per diem when the individual is not present at the program;

- Recreational activities, such as trips to the library, restaurants, museums, health clubs, or shopping centers, are not a part of the scope of this treatment program.

Document History:

Revised Dates:

- 2025: July – Implementation date of Augus 1, 2025. Verbiage updated to align with changes to Provider manual revision 5/28/2025.
- 2025: April – Updated to new format. Effective date 7.1.2025
- 2023: April
- 2022: May, June
- 2021: June, July, October

Reviewed Dates:

- 2024: August

Origination Date: July 2021

Coding Information:

Medically necessary with criteria:

Coding	Description
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
H0024	Behavioral health prevention information dissemination service (one-way direct or nondirect contact with service audiences to affect knowledge and attitude)
S9480	Intensive outpatient psychiatric services, per diem

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products: This guideline is applicable to all Sentara Health Plan Virginia Medicaid products except Sentara Health Plan Virginia Medicaid FAMIS members.
- Authorization Requirements:

- Mental Health Services, App. F - Intensive Clinic Based Support p. 13 (5/28/2025). Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time frame, the begin date of authorization will be based on the date of receipt.
- Initial service authorization requests must include, at a minimum, a complete service authorization request form.
- Continued stay requests must include, at a minimum, the following:
    - A complete service authorization request form;
    - Initial assessment;
    - Current addendum to the initial assessment (can be in a progress note) that describes any new information impacting care, progress and interventions to date, a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria; and
    - Updated ISP
- If services are provided through telemedicine, providers must include, at a minimum, on the initial and all continued stay authorization requests the following information:
    - A schedule that includes when or under which conditions services will be provided through telemedicine and when services are scheduled to be provided in-person.
    - Clinical evidence that the amount, duration and scope of the use of telemedicine is a clinically appropriate modality to meet the treatment needs of the individual.
    - Evidence of how a provider will meet the identified treatment needs documented in the ISP via an in-person modality, when needed.
- **Special Notes:**
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.
    - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider within 60 days of the date of service requested.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Behavioral health professionals are involved in the decision-making process for behavioral healthcare services.

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services. Revision Date: 05/28/2025 Appendix F: Intensive Clinic Based Support. Retrieved 7.21.2025. MHS - Appendix F (updated 5.28.25)_Final.pdf

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SHP Mental Health Intensive Outpatient Services, MH-IOP, SHP Behavioral Health 29