Sentara Health Plans

Medicaid

Mental Health Intensive Outpatient Services (MH-IOP) Medicaid

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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.

Purpose:

This policy addresses Mental Health Intensive Outpatient Services (MH-IOP) Medicaid

Description & Definitions:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p.4 (11/22/2021)

Mental Health Intensive Outpatient Services (MH-IOP) are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time-limited treatment programs that integrate evidence-based practices for youth (ages 6-17 years) and adults (18 years +). Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, children younger than age 6 may receive services based on medical necessity. MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care.

MH-IOP services are appropriate when an individual requires at least six hours of clinical services a week (for youth ages 6-17), or nine hours of clinical services as week (for adults 18 years and older) over several days a week and totaling a maximum of 19 hours per week. A MH-IOP requires psychiatric oversight with medication management included in the

coordinated structure of the treatment program schedule. MH-IOP 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.

Critical Features & Service Components

MH-IOP is an active treatment program of services that includes an individualized treatment plan describing the coordination of those services and how they will address the individual's goals. 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.

Critical features of MH-IOP include:

- 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
- 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.

This service is appropriate for individuals who do not require the intensive level of care of inpatient, residential or partial hospitalization services, but do require more intensive services than traditional outpatient psychiatric services, and would benefit from a structured setting.

MH-IOP services include both the comprehensive, structured delivery of evidence-based therapy services in combination with care coordination activities that seek to support recovery and movement into a lower level of care, such as traditional outpatient psychiatric services. Care coordination services should 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.

Covered service components include assessment, treatment planning, individual, family and group therapy, skills restoration/development, health literacy counseling/psychoeducational activities, crisis intervention, peer recovery support services and care coordination.

Criteria:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p. 11 (11/22/2021)

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

- Initial Care with **all of the following**:
    - 1. The individual must exhibit symptoms consistent with a DSM diagnosis (using the most current version of the DSM) that is documented in the initial assessment that requires and can reasonably be expected to respond to treatment interventions
    - 2. Within the past 30 days, the individual has experienced persistent or increasing symptoms associated with their primary DSM disorder which has contributed to decreased functioning in their home, school, occupational or community settings that has led to negative consequences and difficulties maintaining supportive, sustaining relationships with identified family and peers due to a psychiatric disorder. 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 and supporting recovery for the individual to baseline levels of functional capacity;
    - 3. 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 inpatient hospitalization,

residential crisis stabilization, or a partial hospitalization program and is no longer exhibiting evidence of immediate danger to self or others and does not require 24-hour treatment or medical supervision;
    - 4. The individual has a community-based network of natural supports who are able to ensure individual's safety outside the treatment program hours and a safety plan has been established;
    - 5. The individual requires access to an intensive structured treatment program with an onsite multidisciplinary team;
    - 6. The individual can reliably attend, and actively participate in, all phases of the treatment program;
    - 7. The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program; and
    - 8. For youth, 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:
    - 1. The individual continues to meet admission criteria
    - 2. Another less intensive level of care would not be adequate to administer care
    - 3. Treatment is still necessary to reduce symptoms and increase functioning so the individual may be treated in a less intensive level of care
    - 4. The individual has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan (ISP) has been revised to incorporate new goals
    - 5. The individualized treatment plan (ISP), updated every 30 days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan (ISP)
    - 6. Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan (ISP) is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals
    - 7. A psychiatric medical evaluation documents that medication options have been considered or initiated
    - 8. The individual's natural supports (e.g. individually identified-family/guardian/caregiver) are participating in treatment as clinically indicated and appropriate, or engagement efforts are underway
    - 9.Documentation demonstrates that coordination of care and vigorous, active discharge planning has been ongoing from the day of admission with the goal of transitioning individual to a less intensive level of care. These efforts should be documented to include communication with potential future service providers, community partners, and related resources related to school, occupational or other community functioning.
- If the above criteria are no met, there are some circumstances under which authorization may be extended for up to 10 calendar days. These circumstances included **1 or more** of the following:
    - 1. The individual has clearly defined treatment objectives that can reasonably be achieved through continued MH-IOP treatment, such treatment is necessary in order for the discharge plan to be successful, and there is no less intensive level of care available in which the objectives can be safely accomplished
    - 2. Individuals can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the individual to be discharged directly to a less intensive community rather than to a more restrictive setting
    - 3. The individual is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued by the provider delivering the service but are not available (including but not limited to such resources as placement options, substance use treatment or mental health appointments, therapeutic mentoring, etc.)

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 (formerly CMHRS), App. F - Intensive Clinic Based Support p. 15 (11/22/2021)

The individual meets discharge criteria if any of the following are met (**1 or more of** the following):

- The individual no longer meets admission/continued stay criteria and/or meets criteria for another level of care, either more or less intensive, and that level of care is sufficiently available
- Required consent for treatment is withdrawn or not obtained
- The individual does not appear to be participating in treatment plan (ISP) and has not benefited from MH-IOP despite documented efforts to engage the individual. For youth, there is lack of treatment progress attributable to lack of involvement and engagement by the identified family/caregivers
- The individual's ISP goals have been met, and an appropriate aftercare treatment plan has been established
- If there is any lapse in service indicative of a need for another level of care
- If there is a lapse in service greater than 7 consecutive calendar days
- The individual's level of functioning has improved with respect to the goals outlined in the ISP, and there is reasonable expectations that the individual can to maintain this recovery process at a lower level of treatment
- The individual is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, residential crisis stabilization unit or other residential treatment setting for more than 7 days and is not ready for discharge to home.

Exclusions and Service Limitations: Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p.12 (11/22/2021)

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
- The individual is at imminent risk to harming self or others, or sufficient impairment exists that a more intensive level of service is required
- The individual's psychiatric disorder can be effectively treated or recovery process safely maintained at a less intensive level of care
- The individual, their authorized representative, or their guardian does not voluntarily consent to admission or treatment, and/or refuses or is unable to participate in all aspects of treatment
- The individual requires a level of structure and supervision beyond the scope of the program
- The individual has medical conditions or impairments that needs immediate attention
- The individual's primary problem is social, custodial, economic (i.e. housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric disorder meeting criteria for this level of care, or admission is being used as an alternative to incarceration
- 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 (formerly CMHRS), App. F - Intensive Clinic Based Support p.9 (11/22/2021)

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 with any outpatient or community based behavioral health service may be 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.

- Activities that are not reimbursed or authorized:
  - Time spent in any activity that is not a covered service component
  - Transportation
  - Staff travel time
  - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions
  - Time spent in snacks or meals
  - Time when the individual is not present at the program
  - Time spent in educational instruction
  - Supervision hours of the staff
    - 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.

For continued stay, 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.

Coding:

CPT/HCPCS codes considered **medically necessary** if policy criteria are met:

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

CPT/HCPCS codes considered **not medically necessary** per this policy:

Coding	Description
	None

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.

Document History:

Revised Dates:

- 2025: April – Updated to new format. Effective date 7.1.2025
- 2023: April
- 2022: May, June
- 2021: June, July, October

Reviewed Dates:

- 2024: August

References:

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services. Revision Date: 11/22/2021 Appendix F: Intensive Clinic Based Support. Retrieved 3.24.2025. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-07/MHS%20-%20Appendix%20F%20%28updated%2011.22.21%29_Final.pdf

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 (formerly CMHRS), App. F - Intensive Clinic Based Support p. 15 (11/22/2021). 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.
        - One unit of service is one day.
        - A minimum of 3 sessions is required to achieve 9 to 19 hours of services per week for adults; a minimum of 2 sessions is required to achieve 6 to 19 hours of services per week for youth. The provider shall document any deviation from the ISP in the individual's medical record and reason for the deviation.
        - A maximum of 5 units may be billed per week.
        - In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must notify the MCO or the FFS contractor Utilization Management (UM) staff when the minimum sessions have not been provided. Documentation of any ISP deviation as well as reason for the deviation should be submitted at the time of the next authorization review.
        - If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the FFS contractor UM staff to reassess for another Level of Care or model to better meet the individual's needs.
    - **Required Activities:** Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p.6 (11/22/2021). In addition to the required activities for all mental health services providers located in Chapter IV of the DMAS manual, the following required activities apply to MH-IOP:
        - At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner or Physician Assistant shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter 4 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 4 for details).
        - An evaluation for medication management by a physician, nurse practitioner or physician assistant must be conducted within 72 hours of admission into the service. The provider must coordinate medication management with existing medical and psychiatric providers.
        - Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but 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.

- MH-IOP must be available to allow for 9-19 hours of intervention a week (for adults) or 6-19 hours of intervention a week (youth ages 6-17) with programming to occur across 3-4 days of services weekly.
- Components of the treatment program must include all of the following:
    - 1. Individualized treatment planning
    - 2. Individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others) in the assessment, treatment, and continuing care of the individual
    - 3. Skill restoration / development
    - 4. Health literacy counseling / psychoeducational activities
    - 5. Care coordination & referral for consultation, supplemental, or step-down service providers
    - 6. Crisis intervention
    - 7. Peer Recovery Support Services
    - 8. Medication management
    - 9. Occupational therapy, as an optional supplement, when it is directly related to the behavioral health goals
    - 10. Psychological assessment/testing as an optional supplement
    - 11. Care coordination through referrals to higher and lower levels of care, as well as community and social supports, should include the following:
        - a) The provider should collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care
        - b) The provider should establish and maintain referral relationships with stepdown programs appropriate to the population served
        - c) The provider should, with individual's consent, collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers
- A minimum of 2 distinct service components must be provided daily. If the minimum service components are not met, providers must document the reason in the individual's medical record. If the session involves a Comprehensive Needs Assessment no other component shall be required in order to bill the per diem.
- A minimum of 2 hours of therapy (individual, group or family) by a LMHP, LMHP-R, LMHP-RP or LMHP-S shall be provided per individual per week. Individuals may be pulled out of scheduled skill-based groups to participate in therapy. If the individual continues to meet with an existing outpatient therapy provider, the MH-IOP provider must coordinate the treatment plan with the provider.
- Group therapy shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the licensed mental health professional.
- A minimum of 3 sessions of group-based delivery of skills restoration/development shall be provided per week.
- An updated assessment conducted by a LMHP LMHP-R, LMHP-RP, LMHP-S, nurse practitioner or physician assistant is required at every 90 days of consecutive service. This assessment shall document continued medical necessity and define treatment goals included in the ISP for continued stay. DMAS or its contractor(s) may request the results of this assessment to evaluate approval of reimbursement for continued services. Services based upon incomplete, missing, or outdated Comprehensive Needs Assessment or ISPs shall be denied reimbursement.
- Whenever possible, crisis intervention should be delivered by the MH-IOP staff, including after program hours.
- In cases that an individual does not complete the minimum clinical service hours per week or minimum days in attendance, the provider must document any ISP deviation as well as the reason for the deviation in the individual's medical record and notify the MCO or the FFS contractor Utilization Management (UM) staff when the minimum sessions have not been provided

        - If the individual consistently deviates from the required services in the ISP, the provider should work with the MCO or the FFS contractor care coordination to reassess for another level of care or model to better meet the individual's needs.
        - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV of the DMAS manual).
    - **Special Notes:**
    - Medicaid
        - 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.

Keywords:

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