Sentara Health Plans

Medicaid

Mental Health Skill-Building (MHSS), BH 24

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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 Skill-Building (MHSS) Medicaid.

Description & Definitions:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS) – App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 21 (6.14.2023)

Mental Health Skill-Building services (MHSS) shall be defined as goal directed training and supports to enable restoration of an individual to the highest level of baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS services shall provide face to face activities, instruction, interventions, and goal directed trainings that are designed to restore functioning and that are defined in the ISP in order to be reimbursed by Medicaid. MHSS shall include goal directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities.

MHSS services include the following components:

- Providing opportunities to enhance recovery plans that include but are not limited to:
  - Daily living activities and trainings on personal care/hygiene to restore and regain functional skills and appropriate behavior related to health and safety; and,
  - Skills training and reinforcement on the use of available community resources, such as public transportation to improve daily living and community integration skills and independent use of community resources, etc.
- Recovery and symptom management activities that include but are not limited to:

    - Condition specific education and training and reinforcement of symptom identification designed to increase he individual's ability to recognize and respond to symptoms; and
    - Goal directed and individualized stress management and coping skills training to increase the individual's continued adjustment to management of mental illness; and
    - Training and coaching to facilitate improved communication, problems solving and appropriate coping skills, etc.
- Assistance with medication management.
- Conducting targeted exercises and coaching to restore and individual's ability to monitor and regulate their health, nutrition, and physical condition that includes but is not limited to:
    - Self-assessment exercises and recovery coaching that builds self-awareness of symptoms and how to identify and monitor symptoms; and
    - Coaching and training on maintaining adherence to recommended medical care such as scheduling and keeping medical appointments, etc.

"Comprehensive Needs Assessment" means the face-to-face interaction, in which the provider obtains information from the individual, and parent or other family member or members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) The dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

Criteria:

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services (formerly CMHRS) – App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 21 (6.14.2023)

Commonwealth of Virginia. Department of Medical Assistance Services. Mental Health Services. Chapter IV: Covered Services and Limitations. P. 11. Revision date 11.15.2024.

Individuals qualifying for MHSS must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.
Mental Health Skill-Building is considered medically necessary with **ALL** of the following:

- Individuals must meet medical necessity for appropriate authorization type by meeting **1 or more** of the following
    - Individuals age 21 and over shall meet **ALL** of the following criteria in order to be eligible to receive MHSS:
        - A. The individual shall have **1 or more** of the following as a primary mental health diagnosis:
            - 1) Schizophrenia or other psychotic disorder as set out in the DSM-5,
            - 2) Major Depressive Disorder;
            - 3) Bipolar I or Bipolar II;
            - 4) Any other serious mental health disorder that a physician has documented specific to the identified individual within the past year 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) the individual requires individualized training in order to achieve or maintain independent living in the community.
        - B. 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 system; skills to manage personal hygiene, food preparation, and the maintenance of personal adequate nutrition; money management; and use of community resources.

        - C. The individual shall have a prior history of any of the following: (i) psychiatric hospitalization; (ii) community stabilization, 23-hour crisis stabilization or residential crisis stabilization unit services, (iii) ICT or Program of Assertive Community Treatment (PACT) services; (iv) placement in a psychiatric residential treatment facility as a result of decompensation related to the individual's serious mental illness; or (v) a temporary detention order (TDO) evaluation pursuant to the Code of Virginia §37.2-809(B). This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service. See the Documentation and Utilization Review section for additional information.
        - D. The individual shall have had a prescription for antipsychotic, mood stabilizing, or antidepressant medications within the 12 months prior to the Comprehensive Needs Assessment. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or antidepressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's MHSS record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met upon admission to services, and not for subsequent authorizations of service. See the Documentation and Utilization Review section for additional information.
    - Individuals 18-20 years shall meet **ALL** of the following and above medical necessity criteria listed in paragraphs 1 through 2 (A-D) in order to be eligible to receive MHSS and the following:
        - E. The individual shall not be in a supervised setting as described in §63.2-905.1 of the Code of Virginia. If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition.
    - Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.
- For mental health services requiring service authorization, the medical record content must corroborate information provided to DMAS or its contractor.

Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance use disorder. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed within MHSS as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the Comprehensive Needs Assessment, the ISP, and the progress notes.

Exclusions and Service Limitations: Mental Health Services (formerly CMHRS) – App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 27 (6.14.2023)

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

- TGH and assisted living facility providers shall not serve as the MHSS provider for individuals residing in the providers' respective facility. Individuals residing in facilities may, however receive MHSS from another MHSS agency not affiliated with the owner of the facility in which they reside. "Affiliated" means any entity or property in which a group home or assisted living facility has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.
- MHSS shall not be reimbursed for individuals who are receiving in-home residential services or congregate residential services through the Intellectual Disability (ID) or Individual and Family Developmental Disabilities Support (IFDDS) waivers.

- MHSS shall not be reimbursed for individuals who are also receiving Independent Living Skills Services, the Department of Social Services (DSS) Independent Living Program, Independent Living Services, or Independent Living Arrangement or any CSA-funded independent living skills programs.
- Medicaid coverage for MHSS shall not be available to individuals who are receiving Treatment Foster Care.
- Medicaid coverage for MHSS shall not be available to individuals who reside in intermediate care facilities for individuals with intellectual disabilities (ICF/IDs) or hospitals.
- Medicaid coverage for MHSS shall not be available to individuals who reside in nursing facilities, except for up to 60 calendar days prior to discharge. If the individual has not been discharged from the nursing facility during the 60 calendar day period of services, MHSS shall be terminated, and no further service authorizations shall be available to the individual unless a provider can demonstrate and document that MHSS are necessary. Such documentation shall include facts demonstrating a change in the individual's circumstances and a new plan for discharge requiring up to 60 calendar days of MHSS.
- Medicaid coverage for MHSS shall not be available for residents of Psychiatric Residential Treatment Facilities, except for the assessment code H0032 (modifier U8) in the seven days immediately prior to discharge.
- MHSS shall be not reimbursed if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the individual's MHSS record. Medical record documentation shall fully substantiate the need for services when personal care or attendant care services are being provided. This applies to individuals who are receiving additional services through a Developmental Disabilities Waiver, CCC Plus Waiver, and EPSDT services.
- MHSS shall not be duplicative of other services. Providers have a responsibility to ensure that if an individual is receiving additional therapeutic services that there will be coordination of services by either the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHPA, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-A, QMHP-C, QMHP-E, LMHP, LMHP-S, LMHP-R or LMHP-RP to avoid duplication of services.
- Individuals who have organic disorders, such as delirium, dementia, or other cognitive disorders not elsewhere classified, will be prohibited from receiving/ will not qualify for Medicaid coverage for MHSS unless their physicians issue a signed and dated statement indicating that this service can benefit the individual by enabling them to achieve and maintain community stability and independence.
- Individuals who are not diagnosed with a serious mental disorder but who have personality disorders or other mental health disorders, or both, that may lead to chronic disability, will not be excluded from the MHSS services eligibility criteria provided that the individual has a primary mental health diagnosis from the list included in 12VAC30-50-226 and that the provider can document and describe how the individual is expected to actively participate in and benefit from MHSS and the remaining MHSS service criteria and guidelines are satisfied.
- Academic services are not reimbursable. Any services provided to the individual that are strictly academic in nature shall not qualify for Medicaid reimbursement. These services include, but are not limited to, such basic educational programs as instruction in reading, science, mathematics, or GED.
- Vocational services are not reimbursable. Support services and activities directly related to assisting a client to cope with a mental illness in the work environment are reimbursable. Activities that focus on how to perform job functions are not reimbursable.
- Room and board, custodial care, and general supervision are not components of this service and are not reimbursable.
- Individuals, who reside in facilities whose license requires that staff provide all necessary services, are not eligible for this service.
- Providers shall be reimbursed only for training activities defined in the ISP and only where services meet the service definition, eligibility, and service provision criteria and guidelines as described in the regulations and this manual. Only direct face-to-face contacts and services to the individual members are reimbursable.
- Staff travel time is excluded.

- MHSS may not be authorized or billed concurrently with Assertive Community Treatment, Multisystemic Therapy, Functional Family Therapy, Applied Behavior Analysis. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care. MHSS may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care.
- Service may not be provided in groups where one staff person provides services to two or more individuals at the same time.

Document History:

Revised Dates:

- 2025: April – Removed some service authorization requirements as DMAS Appendix C updated
- 2024: August
- 2023: May
- 2022: May, June
- 2021: June, October
- 2020: August
- 2019: October

Reviewed Dates:

- 2026: April - Implementation date of August 1, 2026. No changes to criteria. Update references and version number only to reflect annual review.

Origination Date: January 2018

Coding:

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

Coding	Description
H0032	Mental health service plan development by nonphysician
H0046	Mental health services, not otherwise specified

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.

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:
  - Initial registration is required by the Plan.
  - Individuals eligible for this service may have a dual diagnosis of either mental illness and developmental disability or mental illness and substance use disorder. If an individual has co-occurring mental health and

substance use disorders, integrated treatment for both disorders is allowed within MHSS as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the Comprehensive Needs Assessment, the ISP, and the progress notes.

- Mental Health Services (formerly CMHRS) – App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 22 (6.14.2023). In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to MHSS:
    - A Comprehensive Needs Assessment shall be required prior to the start of services. The Comprehensive Needs Assessment must be conducted face-to-face by the LMHP, LMHP-R, LMHP-S or LMHP-RP. The Comprehensive Needs Assessment, as defined in Appendix A, shall document the individual's behavior and describe how the individual meets criteria for this service. After any lapse in services of more than 31 calendar days, a new Comprehensive Needs Assessment shall be required unless the provider has a valid Comprehensive Needs Assessment as defined in the Comprehensive Needs Assessment section of chapter IV. If the provider has a valid Comprehensive Needs Assessment, the provider shall update the Comprehensive Needs Assessment following any lapse of greater than 31 calendar days. The LMHP, LMHP-R, LMHP-RP, LMHP-S performing the Comprehensive Needs Assessment shall document the primary mental health diagnosis on the Comprehensive Needs Assessment.
    - MHSS services that continue more than six months shall be reviewed by the LMHP, LMHP-R, LMHP-RP, or LMHP-S to support that the individual continues to meet the medical necessity criteria. The LMHP, LMHP-R, LMHP-RP or LMHP-S shall determine and document the continued need for the service in the individual's medical record as described in the Comprehensive Needs Assessment section of chapter IV. This review may be requested by DMAS or its contractor to receive approval of reimbursement for continued services.
    - The ISP shall be developed as described in the ISP Requirements section of this found in chapter IV within 30 calendar days of the admission to this service. The ISP shall include documentation of the frequency of services to be provided (that is, how many days per week and how many hours per week) to carry out the goals in the ISP. The total time billed for the week shall not exceed the frequency established in the individual's ISP. Exceptions to following the ISP must be rare and based on the needs of the individual and not provider convenience. The ISP shall indicate the specific training and services to be provided, the goals and objectives to be accomplished and criteria for discharge as part of a discharge plan that includes the projected length of service. The ISP shall include the dated signature of the individual, if the individual refuses to sign the ISP, this shall be noted in the individual's medical record documentation.
    - Every three months (defined as 90 calendar days), the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E shall review with the individual in the manner in which he may participate with the process, modify as appropriate, and update the ISP. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs as well as any newly identified problem. Documentation of this review shall be added to 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, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual. The ISP shall be rewritten annually.
    - The ISP shall include discharge goals that will enable the individual to achieve and maintain community stability and independence. The ISP shall fully support the need for interventions over the length of the period of service requested from the service authorization contractor.
    - Reauthorizations for service shall only be granted if the provider demonstrates to the service authorization contractor that the individual is benefitting from the service as evidenced by updates and modifications to the ISP that demonstrate progress toward ISP goals and objectives.
    - If the provider knows of or has reason to believe that the individual is not adhering to the medication regimen, medication compliance shall be a goal in the individual's ISP. If the care is delivered by the QPPMH, the supervising LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall be informed of any non-compliance. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C shall coordinate care with the prescribing physician regarding any

medication regimen non-compliance concerns. The provider shall document the following minimum elements of the contact between the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, or QMHP-C and the prescribing physician:
    - name and title of caller;
    - name and title of professional who was called;
    - name of organization that the prescribing professional works for;
    - date and time of call;
    - reason for care coordination call;
    - description of medication regimen issue or issues to be discussed; and
    - resolution of medication regimen issue or issues that were discussed.
  - Documentation of prior psychiatric services history, to include psychiatric medication history, as described in Chapter VI of this manual shall be maintained in the individual's MHSS medical record.
  - Only direct face-to-face contacts and services to an individual shall be reimbursable.
  - Support activities and activities directly related to assisting an individual to cope with a mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment shall be billable. However, any service provided to individuals that are strictly vocational in nature shall not be billable.
  - Provider qualifications. The enrolled provider of MHSS shall have a Mental Health Community Support license through DBHDS. Individuals employed or contracted by the provider to provide MHSS must have training in the characteristics of mental illness and appropriate interventions, training strategies, and support methods for persons with mental illness and functional limitations. MHSS shall be provided by either an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or QPPMH. The LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A or QMHP-C will supervise the care weekly if delivered by the QMHP-E or QPPMH. Documentation of supervision shall be maintained in the MHSS record. All Registered QMHPs shall follow DHP licensing requirements for supervision.
  - MHSS must be documented through a daily log of time involved in the delivery of services and a minimum of a weekly summary note of services provided. The provider shall clearly document services provided to detail what occurred during the entire amount of the time billed.
  - If MHSS is provided in a Therapeutic Group Home, mental health supervised living setting or assisted living facility the ISP shall not include activities that contradict or duplicate those in the treatment plan established by the group home or assisted living facility. The provider shall attempt to coordinate MHSS with the treatment plan established by the group home, mental health supervised living setting or assisted living facility and shall document all coordination activities in the medical record.
  - All services must be provided on a one-to-one basis with one staff person and one Medicaid member with the exception of care coordination.
- **Care Coordination:**
  - Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

- 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.

References:

References used include but are not limited to the following:

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services. Revision Date: 6.14.2023. Appendix H: Community Mental Health Rehabilitative Services. Retrieved 2.17.2026. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-07/MHS%20-%20Appendix%20H%20%28updated%206.14.23%29_Final.pdf

Commonwealth of Virginia. Department of Medical Assistance Services. Provider Manual Title: Mental Health Services. Revision Date: 7/17/2025. Appendix A: Definitions. Retrieved 2.17.2026. https://vamedicaid.dmas.virginia.gov/sites/default/files/2025-07/MHS%20-%20Appendix%20A%20%28updated%207.17.25%29_Final.pdf

Keywords:

SHP Behavioral Health 24, BH, mental health skill building, goal directed training, community stability, functional skills, medication management, home-based counseling, direct clinical services, treatment plans, therapists, social workers, case managers