Sentara Health Plans

Medicaid

Mental Health Partial Hospitalization Program (MH-PHP), BH 30

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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:

Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p. 19 (11/22/2021)

Mental Health Partial Hospitalization (MH-PHP) services are short-term, non-residential interventions that are more intensive than outpatient services and that are required to stabilize an individual's psychiatric condition. The service is delivered under physician direction to individuals at risk of psychiatric hospitalization or transitioning from a psychiatric hospitalization to the community. Individuals qualifying for this service must demonstrate a medical necessity for the service arising from behavioral health disorders that result in significant functional impairments in major life activities.

Mental Health Partial Hospitalization Programs (MH-PHPs) are highly structured clinical programs designed to provide an intensive combination of interventions and services similar to an inpatient program, but available on a less than 24-hour basis. MH-PHPs are active, focused and time-limited treatment programs intended to stabilize acute symptoms in youth (6-17 years old) 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. The average length of stay may be four to six weeks, though length of stay should reflect individual symptom severity, needs, goals and medical necessity criteria. MH-PHP can serve as a transition program, such as a step-down option following an inpatient hospitalization. MH-PHP can serve as a diversion for an individual from inpatient care, by providing an alternative that allows for intensive clinical services without hospital admission. The target population consists of individuals that would likely require inpatient hospitalization in the absence of receiving this service. MH-PHPs may occur in either a hospital- or community-based location.

MH-PHP services are appropriate when an individual requires at least four hours of clinical services a day, over several days a week and totaling a minimum of 20 hours per week. A MH-PHP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule.

MH-PHP tapers in intensity and frequency as an individual's symptoms improve, they are able to establish/reestablish community supports, and they are able to resume daily activities or are able to participate in a lower level of care.

Critical Features & Service Components

Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p. 20 (11/22/2021)

MH-PHP involves a multidisciplinary team approach under the direction of a physician. MH-PHP programs include structured schedules for participants. MH-PHP must be available at a minimum of 20 hours per week, a minimum of five days per week, four hours per day. 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. Emergency services must be available through the MH-PHP 24-hours a day and seven days a week.

Programs for youth should accommodate for or integrate required academic instruction in coordination with the appropriate funding source, but the academic instruction itself is not a critical feature or eligible for Medicaid reimbursement.

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
- care coordination

Admission Criteria:

Mental Health Services (formerly CMHRS), App. F - Intensive Clinic Based Support p. 26 (11/22/2021)

Mental Health Partial Hospitalization Program (MH-PHP) 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. There is a clinical determination that in the last 14 days, the individual has manifested an acute and significant or profound impairment in daily functioning in the home, school, community or occupational setting that has led to negative consequences and difficulties maintaining supportive, sustained relationships with identified family and peers due to a psychiatric disorder
    - 3. The individual is at risk for admission to inpatient hospitalization or residential crisis stabilization 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 or residential crisis stabilization 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, including psychiatric interventions for medication management
    - 6. The individual can reliably attend, and actively participate in, all phases of the treatment program necessary to stabilize his/her condition
    - 7. The severity of the presenting symptoms cannot be safely or adequately addressed in a less intensive level of care
    - 8. The individual has demonstrated willingness to recover in the structure of an ambulatory treatment program
    - 9. If an individual is being admitted to MH-PHP for an eating disorder**, all of the following** must also be met:
        - a. The individual exhibits symptoms consistent with an eating disorder diagnosis and requires at least **two of the** following:

                - i. As a result of eating disorder behaviors, weight stabilization above 80% IBW (or BMI 15-17)
                - ii. Daily, or near daily supervision and structure that could not be attained in a less intensive setting, to interrupt compensatory weight management behavior, such as caloric restriction, intake refusal, vomiting/purging, excessive exercise, compulsive eating/binging
                - iii. Individual misuse of pharmaceuticals with an intent to control weight (e.g., laxatives, diuretics, stimulants) and cannot be treated at a lower level of care.
            - b. Medical comorbidity or medical complications resulting from the eating disorder are absent or manageable and do not require 24-hour medical monitoring or procedures provided in a hospital level of care.
            - c. If the above criteria are not met, service authorization requests and medical necessity will be assessed on an individualized basis to determine if the individual's treatment needs can be best met in this setting and can be delivered in a safe and effective manner.
- Continuation of services for individuals who 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 individualized treatment plan (ISP), updated every 30 calendar days or as clinically appropriate, contains evidence suggesting that the identified problems are likely to respond to current treatment plan (ISP)
    - 5. Documentation indicates that regular monitoring of symptoms and functioning reveals that the individual is making progress towards goals, or the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals
    - 6. A psychiatric medical evaluation documents that medication options have been considered or initiated
    - 7. 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
    - 8. 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.
    - 9. If an individual is being admitted to MH-PHP for an eating disorder, then **1 or more** of the following must also be met:
        - a. Individual has had no stabilization of weight since admission or there is continued instability in food intake
        - b. The eating disorder behaviors persist and continue to put the individual's medical status in jeopardy.
- If the above criteria are not met, there are some circumstances under which authorization may be extended for up to 10 calendar days. These circumstances include **1 or more** of the following:
    - 1. The individual has clearly defined treatment objectives that can reasonably be achieved through continued MH-PHP 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 20 hours a week 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:

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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) despite documented efforts to engage the individual
- 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
- For eating disorders, individual has gained weight, or is in better control of weight reducing behaviors/actions, and can now be safely and effectively managed in a less intensive level of care
- If there is a lapse in service greater than seven consecutive calendar days, including circumstances where this lapse is due to admission for a medical or psychiatric inpatient hospitalization.

Exclusions and Service Limitations:

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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-PHP shall not be authorized concurrently with Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0, Psychosocial Rehabilitation, Therapeutic Day Treatment, Intensive In-Home Services, Therapeutic Group Home, Applied Behavior Analysis, Mental Health Intensive Outpatient Services, Community Stabilization, Residential Crisis Stabilization Unit (RCSU), Multisystemic Therapy, Functional Family Therapy, Psychiatric Residential Treatment or Inpatient Hospitalization. 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-PHP that is not allowed to be authorized concurrently with MH-PHP, an initial service authorization request to resume previously authorized services may not be required if the individual is discharged from MH-PHP within 31 days. Contact the individual's MCO or FFS Contractor for authorization requirements.
- If an individual is participating in Assertive Community Treatment and has a concurrent admission to a Partial Hospitalization Program, the team should conduct close care coordination with those providers to assure alignment of the treatment plan (ISP) and avoid any duplication of services.
- Activities that are not reimbursed or authorized include:
    - 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.

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Individuals meeting 1 or more of the following are ineligible for MH-PHP:

- The individual's 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.

Document History:

Revised Dates:

- 2025: May – Implementation date of August 1, 2025. Updated to new format only. No change to DMAS manual.
- 2024: June – Updated Description of Service, and Exceptions and Limitations language per DMAS manual update of 6/14/2023.
- 2023: July
- 2022: June
- 2001: July, October

Reviewed Dates:

- 2024: June – Annual review. No change to criteria. DMAS manual has not updated.

Origination Date: January 2018

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)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0035	Mental health partial hospitalization, treatment, less than 24 hours

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:
    - Pre-certification by the Plan is required.
    - Provider Manual Title: Mental Health Services. Revision Date: 11/22/2021 Appendix F: Intensive Clinic Based Support p. 30
    - Service Authorization:
        - MH-PHP requires service authorization and shall be delivered by a service provider who meets the provider qualifications listed above.
        - 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.
        - An individual may participate in MH-PHP services concurrent with Opioid Treatment Services/Medication Assisted Treatment. The MH-PHP provider and the buprenorphine-waivered practitioner shall collaborate and corroborate these efforts in documentation.
            - One unit of service is one day.
            - The minimum number of service hours per week is 20 hours with at least four service hours per service day, a minimum of 5 days per week.
            - In cases that an individual does not complete the minimum of four clinical service hours per service day or attend treatment a minimum of five days per week, the provider shall:
                - Document any ISP deviation as well as the reason for the deviation in the individual's medical record; and
                - Notify the MCO or the Fee for Service contractor Utilization Management (UM) staff when they have not been able to provide the minimum required sessions. The provider shall submit documentation 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 Fee for Service 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. 20 (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-PHP:

- 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 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-PHP and cannot be used as a comprehensive needs assessment by the provider for other mental health services (see Chapter IV for details)
- Initial medication evaluation must be conducted by the Psychiatrist, Nurse Practitioner, or Physician Assistant with the individual via in-person or telemedicine evaluation within 48 hours of admission.
- Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. The initial treatment plan (ISP) shall be completed on the day of admission to the service. 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
- Components of the treatment program must include all of the following:
    - Individualized treatment planning
    - Daily individual, group and family therapies involving natural supports (family as defined by the individual, guardians or significant others)
    - Skill restoration/development and health literacy counseling/psychoeducational interventions
    - Medication management as well as additional clinically indicated psychiatric and medical consultation services must be available. Referrals for consultation to external prescribing providers are allowable and must be made via formal agreement. The provider must coordinate medication management with existing medical and psychiatric providers
    - Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral
    - Crisis intervention and safety planning support available 24/7
    - Peer recovery support services, offered as an optional supplement for individuals
    - Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following:
        - The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care
        - The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served

    - The provider shall, 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.
- At least **three of the following** service components shall be provided per day based on the treatment needs identified in the initial comprehensive assessment:
    - Daily therapeutic interventions with a planned format including individual, group or family therapy;
    - medication management (as clinically indicated; minimum of weekly)
    - Skill restoration/development
    - Health literacy counseling/psychoeducation interventions
    - Occupational and/or other therapies performed by a professional acting within the scope of their practice.
- If the session involves a Comprehensive Needs Assessment as a service component, only one of the above listed components shall be required in order to bill the per diem that day.
- The minimum number of service hours per week is 20 hours with at least four service hours per session, a minimum of 5 days 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 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 at the next service authorization request (see service authorization section for additional information).
- If the individual consistently deviates from the required services in the ISP, the provider would work with the MCO or the FFS Contractor care coordinator to reassess for another level of care or model to better meet the individual's needs.
- Group mental health therapy by LMHPs, LMHP-Rs, LMHP-RPs and LMHP-Ss shall have a recommended maximum limit of 10 individuals in the group. Group size may exceed this limit based on the determination of the LMHP, LMHP-R, LMHP-RP, and LMHP-S.
- If the individual continues to meet with an existing outpatient therapy provider, the MH-PHP provider must coordinate the treatment plan with the provider.
- Whenever possible, crisis intervention should be delivered by the MH-PHP staff, including after program hours.
- An updated assessment conducted by a LMHP LMHP-R, LMHPRP, 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 services. 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.
- 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 withing 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: 11/22/2021 Appendix F: Intensive Clinic Based Support Retrieved 4.24.2025. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-07/MHS%20-%20Appendix%20F%20%28updated%2011.22.21%29_Final.pdf

Keywords:

Mental Health Partial Hospitalization Program, MH-PHP, SHP Behavioral Health 30