Sentara® Health Plans

Medicaid

Mental Health Case Management, BH 22

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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 Case Management.

Service Requirements:

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The following services and activities must be provided:

- Assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessment, but does include referral for such). An assessment must be completed by a qualified mental health case manager to determine the need for services or included as a recommended service on a Comprehensive Needs Assessment conducted by a LMHP, LMHP-R, LMHPRP or LMHP-S. If completed by a qualified case management who is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the assessment is conducted as part of the first month of case management service. Case Management assessments and intakes must be provided in accordance with the provider requirements defined in DBHDS licensing rules for case management services. The assessment serves as the basis for the ISP.
- The ISP must document the need for case management and be fully completed within 30 calendar days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review. The ISP shall be updated at least annually.

- Mandatory monthly case management contact, activity, or communication relevant to the ISP. Written plan development, review, or other written work is excluded
- Linking the individual to needed services and supports specified in the ISP
- Provide services in accordance with the ISP
- Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources
- Coordinating services and service planning with other agencies and providers involved with the individual.
- Enhancing community integration by contacting other entities to arrange community access and involvement including opportunities to learn community living skills, and use vocational, civic, and recreational services.
- Making collateral contacts, which are non-therapy contacts, with significant others to promote implementation of the service plan and community adjustment.
- Following up and monitoring to assess ongoing progress and ensuring services are delivered.
- Monitoring service delivery as needed through contacts with service providers as well as periodic site visits and home visits.
- Education and counseling, which guide the individual and develop a supportive relationship that promotes the service plan. Counseling, in this context, is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities must be linked to the goals and objectives on the Case Management ISP.
  Educational activities do not include group activities that provide general information and that do not provide opportunities for individualized application to specific individuals. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not case management activities.
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the individual's receipt of CMHRS services, specifically mental health case management.
- A face-to-face contact must be made at least once every 90 calendar day period. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are in fact being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the member's status.

Case Management services are intended to be an individualized client-specific activity between the case manager and the member. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was consumer-specific. For example, the case manager needs to work with two individuals, each of whom needs help to apply for income assistance from Social Security. The case manager can work with both individuals simultaneously for the purpose of helping each individual obtain a financial entitlement and subsequently follow-up with each individual to ensure he or she has proceeded correctly.

Case Management Agency Requirements

- The assessment and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial assessment must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.
- All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP.
- There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.
- A release form must be completed and signed by the individual for the release of any information.

- There must be an ISP from each provider rendering services to the individual. The ISP is the service plan developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. ISPs help to determine the overall ISP for the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms. For case management services, specific objectives for monitoring, linking, and coordinating must be included.
- Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Monitoring and Re-Evaluation of the Service Need by the Case Manager

- The case manager must continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. At a minimum, the case manager shall review the ISP every three months to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications to the ISP are necessary. Providers must coordinate reviews of the ISP with the case manager every three months.
- This quarterly re-evaluation must be documented in the case manager's file. The case manager must have monthly activity regarding the individual and a face-to-face contact with the individual at least once every 90 calendar days.
- The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers change. When such a change occurs, the case manager must involve the individual in the discussion of the need for the change.

Description & Definitions:

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Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services.

Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, 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 assessment, the ISP, and the progress notes.

Criteria:

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The Medicaid eligible individual shall meet the Department of Behavioral Health and Developmental Services (DBHDS) criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance. There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent with **all of the following:**

- The individual's degree of illness must meet **1 or more of the following**:
    - 1. Serious Mental Illness - Adults, 18 years of age or older, who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance use disorder or developmental disability are included. The population is defined along three dimensions: diagnosis, level of disability, and duration of illness. **All of the following three** dimensions must be met to meet the criteria for serious mental illness.

        - a. Diagnosis - There must be a major mental disorder diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy these criteria.
        - b. Level of Disability - There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least **2 or more of the following** criteria on a continuing or intermittent basis
            - 1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
            - 2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
            - 3) Has difficulty establishing or maintaining a personal social support system.
            - 4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
            - 5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
        - c. Duration of Illness - The individual is expected to require services of an extended duration, or the individual's treatment history meets at least **1 or more of the following criteria:**
            - The individual has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization).
            - The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
    - 2. Serious Emotional Disturbance - Serious emotional disturbance in children ages birth through 17 is defined as a serious mental health problem that can be diagnosed under the DSM, or the child must exhibit **all of the following**:
        - a. Problems in personality development and social functioning that have been exhibited over at least one year's time; and
        - b. Problems that are significantly disabling based upon the social functioning of most children that age; and
        - c. Problems that have become more disabling over time; and
        - d. Service needs that require significant intervention by more than one agency.

        NOTE: Children diagnosed with Serious Emotional Disturbance and a co-occurring substance use disorder or developmental disability diagnosis are also eligible for Case Management for Serious Emotional Disturbance.

    - 3. At Risk of Serious Emotional Disturbance - Children aged birth through seven are considered at risk of developing serious emotional disturbances if they meet at least **1 or more of the following** criteria:
        - The child exhibits behavior or maturity that is significantly different from most children of that age and which is not primarily the result of developmental disabilities;
        - Parents, or persons responsible for the child's care, have predisposing factors themselves that could result in the child developing serious emotional or behavioral problems (e.g., inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, etc.);
        - The child has experienced physical or psychological stressors that have put him or her at risk for serious emotional or behavioral problems (e.g., living in poverty, parental neglect, physical or emotional abuse, etc.)
- There must be documentation of the presence of serious mental illness for an adult individual or of serious emotional disturbance or a risk of serious emotional disturbance for a child or adolescent.

- The individual must require case management as documented on the Individualized Service Plan (ISP) which is developed by a qualified mental health case manager based on an appropriate assessment and supporting documentation.
- The individual is an “active client” which means that the individual has an Individualized Service Plan (ISP) in effect which requires regular direct or client-related contacts and communication of activity with the client, family, service providers, significant others, and others, including a minimum of one face to face contact every 90 calendar days.

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No other type of case management, from any funding source, may be billed concurrently with targeted case management.

Limited services are available to individuals in institutions (see billing requirements section)

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A billing unit is one calendar month.

Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the face to face visit, or the date the monthly summary note has been documented, or a specific date service was provided. In order to support the 1 billing unit per calendar month, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. Providers are NOT to span the month for Case Management services.

Reimbursement shall be provided only for "active" case management clients, as defined. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90 calendar day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

In accordance to 42 CFR 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

Services rendered during the same month as the admission to the IMD is reimbursable for individuals ages 22 - 64 as long as the service was rendered prior to the date of the admission.

Two conditions must be met to bill for Case Management services for individuals that are in an acute care psychiatric units or who are in institutions and who do not meet the exclusions noted above. The services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management services provided to the individual are limited to one month of service, 30 calendar days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

Case Management services for the same individual must be billed by only ONE type of Case Management provider. See Chapter V for billing instructions.

Providers must follow the requirements for the provision of telemedicine described in the "Telehealth Services Supplement" including the use of the GT modifier for units billed for services provided through telemedicine. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Coding:

Medically necessary with criteria:

Coding	Description
H0023	Behavioral health outreach service (planned approach to reach a targeted population)

Considered Not Medically Necessary:

Coding	Description
	None

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

Document History:

Revised Dates:

- 2023: June
- 2022: April, June
- 2021: June, October
- 2019: October

Reviewed Dates:

- 2024: April
- 2023: March
- 2018: December

Effective Date:

- January 2018

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: 1/13/2023 Appendix I: Case Management. Retrieved 4.4.2024. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/MHS%20-%20Appendix%20I%20%28updated%201.13.23%29_Final.pdf

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.*

Keywords:

Behavioral Health 22, BH, OHCC, Optima Health Community Care, CMHRS, Community Mental Health Resource Services, Mental Health Case Management, MHCM, mental illness, Diagnostic and Statistical Manual of Mental Disorders, DSM, emotional disturbance,