Sentara Health Plans

Medicaid

Psychosocial Rehabilitation, BH 21

Table of Content

Description & Definitions
Clinical Indications for Procedure
Document History
Coding Information
Policy Approach and Special Notes
References
Keywords

Effective Date	8/1/2026
Next Review Date	4/2027
Coverage Policy	BH 21
Version	12

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 - Appendix H: Community Mental Health Rehabilitative Services (CMHRS) p. 16 (06/14/2023)

Psychosocial Rehabilitation is a program of two or more consecutive hours per day provided to groups of individuals in a community, nonresidential setting who require a reduction of impairments due to a mental illness and restoration to the best possible functional level in order to maintain community tenure. This service provides a consistent structured environment for conducting targeted exercises and coaching to restore an individual's ability to manage mental illness. This service provides education to teach the individual about mental illness, substance use, and appropriate medication to avoid complication and relapse and opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a consistent program structure and environment. Services may be provided in groups or on a one-to-one basis as clinically indicated.

Clinical Indications for Procedure:

Mental Health Services– App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 18 (6/14/2023)

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.

Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.

Individuals must **meet both Criteria A and B** to qualify for reimbursement.

Psychosocial Rehabilitation is considered medically necessary with **ALL of the following**:

- A. Individuals must **meet 2 or more of the following** criteria on a continuing or intermittent basis:
  - 1) Experience difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports
  - 2) Experience difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized
  - 3) Exhibit such inappropriate behavior that repeated interventions **documented** by the mental health, social services, or judicial system are or have been necessary
  - 4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. "Cognitive" is defined as the individual's ability to process information, problem-solve and consider alternatives, it does not refer to an individual with an intellectual or other developmental disability
- B. The individual must meet **1 or more of the following** criteria :
  - 1) Have experienced long-term or repeated psychiatric hospitalizations
  - 2) Experience difficulty in activities of daily living and interpersonal skills
  - 3) Have a limited or non-existent support system
  - 4) Be unable to function in the community without intensive intervention
  - 5) Require long-term services to be maintained in the community

Exceptions and Limitations: Mental Health Services App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 19 (6/14/2023)

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

- The following services are specifically excluded from payment for psychosocial rehabilitation services:
  - Vocational services,
  - Prevocational services,
  - Supported employment services

Psychosocial rehabilitation may not be authorized or billed concurrently with Mental Health Intensive Outpatient, Mental Health Partial Hospitalization Program services, or Applied Behavior Analysis services. Psychosocial rehabilitation 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.

Providers shall not bill for time when the individual is not present at the program.

Document History:

Revised Dates:

- 2025: May – 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: June
- 2022: June
- 2021: June, October
- 2020: August
- 2019: October

Reviewed Dates:

- 2026: April – Implementation date of August 1, 2026. Annual review. No updates to DMAS manual criteria since last review.
- 2019: June
- 2018: December

Coding Information:

Medically necessary with criteria:

Coding	Description
H0032	Mental health service plan development by nonphysician
H2017	Psychosocial rehabilitation services, per 15 minutes

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
- Authorization Requirements: Pre-certification by the Plan is required.
    - Service Requirements:
        - Mental Health Services - App. H - Community Mental Health Rehabilitative Services (CMHRS) p. 17 (6/14/2023)
            - Service authorization is required. See Appendix C

- 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.

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: 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

Keywords:

SHP behavioral health 21, BH, OHCC, Optima Health Community Care, CMHRS, Community Mental Health Resource Services, Psychosocial Rehabilitation, psych, rehab, PSR