Mental Health Skill-building Services (MHSS) Frequently asked questions

Thank you for being a Magellan Complete Care of Virginia (MCC of VA) provider and providing high quality healthcare services to our members. This document will answer some of the questions you may have regarding MHSS.

What is the authorization timeframe for MHSS?

- MHSS may be authorized for up to three months at a time or based upon medical necessity.
- Providers should individualize the service request including the number or units, timeframe and duration expected based on the member's clinical needs instead of submitting blanket requests.
- In the review process, MCC of VA looks for alignment of the timeframe, units and duration requested with the service plan and goals.

Are there any limits or exclusions related to MHSS services?

Yes, MCC of VA operates in accordance with the Community Mental Health and Rehabilitative Services (CMHRS) manual that specifies limitations and exclusionary criteria for MHSS. These limits and exclusions can be found in (Chapter IV, pages 49-51) of the CMHRS provider manual. Examples are:

- MHSS shall not be duplicative of other services. Providers have a responsibility to ensure that if a member is receiving additional therapeutic services that there will be coordination of services to include a detailed rationale as to why additional services are needed for member.
- MHSS shall not be reimbursed if personal care services or attendant care services are being receiving simultaneously, unless justification is provided why this is necessary in the member's MHSS record.
- Members who have organic disorders, such as delirium, dementia or other cognitive disorders not elsewhere classified, will be prohibited from receiving/will not qualify for MHSS.
- Medicaid coverage for MHSS shall not be available to members who reside in nursing facilities, except for up to 60 days prior to discharge.
- Therapeutic Group Home (TGH) and assisted living facility providers shall not serve as the MHSS provider for members residing in the provider's respective facility.

What are examples of duplication of services and what is the provider's role when a member is receiving multiple concurrent services?

As described in the CMHRS provider manual Chapter IV, page 50, "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".

- MCC of VA views a duplication of services as two services whose treatment plans, objectives, and strategies are substantially similar, with little differentiation of benefit to member.
- If a member resides in an Assisted Living Facility (ALF) and does not intend to live independently, providers should assess whether the proposed goals are already being addressed by the ALF (e.g. medication management for a member who already receives medications from ALF staff and adherent to taking medications).
- For members receiving Long Term Services & Supports (LTSS), providers should specify how the MHSS goals differ from the needs and/or goals addressed through LTSS Home Health/Personal Care Services.

How does MCC of VA manage personal care and attendant services that are being rendered simultaneously?

- When simultaneous services are identified either through the service request for authorization (SRA) or through the member's medical record on file, Utilization Management (UM) will review for potential duplication of services.
- UM may reach out to the MHSS provider to ensure appropriate treatment goal alignment and care coordination among various providers.
- In cases of duplication in treatment goals, or when the two services are exclusionary, the UM staff will evaluate member impact and coordinate with our MCC of VA care coordinator and member, to ensure the right service is in place at the right time to meet the member's needs. This may include a plan to transition the member out of one service in lieu of another that better fits their clinical needs.

How should the SRA reflect individualized treatment for MHSS?

- MCC of VA reviews both the SRA and the service plan for alignment of units, duration and goals. SRAs should:
    - Describe member strengths and resources
    - Identify barriers and strategies to overcome them
    - Include goals and objectives that target the member's specific functional impairments, and all service interventions and activities should align with these goals
    - Consider baseline functioning and what realistic recovery might be at discharge
    - Incorporate the member's voice and choice
    - Include timelines and measurable outcomes of success in the treatment plan
    - List the specific improvements on goals and objectives since the last SRA
    - Revise the treatment plan as the member progresses and/or new barriers are identified

What can providers expect from the UM staff in the authorization review process?

- UM professionals engage in care coordination to support the authorization process and help support the care coordination team that assist members in the community.

- Providers should ensure the SRA is completed in its entirety with no section left incomplete or blank, as this will delay the authorization request or result in a denial. UM staff will reach out to the clinical contact listed on the SRA to receive additional information, so please be responsive in these requests to ensure timely reviews.
- UM collaborates with participating providers to support authorization requests.
- Throughout the review process, UM looks for individualized treatment planning, care coordination from the MHSS provider with other providers and comprehensive discharge planning.

How can I best work with MCC of VA on discharge planning for a member?

- MCC of VA encourages providers to include a comprehensive discharge plan on the SRA. Remember, discharge planning begins at admission to the service.
- The discharge plan should include:
    - The member's caregivers and support system
    - Individualized step-down care, including type of service, what agency the member is being linked with and any upcoming intakes
    - Community resources and supports
    - Potential barriers to discharge
    - Behavioral and physical health needs and any collaboration with other health providers
    - Maintenance support of new skills or a transition to an appropriate level of care
    - An estimated discharge date that is based on the member's current status, progress and treatment goals
- Reach out to the member's care coordinator for assistance linking to other services when needs are identified or barriers are present. Our care coordinators work directly with our members and are always willing to help with coordinating services, unmet needs and transition of care.

How should providers document progress or lack of progress? Does lack of progress mean MHSS will be denied?

- MCC of VA operates under the definition for "failed service" under the guidance of the CMHRS provider manual and Centers for Medicare & Medicaid Services (CMS) (12VAC30-60-61). If the service is not benefiting the member as evidenced by lack of skill retention or inability to resolve the member's goals, discharge from the service may be required (CMHRS Manual, Chapter IV).
- The expectation of the service is to be more than just a support or maintenance, it should result in progress toward the member's person-centered goals.
- If a member is not demonstrating progress, despite the length of time in treatment and interventions attempted, MCC of VA will assist providers in discharge planning and in identifying another level of care or other supportive services that might be appropriate. Our goal is to provide continuity of care and help transition the member appropriately, which in some cases means to shorten the authorization timeframe and titrate units as we transition the member.

How do providers ensure efficient processing of claims for MHSS?

- MCC of VA encourages providers to contact customer service or their network representatives if they have questions about their claims.
- Please do not submit an additional claim as this will result in a duplicate denial.
- Resubmissions with the corrected bill indicator should only be used when data on the claim has changed.
- If you have any questions regarding appeals of denied claims please reference our website page on appeals below: https://www.mccofva.com/providers/for-providers/provider-tools/forms/appeals/

Are there any specific credentialing requirements for MHSS?

- Providers with multiple locations should ensure that all locations providing MHSS services are credentialed.
- Starting January 1, 2019, all Qualified Mental Health Professionals QMHPs providing MHSS under the provider's National Provider Identifier (NPI) will need to be registered with the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

If you have any questions please contact your Regional Network Manager or call 1-800-424-4524 for CCC Plus or 1-800-424-4518 for Medallion 4.0. Or you can email us at UM_MCCofVA@mccofva.com.