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Clinical UM Guideline

Subject: Mental Health Support Services
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Description

This document addresses mental health support services (MHSS). The medical necessity criteria outlined in this guideline for MHSS includes two categories: Severity of Illness and Continued Stay. Severity of Illness criteria includes descriptions of the member's condition and circumstances. For continued authorization of the requested service, Continued Stay criteria must be met, along with Severity of Illness criteria.

MHSS assist members with significant mental illness in maintaining community stability and independence in the most appropriate and least restrictive environment. Services are more intense than traditional psychiatric services. MHSS use individualized training to improve functional skills related to the member's mental health condition, social awareness, appropriate behaviors, activities of daily living, use of community resources, assistance with medication management, nutrition and monitoring of behavioral health and physical health. MHSS are training services and not companion care. Members in MHSS may also be considered for other services, as consistent with medical necessity.

Note: Please see the following related document(s) for additional information:

- CG-BEH-03 Psychiatric Disorder Treatment
- CG-BEH-09 Assertive Community Treatment
- CG-BEH-10 Basic Skills Training/Social Skills Training
- CG-BEH-12 Psychosocial Rehabilitation Services
- CG-BEH-13 Targeted Case Management

Clinical Indications

Medically Necessary:

Severity of Illness

Mental health support services are considered **medically necessary** when **all** of A-F and G or H are present:

A. Interventions will focus on the presenting symptoms and complaints that have led to a decrease in the member's cognitive and behavioral functioning; **and**
B. The member experiences symptoms that meet the diagnostic criteria for a diagnosis from Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or International Classification of Diseases (ICD) for psychiatric outpatient treatment covered by the member's plan; **and**
C. A well-defined clinical rationale is documented that explains why the member would benefit from individualized training in symptom management, adherence to treatment plans, social skills, personal support system, personal hygiene, food preparation, and/or money management consistent with their DSM-5/ICD diagnosis; **and**
D. A history of mental health treatment (for example, psychiatric hospitalization, residential treatment, crisis stabilization, intensive community treatment, etc.); **and**
E. A prescription for anti-psychotic, mood stabilizer, or antidepressant medication within the past 12 months unless there is physician documentation that medications are contraindicated; **and**

F. The member demonstrates motivation for training and is capable of benefiting from training planned; **and**

G. Serious mental illness characterized as a mental, behavioral or emotional disorder defined by current diagnostic criteria (DSM-5/ICD) that results in functional impairment which substantially interferes with or limits one or more major life activities (for example, maintaining interpersonal relationships, activities of daily living, self-care, education, employment, recreation) that have occurred within the last year; **or**

H. A health care provider practicing within the scope of their license has determined that the member experiences severe mental illness resulting in severe and recurrent disability that produces functional limitations in major life activities such as maintaining interpersonal relationships, activities of daily living, self-care, education, employment, and/or recreation and these limitations require individualized training to achieve and maintain independent living in the community.

Continued Stay Criteria

Continuation of mental health support services is considered **medically necessary** when **all** of A-E and F or G are present:

A. The member continues to meet the Severity of Illness criteria; **and**

B. Documentation of member's participation and engagement in services; **and**

C. The goals of mental health support services are not primarily for providing support, targets are not primarily functioning that is either chronic and not likely to improve with the type of training being used, or primarily self-improvement; **and**

D. Functional impairment of at least moderate degree as evidenced by report of specific domains are still present related to the DSM-5/ICD diagnosis listed and likely to improve with continued training; **and**

E. Skills have not been acquired where sustained improvement is not likely, and the purpose of continued training is to prevent relapse or maintain previous achieved progress; **and**

F. Progress with the targeted functioning is documented at the expected pace given the presence of medical/physical conditions, stressors and level of support, as evidenced by adherence with treatment, improving severity of functional impairment, and continued progress is expected for the targeted skills with the training approaches being used; **or**

G. If progress is not documented, either diagnosis has been re-evaluated and changed if appropriate, medication has been re-evaluated and changed if indicated, or mental health support services and treatment approach has been re-evaluated and changed if appropriate to include new goals/targets.

Not Medically Necessary:

Mental health support services are considered **not medically necessary** when the above criteria are not met.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Note: The following list of procedure codes are examples only and may not represent all codes being used for mental health support services. Please contact the member's plan for applicable coding conventions as these may vary.

HCPCS

H0034	Medication training and support, per 15 minutes
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0046	Mental health services, not otherwise specified [when specified as support services]
H2001	Rehabilitation program, per 1/2 day
H2015	Comprehensive community support services, per 15 minutes
H2016	Comprehensive community support services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes

ICD-10 Diagnosis

	For the following diagnoses codes, including but not limited to:
F01.50-F99	Mental, behavioral and neurodevelopmental disorders

Discussion/General Information

MHSS consist of individualized training to improve functional skills related to the member's mental health condition. Services address functional skills, appropriate behaviors, activities of daily living, use of community resources, assistance with medication management, and monitoring of health, nutrition, and physical health.

MHSS should not be primarily for the avoidance of incarceration of the member or to satisfy a programmatic length of stay (refers to a predetermine number of days or visits for a program's length instead of an individualized determination of how long a member needs to be in that program). There should be a reasonable expectation that the member's illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the member's illness. The population served by MHSS may be burdened with severe and persistent mental illness.

Standard components of MHSS include:

- Basic Living and Self-Care Skills: Members are taught how to manage their daily lives, including knowledge and behaviors such as housekeeping and budget management. They are also taught safe behaviors and encouraged to maintain the knowledge and behaviors to improve quality of life;
- Social Skills: Members are taught how to identify and comprehend the physical, emotional, and interpersonal needs of others, – encouraging effective and meaningful interaction with others;
- Communication Skills: Members are encouraged to communicate their physical, emotional, and interpersonal needs to others – and to listen and identify the needs of others;
- Parental Training: Parental training focuses on understanding MHSS techniques. The objective is to help parents/guardians continue the member's care in home and community based settings. Parental training must target the restoration of the member's cognitive and behavioral mental health impairment needs. Parental training must be centered on the member;
- Organization and Time Management Skills: Members are taught how to manage and prioritize their daily activities; and/or
- Transitional Living Skills: Members are taught life skills to begin partially independent and/or fully independent lives in a less restrictive environment, building strengths that improve the quality of life and increase autonomy.

Standard outcomes of MHSS include:

- Improved learning and application of knowledge
- Improved communication
- Improved independence
- Improved self-care
- Improved domestic life

- Improved interpersonal interactions and relationships
- Improved communication and social life
- Improved support and relationships
- Improved access to resources and supports

As an example, New Jersey programs are licensed by Department of Human Services (DHS) as Adult Mental Health group homes/supervised apartments per NJAC 10:77 A NJ 10:37A. Member placement and service provisions are compliant with levels of care as described in state-specific law and regulations.

Adult Mental Health Rehabilitation (AMHR) levels	**Risk of harm to self or others**	**Recovery history**	**Level of Supervision and Residential support needed**	**Ability and access to community support**
Supervised Residence A+	Very High	Very Low	Very High (medication needs to be administered and needs ongoing support with ADLs)	Very low
Supervised Residence A	High	Low	High (needs some supervision (reminders) and support with medication administration and with ADLs)	Low
Supervised Residence B	Low	High	High (needs some supervision (reminders) and support with medication administration and with ADLs	High
Supervised Residence C	Very Low	Very high	Very low – is independent but benefits with weekly check in	Very high
Family Care D	Very High	Very Low	Very High (medication needs to be administered and needs ongoing support with ADLs)	Very low

Certain conditions should be in place for effective provision of MHSS. A comprehensive functional assessment that identifies a need for MHSS should be completed prior to training and at least annually thereafter. A person-centered plan should be created to address goals, objectives and criteria for discharge from MHSS in a manner that reflects member goals, DSM-5/ICD diagnoses listed and the functional assessment. The planning process should be reviewed with the member every 3 months and rewritten no less often than annually. Changes in clinical status (for example, developing new symptoms or findings) should result in reassessment and changes in the treatment plan more often. Training on medication management should be provided when medications are prescribed, and if not, there should be documentation of the reason and education addressing the lack of medication provided. Training addressing substance use/dependence should be provided when a diagnosis of substance use disorder is present or there is a risk for the development of a substance use disorder. Training for monitoring and communicating physical health needs should be provided

and there should be documented communication with the primary care provider (PCP), nurse practitioner, advanced practice nurse, or physician assistant as is consistent with licensing standards. Coordination of care with other clinicians providing care to the member or family members, including psychiatrist/therapist, PCP (or equivalent) and other medical professionals should be documented. Family participation in treatment should be documented unless contraindicated. If family participation is not clinically appropriate, the record should give an explanation. Community/natural supports and resources should be identified and utilized, and skills training should include the development of and communication with community/natural supports, including school/work, self-help or diagnosis specific support groups, spiritual/religious, and community recreational activities. Treatment should not duplicate other services being provided for the same reasons/diagnoses. Services should be provided at the frequency and intensity needs of the member in accordance with benefit limits.

Definitions

Mental Health Support Services (MHSS): Individualized training to improve functional skills related to the member's mental health condition. Services address functional skills, appropriate behaviors, activities of daily living, use of community resources, assistance with medication management, and monitoring of health, nutrition, and physical health. The scope and intensity of services distinguish MHSS from traditional outpatient treatment. In New Jersey, this benefit is called "Adult Mental Health Rehabilitation Services."

Outpatient Treatment: A level of care in which a mental health professional licensed to practice independently provides care to individuals in an outpatient setting, whether to the member individually, in family therapy, or in a group modality.

Severe and Persistent Mental Illness: A mental, behavioral or emotional disorder according to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, in members 18 years and older, that results in functional impairment which substantially interferes with or limits one or more major life activities (for example, maintaining interpersonal relationships, activities of daily living, self-care, employment, recreation) that have occurred within the last year. All of these disorders may have acute episodes as part of the chronic course of the disorder. An organization may also use its state's definition or the definition of another appropriate regulatory authority (National Committee for Quality Assurance [NCQA], 2014).

References

Peer Reviewed Publications:

1. Bowie CR, McGurk SR, Mausbach B, et al. Combined cognitive remediation and functional skills training for schizophrenia: effects on cognition, functional competence, and real-world behavior. Am J Psychiatry. 2012; 169(7):710-718.
2. Kurtz MM, Mueser KT. A meta-analysis of controlled research on social skills training for schizophrenia. J Consult Clin Psychol. 2008; 76(3):491-504.

Government Agency, Medical Society, and Other Authoritative Publications:

1. Anthony WA, Farkas MD. A primer on the psychiatric rehabilitation process. Boston: Boston University Center of Psychiatric Rehabilitation. 2009.
2. Department of Medical Assistance Services. Mental Health Support Services. Available at: http://www.dmas.virginia.gov/Content_atchs/obh/cmh-trngs5.pptx. Accessed on January 24, 2018.
3. National Committee for Quality Assurance (NCQA). Definition of severe and persistent mental illness (SPMI). 2014. Available at:

http://ncqa.force.com/faq/FaqArticleDetail?id=ka0G0000000HKmuIAG&product=HP. Accessed on January 24, 2018.
4. World Health Organization. International Classification of Functioning, Disability, and Health. Available at: http://www.who.int/classifications/icf/en/. Accessed on January 24, 2018.

History

Status	Date	Action
Reviewed	03/22/2018	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	02/23/2018	Behavioral Health Subcommittee review. Updated Definitions and References sections.
	02/21/2018	Updated Coding section; added HCPCS code H2033. The document header wording updated from "Current Effective Date" to "Publish Date."
Revised	08/03/2017	MPTAC review.
Revised	07/21/2017	Behavioral Health Subcommittee review. Formatting updated and acronyms spelled out in Clinical Indications section. References sections updated.
Reviewed	08/04/2016	MPTAC review.
Reviewed	07/29/2016	Behavioral Health Subcommittee review. References section updated. Removed ICD-9 codes from Coding section.
Revised	08/06/2015	MPTAC review.
Revised	07/31/2015	Behavioral Health Subcommittee review. Multiple clarifications to Medical Necessity Criteria. Moved Intensity of Service from criteria to Discussion/General Information section. Description, Discussion/General Information and References sections updated.
New	08/14/2014	MPTAC review.
New	08/08/2014	Behavioral Health Subcommittee review. Initial document development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

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