

FALL CMHRS CHILDRENS' TRAINING
Frequently Asked Questions
(revised 12/09/09)

INTENSIVE IN-HOME (IIH)

#	QUESTION	ANSWER
ASSESSMENTS (H0031)		
A1	How many comprehensive assessments will be covered and reimbursed?	As of December 1, 2009, there will be a maximum of two per recipient per provider per fiscal year. This increase is effective for dates of service on and after July 1, 2009.
A2	With the new requirement for the IIH assessment code H0031 to be billed prior to billing H2012, what should providers do regarding the LMHP approval of the assessment required within 30 days of service initiation?	Billing for the assessment does not need to be pended while awaiting the LMHP approval and dated signature. Currently the DMAS manual requires that upon review of the record, the LMHP approval and signature is required within 30 days of service initiation. DBHDS will be requiring that this be completed within 72 hours.
A3	Does the assessment have to be billed and paid before the H2012 will pay?	For new recipients' as of 12/1/09 an assessment (H0031) must have been billed before the treatment code (H2012) will pay.
A4	Do the 12 units without PA in the first week of treatment for new admissions include the 1 unit for the assessment?	No. The assessment is billed with code H0031 and up to 12 units could be billed using code H2012. Providers should not incorporate time spent on the assessment in the billing of H2012. If the assessment time is incorporated into the billing units for H2012, the time conducted to perform the assessment will be retracted. Providers must use H0031 to bill assessments.
A5	Must you do a second assessment before the first 12 weeks is up?	A second assessment is not required.
A6	Do you have to wait until you have the LMHPs signature on your assessment before you can begin to provide the service?	No. Currently according to DMAS requirements you have up to 30 days for the LMHP to review and sign the assessment. DMAS does not currently require an LMHP signature on ISPs.
BILLING		
B1	What should a provider do if it is determined that another provider is billing for the same dates of service?	The recipient has the right to choice of providers. You must make them aware that only one provider may provide service at a time and they need to make a choice. Only the first payer that submits will be paid.
B2	Will the weeks still be counted Sunday – Saturday?	Yes. The Medicaid week is Sunday through Saturday for IIH.
B3	If a recipient starts on a Wednesday, what is the Medicaid week?	The Medicaid week runs from Sunday through Saturday. If a recipient starts on Wednesday the 1 st week will end on Saturday. (Week 1 would be Wednesday through Saturday in this example).
B4	Explain the 26 weeks of SPO and EPSDT?	The first 26 weeks of IIH benefits are covered under State Plan Option, regardless of the date of admission. If the recipient is in need of services beyond the State Plan Option Service limit of 26 weeks, providers must request the service extension through KePRO under EPSDT. Upon submitting the EPSDT request to KePRO, the provider must indicate it is an EPSDT request. The MMIS claims payment system will stop payment for State Plan Option Services when claims exceed the 26 week service limit

#	QUESTION	ANSWER
		allowed in the regulations. Each July 1 st , the MMIS system begins counting the State Plan Option Service to determine when 26 weeks are utilized. Once the 26 weeks are used under State Plan Option, providers may request extended services under EPSDT to cover remaining services needed through June 30 th of each year. Providers may look in ARS or MediCall to find out how many weeks of service have been provided to the recipient, regardless of the number of providers.
B5	If the child has been with another provider, how can the new provider tell how many weeks of the 26 have been used?	You may check weeks used with Medicaid or ARS. See Chapter I of the CMHRS manual for specific details on how to access these systems.
B6	Will the system count and show the one week without PA?	Yes. You must bill for units provided during that week. The maximum number of units that may be billed in the first week for new admissions is 12.
B7	Will the system also count the total 26 weeks and will this include the one week without PA?	Yes, the one week without PA is included in the total 26 weeks.
B8	If the recipient is in a short-term in-patient psych stay, detention or incarceration, may you bill for IIH?	No, you may not bill for any service provided during the situations described.
B9	Can you bill for IIH while you are working with the family, in preparation for the child returning home from some other placement?	No. The child's needs should be met by the facility that is currently providing treatment. Billing for IIH while a recipient is in acute care, psychiatric residential treatment or the judicial system is not allowed.
B10	I thought we could bill for one week to transition a child out of a residential facility. I also thought that a face-to-face with the client would be necessary and of course working with the family. The answer to this question indicates that we can no longer do this. Is this correct?	CMS does not pay for any duplication of services and that is what this would be considered. The required face to face assessment should be completed when the child is discharged from the residential facility.
KEPRO/PRIOR AUTHORIZATION		
PA1	What steps can a provider take if the previous provider has not released sessions?	KePRO should be contacted so they can contact the provider on record to obtain the last day of service they provided.
PA2	If the PA is still active and the client has not received IIH for a short period of time, will a new PA be needed?	The PA will have a start date and an end date that authorization is approved. If the client resumes services with the same provider within the authorized dates, no new PA request is needed. If the services are resumed after the end date of the PA, then the provider will need a new PA.
PA3	Can the 12 units in the first week without PA be extended if they are not all used in that first week?	No, in the first week for new recipients, up to 12 units may be used and cannot be carried over to other weeks. When PAs are issued, they are issued with a "from and thru" date. A PA request will be required by the end of the first week in order for claims to pay if the child meets the medical necessity
PA4	Will a PA remain in effect for a recipient while in detention?	The PA will remain in effect as long as the recipient maintains their Medicaid eligibility however, you cannot bill for Medicaid services while the recipient is in detention.
PA5	Is the PA Checklist on KePRO's website the one to use to start requesting services 11/01?	Yes, the new one was posted 11/19/09.
PA6	When we begin the new IIH process in December, how many weeks may	When requesting PA, you should request the treatment time that you feel is

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	you request?	medically necessary and supported by the client's needs. Up to 13 weeks for the initial PA request under State Plan Option can be requested if medically necessary and up to 12 weeks for the continued PA request can be requested if medically necessary. Once these 26 weeks are utilized under State Plan, if the recipient continues to need treatment, a request may be made to KePRO for IIH under EPSDT benefits.
PA7	A recipient received IIH services in Jan. 09 and only used 1 week without PA. They did not return to IIH services until Dec. 09. The recipient would be considered an existing recipient in Dec. 09. Will they still have 26 weeks of SPO since the fiscal year and new service limit began July 01?	In this situation, since the service limit of 26 weeks renews each July 1 st , they would have 26 weeks remaining.
PA8	What current symptoms and behaviors are required for a PA Initial and Continued Stay Request?	Please note the assessment criteria listed in the CMHRS manual. Also KePRO has a checklist for IIH PA requests for initial admissions and continuing services which is posted on the KePRO website. https://dmas.kepro.org .
PA9	Will the iEXCHANGE format be different due to the changes in IIH PA?	No, the iEXCHANGE format will not change. Remember to utilize KePRO's PA checklist.
PA10	How does a provider communicate a client's discharge status to KePRO?	As an iEXCHANGE user, you can pull up the client's case and notify KePRO of client's discharge date by adding this in the additional comment field.
PA11	PAs are being rejected by MMIS edits with a reason 4310 – "recipient not eligible on dates of service". Why won't my PAs go through?	The Medicaid eligibility has been ended by DSS. When a PA is transmitted to MMIS, the PA subsystem is reading the recipient eligibility segments; since the DSS has determined the recipient is not eligible past the last day of the month, the PA does not post since the dates on the PA span past the end date of the recipient's eligibility. In these instances, the provider and/or recipient must contact the recipient's DSS worker to discuss ongoing eligibility requirements.
PA12	If a provider gets a PA request denied what is the Appeal Process? If a provider feels that the services are still needed what should the agency do?	<p>The Code of Federal Regulations at 42 CFR §431 et seq., and the Virginia Administrative Code at 12VAC30-110-10 through 380, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, and reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.</p> <p>If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client</p>

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		<p>may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.</p> <p>Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.</p> <p>A copy of the notice or letter about the action should be included with the appeal request. The appeal request must be signed and mailed to the:</p> <p>Appeals Division Department of Medical Assistance Services 600 E. Broad Street, 11th floor Richmond, Virginia 23219 Appeal requests may also be faxed to: (804) 371-8491</p>
REQUIRED ACTIVITIES/TREATMENT		
AC1	Is there any time limit on how long there should be between the sessions?	A minimum of 3 hours per week is required. Service should be provided based on the client's needs
AC2	How long should a client be away from IIH services before they are considered discharged?	DMAS suggests discharging a recipient if they have not received IIH for more than 7 consecutive days and where there is no indication they will be returning to receive service. Be sure to notify KePRO of this discharge to release the PA dates.
AC3	If a client goes to a different level of care and comes back to IIH, is a discharge summary and a new assessment necessary required?	DMAS does not require a discharge summary, but a description of the reasons for transitioning out of IIH is needed. If it has been longer than two weeks and the client is at risk of removal due to his mental health condition, providers must complete an assessment to describe how the recipient meets eligibility and medical necessity for this intensive mental health service. Remember to follow guidelines for assessments outlined in the CMHRS manual. DMAS expects the provider to be in compliance with DBHDS regulations.
AC4	DMAS states at least 50% of IIH services must occur in the home. Is that per visit or per billing cycle?	More than half of IIH services must be provided in the home. During utilization review we look at documentation to make this determination and it is based on your billing cycle. If it is clinically appropriate to provide IIH elsewhere this must be clearly documented in the clinical record.
AC5	Is IIH allowed for a recipient in a foster home?	Yes, but not for a recipient that is in a Therapeutic or Treatment Foster Care home.
AC6	If a child is in a group home, can IIH be provided?	No. This would be considered a duplication of services
AC7	If the child needs to go outside of the home for some other treatment or detention, must you discharge immediately?	If the child will return within a week (7 days), then you may keep the case open and resume upon the child's return home. A brief re-assessment and

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		ISP update should be documented in the record. If the child is gone longer than a week's time, close the case and notify KePRO of discharge.
AC8	Can IIH case management take place with parents as a part of IIH without the client present?	It may be appropriate to assist with the needs of the child through the parent/guardian, remember to document why this is being done. This should be infrequent.
AC9	For crisis related services what is the role of IIH provider and the CSB?	A part of IIH's bundled service includes crisis intervention. If an IIH recipient is in crisis, the IIH provider must provide necessary interventions. If a prescreening is required for a TDO admission for example, the IIH worker can coordinate the recipient getting these services from the CSB. Only CSBs can conduct crisis intervention prescreening assessments for acute care admissions.
AC10	If a client is being rewarded with a community outing, can this be billed, i.e. 20 min game of basketball for taking meds appropriately all week?	DMAS does not reimburse for rewards. All planned activities should be based on medically necessary clinical interventions and documented in the ISP. All billed units must describe a therapeutic intervention.
AC11	Observation in the classroom-The manual says no more than 2 hours billable but trainers are saying no observation billable.	The manual states... Extensive observational sessions greater than two hours conducted in the school environment during the school day may not be reimbursable. If interventions are clinically indicated---such as a crisis in school, there may be a need to be in the classroom. Simply observing in the classroom with no clinical justification documented in the record is not reimbursable.
AC12	If you notify the CSB case manager that you are providing IIH services and there is a duplication of services, which party is responsible for payback?	When a child/adolescent begins receiving IIH services, the IIH counselor must notify any other case manager if the child is currently receiving case management services. At that time, the provider of case management services must stop billing Medicaid for case management.
AC13	Does MHSS allow for an overlap of services the last week of IIH service?	No. IIH would need to stop, if MHSS is started. Remember, MHSS is a supportive service that is designed to assist older adolescents and adults (16 years and older) with living independently
AC14	Can case management be provided if the client is transitioning to an out of home placement?	IIH includes case management as a part of this bundled service. IIH cannot be billed if the recipient is in a Level A, B or C Residential, or Acute psychiatric placement or in Treatment Foster Care.
AC15	Can the LMHP diagnose the child? What if the parents disagree with the psychiatric evaluation?	As a part of the IIH assessment process, the LMHP must provide a diagnosis. Based on clinical need a referral for a psychological testing or psychiatric medication evaluations may be needed. The parents may need education of benefits the child may get by having a psychiatric evaluation. A psychological or psychiatric evaluation is completed by a psychologist or psychiatrist respectively.
AC16	I thought we had to close to intensive in-home once an out of home placement was being pursued?	When a more intensive level of care is needed and the clinical decision and placement for this has been made, the IIH agency must not bill for services.

THERAPEUTIC DAY TREATMENT FOR CHILDREN AND ADOLESCENTS (TDT)

#	QUESTION	ANSWER
ASSESSMENT (H0032U7)		
A1	Can the assessment be billed after the service code has been billed for existing clients?	Yes, but in order for claims to pay, once a claim for an assessment goes in claims processing system VAMMIS will be looking for a PA in order for H0035HA claims to pay.
A2	Does the licensed person have to sign off on the assessment before PA can be requested?	The diagnostic assessment must be authorized /approved by the LMHP prior to service initiation. For new recipients, the agency will have 5 units that can be billed before a PA is required.
A3	For existing clients, will there be a problem if the assessment is not billed for existing clients?	No, it is the provider's choice to bill the assessment for TDT recipients.
BILLING		
B1	Is an Axis II required for TDT?	No, an AXIS I is required for PA & billing
B2	Can the provider bill for observing the child in the school setting?	Yes, since TDT provides intensive mental health services in a group setting. Part of the time may be spent providing interventions to other children in the classroom, after school, or summer school setting, with the recipient benefiting from these interactions.
B3	If you only use 15 hours of service per week between 04/09-08/09, what happens to those units on 07/01/09?	The system automatically resets service limits to the allowable annual limit each July 1 (26 weeks). PAs will end at different times, depending on when the 1 st week is used for new recipients, and when the 26 weeks of State Plan Option is used. Approved PAs can continue past this reset date. Fifteen units per week is maximum units per week and providers should only be using this amount of units per week when the recipient is in crisis. It is expected that the 15 units provided would decrease when the crisis is under control.
KEPRO/PRIOR AUTHORIZATION		
PA1	Can the assessment code and PA service code be billed on the same day? Can they be billed in the same week?	Yes, the assessment code (H0032 plus modifier) may be billed on the same day as the H0035HA service code as they are different
PA2	Is it necessary to use/bill the 5 units without PA?	For new TDT client (those who have not received TDT from 1/1/2009 through 8/31/09, the first 5 units without PA must be used before billing with your PA number.
PA3	KePRO sometimes asks you to provide a reason for why the recipient is at risk of removal from the home, when you are addressing difficulties in interpersonal relationships. What do you do?	Make sure you clearly explain the severity, intensity and duration and the specific behaviors the client is having that justify the need for this service.
PA4	What procedure code is the 5 units without PA billed under?	The code for TDT is H0035HA
PA5	PAs are being rejected by MMIS edits with a reason 4310 – “recipient not eligible on dates of service”. Why won't my PAs go through?	The Medicaid eligibility has been ended by DSS. When a PA is transmitted to MMIS, the PA subsystem is reading the recipient eligibility segments; since the DSS has determined the recipient is not eligible past the last day of the month, the PA does not post since the dates on the PA span past the end date of the recipient's eligibility. In these instances, the provider and/or recipient must contact the recipient's DSS worker to discuss ongoing eligibility requirements.
REQUIRED ACTIVITIES/TREATMENT		

#	QUESTION	ANSWER
AC1	Can a recipient have a combined ISP or Master Tx. Plan for both TDT and Level B Residential?	If a provider of both services utilizes a master Treatment Plan, it should include specific goals/objectives/interventions related to each service.
AC2	Must you specify the numbers of hours you provided direct services?	It is best to document a start and stop time. Your progress note(s) must also include a description of services provided that correlate with the units billed.
AC3	Does a Master's degree in Counseling meet QMHP criteria?	Yes, but a staff person with this educational background must also have a year of direct clinical experience prior to performing the service.
AC4	Can TDT & IIH be provided concurrently to the same recipient?	Yes. A component of IIH is case management and therefore coordination of care must occur between providers.
AC5	Do you need a DBHDS License for each TDT site?	Yes. Each site must be licensed as a provider of Day Treatment Services by DBHDS
AC6	Are the progress notes and summary two different documents? How is this different from the daily log?	The minimum requirement is a log of services provided and a weekly summary. It is recommended to complete a daily progress note. Daily Progress notes allow the worker to clearly describe all of the activities and services for that day.
AC7	Can meetings with the school personnel i.e. teachers, principals be billed for as a part of the TDT treatment day?	Yes. These would be considered indirect services and are billable.
AC8	Can both the IIH CM and TDT worker get paid if they are a part of the same meeting?	Yes. The role of IIH provider in this situation would be to act as the case manager. There should be coordination between the IIH provider and the TDT provider.
AC9	What is the staff / client ratio?	The DMAS provider does not specify a client to staff ratio. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the Individualized Service Plan (ISP).
AC10	Can you still perform TDT services with children that are in in-school suspension?	There is no regulatory provision or manual requirement that would prohibit TDT services during in school suspensions. The ISP should reflect what specific interventions will be provided in such situations.
AC11	Does at risk of being expelled from school help meet the criteria for out of home placement?	Risks of school expulsions may not be directly related to an out of home placement. Specific descriptions of the severity, intensity and duration of behaviors that demonstrate how recipients meet eligibility criteria must be provided.
AC12	Are psychiatric evaluations recommended for all clients?	Psychiatric evaluations should be recommended based on clinical need.
AC13	If the IEP goals are being addressed by the school, is there a need for TDT?	There should be no duplication of services. The IEP may or may not contain all of the client's behavioral health needs.
AC14	Does the child's response to the interventions need to be in the progress notes?	The response to interventions must always be documented in progress notes.

LEVEL A&B RESIDENTIAL

#	QUESTION	ANSWER
ASSESSMENT		
A1	What is a UAI?	This is the Uniform Assessment Instrument, which is now the CANS. It is

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		the assessment/screening tool used to identify the strengths of the individual and identify areas where treatment needs are.
A2	How often do the CANS have to be completed?	Within 30 days of placement.
A3	Are Level A & B providers required to submit CANS with the PA request?	No. The provider must confirm that it was done and provide the date completed.
A4	Can a psychiatrist sign the CON?	Yes, For CSA children, the CON must be signed by the independent team (FAPT) and a physician. For Non-CSA children, a physician and independent LMHP must sign an assessment certifying the need for this service. The physician should coordinate care with the child's PCP or the EPSDT doctor. See Chapter 4 of the CMHRS manual for requirement details.
BILLING		
B1	If the provider has 2 residences right beside each other, are they entitled to 16 beds each?	No.
B2	Does the Level A program apply to female teens and their babies? Is the bed space counted for both the mother and child?	The bed count applies only to the identified recipients receiving treatment.
B3	Can a home pass be extended based on special circumstances i.e. death in the family?	Provision of active therapeutic services while on overnight passes is required to bill for days away from the facility. You must document the issues related to the pass. You should also document any therapeutic intervention that was provided if you plan to bill the daily rate.
B4	Can individual and group therapy be billed on the same day for Level A & B recipients?	Yes, these services may be provided and billed on the same service date.
KEPRO/PRIOR AUTHORIZATION		
PA1	If the recipient is seeing an outside therapist that is only providing sessions 2 times per month, is the recipient still meeting DMAS criteria for Level A & B?	No, weekly individual therapy is required for this intensive mental health service.
PA2	If a child is receiving outpatient services outside the Group Home, do they operate under the same PA guidelines of 26 sessions?	Level B Residential IT, GT, and FT may be approved or PA'd for more than 26 sessions due to their being in a Level B Residential program
PA3	PAs are being rejected by MMIS edits with a reason 4310 – “recipient not eligible on dates of service”. Why won't my PAs go through?	The Medicaid eligibility has been ended by DSS. When a PA is transmitted to MMIS, the PA subsystem is reading the recipient eligibility segments; since the DSS has determined the recipient is not eligible past the last day of the month, the PA does not post since the dates on the PA span past the end date of the recipient's eligibility. In these instances, the provider and/or recipient must contact the recipient's DSS worker to discuss ongoing eligibility requirements.
REQUIRED ACTIVITIES / TREATMENT		
AC1	What is the difference between Level A & Level B Residential?	Level A is licensed by DSS and Level B is licensed by DBHDS. Level B also includes a requirement for weekly group therapy.
AC2	Do the clinical services by the LMHP have to be performed on site?	No, but documentation of the provision of IT, GT, and FT must be included in the residential clinical record.
AC3	What do you do if the child is not returning home upon discharge?	Document why this is occurring and the coordination of discharge planning.

#	QUESTION	ANSWER
		The facility/group home must coordinate services with other providers
AC4	Is there a limit on the number of day passes allowed?	Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to an overnight pass. No more than 24 days of therapeutic leave annually are allowed.
AC5	Should therapeutic passes be included in CIPOC goals?	Yes, documentation of the plan to utilize therapeutic passes must be included in the clinical record. Therapeutic activity provided during these passes must also be documented in order to justify billing.
AC6	Are two or three day passes allowed?	Yes, with appropriate documentation of the clinical rationale for the pass. These should be used as a part of discharge planning
AC7	What if the court mandates you take a certain action? Are you required to do so?	A child may be mandated to Level A/B services, but in order for a provider to be reimbursed by Medicaid, that child must meet Medicaid requirements. You may want to suggest other services to the court if you feel the recipient does not meet Medicaid criteria for the mandated service.
AC8	How long should the psycho-educational groups be?	There is no written minimum or maximum time limit, but the clinical expectation is that the group last 30 minutes.
AC9	What do we do if a client refuses to attend group therapy when it is scheduled?	You must document the refusal. If this continues as a pattern the child is not receiving the required treatment intervention and discharge should be discussed. PA for continued service may be denied. Providers should not bill for treatment sessions that are refused as there was no therapeutic intervention provided.
AC10	Is there a specific recommended progress note format that is to be used for Level A & B?	DMAS does not prescribe any specific progress note format. The format you use should describe behaviors noted, specific staff intervention and the client's response

OUTPATIENT PSYCHIATRIC SERVICES FOR RECIPIENTS IN LEVEL A & B RESEDENTIAL SERVICES

#	QUESTION	ANSWER
BILLING		
B1	What about clients beyond the maximum number of sessions who have Anthem and in an HMO?	You must follow the third party payer's reimbursement policy.
B2	Can we bill for individual and group therapy on the same day? What about individual, group, and family therapy on the same day?	Yes, you may bill for individual and group, as well as family therapy on the same day. If conducted by the same provider, a modifier must be used on the claim form. Remember, no more than three sessions may be provided each seven day period, that is the limit. See the Psychiatric Service Manual under Specific Service Limits for this information
KEPRO/PRIOR AUTHORIZATION		
	PAs are being rejected by MMIS edits with a reason 4310 – “recipient not eligible on dates of service”. Why won't my PAs go through?	The Medicaid eligibility has been ended by DSS. When a PA is transmitted to MMIS, the PA subsystem is reading the recipient eligibility segments; since the DSS has determined the recipient is not eligible past the last day of the month, the PA does not post since the dates on the PA span past the end date of the recipient's eligibility. In these instances, the provider and/or

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		recipient must contact the recipient's DSS worker to discuss ongoing eligibility requirements.

GENERAL MEDICAID GUIDELINES & STAFF QUALIFICATIONS

#	QUESTION	ANSWER
G1	How often do you have to have supervision for a QMHP?	Supervision of a QMHP is not a Medicaid requirement for IIH or TDT. Specific to TDT, supervision requirements of a paraprofessional by a QMHP is explained in Chapter 4 of the CMHRS Manual.
G2	If a person has completed all the requirements for licensure but has not taken the test; do they still need to be supervised?	For outpatient psychotherapy: they cannot bill until they actually are licensed, but can be supervised by a LMHP. For the CMHRS services: someone who is licensed eligible would meet QMHP status and would not need to be supervised
G3	Do you have to put instances of abuse in the KePRO PA narrative request?	Yes, if it is current abuse and you should clarify what your agency has done to respond to this situation.
G4	Does someone with a Master's in Criminal Justice meet QMHP requirements?	Criminal Justice is not recognized by DMAS as a human service field. Someone with this educational background would need to have three years of direct clinical experience to qualify as a QMHP.
G5	What is required to hire someone in the special education degree?	They should have the required year of direct clinical experience. As with other positions, check their background and credentials against the requirements.
G6	Do the rules for an LMHP also apply to an LPC?	Yes, a LPC is considered an LMHP.
G7	What is the difference between a QMHP and mental health workers?	A QMHP can be a psychiatrist, a psychologist, a BSW/MSW with one year of clinical experience, or a mental health worker whose qualifications are detailed in Chapter 2 of the CMHRS Manual.
G8	Do QMHPs require supervision?	Currently this is not a DMAS requirement, but your agency must follow DBHDS requirements.
G9	Clarify the definition of a QMPH that is working toward licensure.	Psychiatric Services (to include outpatient psychotherapy) can be provided by an individual who is working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual profession. See Chapter 2 of the Psychiatric Services Manual for details regarding direct supervision of an unlicensed individual.
G10	Is the on-site supervision only for the non paraprofessional?	For TDT and Level A/B services, non paraprofessionals must work directly with a qualified paraprofessional on-site and must be supervised by a QMHP.
G11	Do non-qualified paraprofessional need someone on site with them at all times?	Yes, in order to bill Medicaid for services (for TDT and Level A/B).
G12	We note that the DBHDS requirements for QMHPs and the supervision of them are different requirements in the DMAS manual. How should we deal with this issue?	As an agency and participating Medicaid provider you are required to maintain licensure in good standing with DBHDS. DMAS will be making modifications to the CMHRS manual so that requirements will mirror those of DBHDS.

