Community Psychiatric Support and Treatment (CPST) – Youth, School Setting

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Section 1. Definitions

Refer to Appendix A and the Telehealth Services Supplement for definition of terms used in this Appendix. The following definitions are specific to Community Psychiatric Support Teams (CPST).

Affiliated means any entity or property in which a DMAS enrolled provider has a direct or indirect ownership interest of 5 percent or more, or any management, partnership or control of an entity.

Comprehensive Assessment of Needs and Strengths (CANS Lifetime): CANS Lifetime is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services for both adults and youth. The CANS Lifetime was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

CPST Clinical Director means a full-time Licensed Mental Health Professional (LMHP) who holds a current, active, and unrestricted Virginia license from the Department of Health Professions and who has overall clinical and programmatic oversight responsibility for the CPST program at the agency. The CPST Clinical Director is accountable for the quality, integrity, and regulatory compliance of all CPST services delivered by the agency. The CPST Clinical Director may also serve as an LMHP Clinical Supervisor and may carry a clinical caseload, provided that doing so does not compromise the individual's ability to fulfill the oversight and supervisory responsibilities of the role.

The duties of the CPST Clinical Director shall include, but are not limited to: (i) ensuring all CPST staff practice within their scope of education, training, and licensure; (ii) overseeing the development, implementation, and regular review of individual service plans; and (iii) providing or delegating clinical supervision of CPST staff in accordance with the requirements set forth in Section 4 of this Appendix.

Additional Duties:

The Clinical Director shall complete the following duties, except when they are specifically assigned to another agency administrator as written in agency policy: (i) ensuring compliance with all applicable DMAS and DBHDS policies, regulations, and documentation requirements; (ii) establishing and maintaining agency policies and procedures governing CPST service delivery, crisis consultation, and staff caseloads; and (iii) serving as the responsible party for the agency's compliance with evidence-based practice standards and statewide training requirements for CPST.

An LMHP who holds the title of Clinical Supervisor and who executes all required duties of the CPST Clinical Director as described in this definition and in Section 4 of this Appendix shall be considered in compliance with the CPST Clinical Director requirement, regardless of job title. A CPST Clinical Director shall not simultaneously serve as the

CPST Clinical Director for more than one DBHDS licensed agency. A CPST director may oversee within the same DBHDS licensed agency, a youth and adult CPST program. The CPST Clinical Director shall be available to provide in-person services and support to agency staff when clinically or operationally needed.

A CPST Clinical Director employed by an agency satisfies the requirement to provide in-person services and support to agency staff when clinically or operationally needed, provided that: (a) the Clinical Director holds an active, unrestricted Virginia license and is physically present in Virginia; (b) agency policies document the process by which in-person support will be arranged within a clinically appropriate timeframe; and (c) the Clinical Director is available to travel to an individual's location when the clinical situation requires in-person contact.

Crisis Mitigation Plan means a dynamic, individualized plan developed collaboratively with the individual and their natural supports to build the capacity to prevent, reduce the severity of, and manage behavioral health crises. The plan emphasizes proactive prevention and provider-delivered crisis support before escalating to external crisis resources.

Early Serious Mental Illness (Adults) means the initial onset of a diagnosable mental, behavioral, or emotional disorder that significantly impacts an individual's functioning, potentially hindering their ability to achieve expected levels of interpersonal, academic or occupational success.

Face-to-face means the service component may be delivered via telemedicine if clinically appropriate. Refer to the Telehealth Services Supplement for the definition of telemedicine and requirements for service delivery through telemedicine.

Full-time means employment averaging 30 or more hours per week with a single employer.

In-Person means physically in the presence of the individual/caregiver.

Licensed Mental Health Professional or **LMHP** means the same as defined in 12VAC35-105-20. LMHPs are fully licensed to practice independently.

Licensed Mental Health Professional-type or LMHP-type means A LMHP-Resident in Counseling (LMHP-R), LMHP-Resident in Psychology (LMHP-RP) or LMHP-Supervisee in Social Work (LMHP-S). LMHP residents/supervisees shall only perform activities where indicated as allowed by a LMHP-R, LMHP-RP, LMHP-S or LMHP-type.

Natural, community-based settings are defined as everyday environments where people typically participate, including but not limited to the individual's home, workplace, educational institutions, libraries, parks, recreational facilities, places of worship, community centers, and other integrated community locations. These settings provide opportunities for interaction with other community members, reflect the individual's cultural and linguistic preferences, and support full participation in community life.

Natural Supports means individuals in a person's life who provide informal, unpaid assistance, encouragement, and connection as part of an ongoing relationship, rather than as part of a formal service delivery arrangement. Natural supports may include family members, caregivers, friends, neighbors, faith community members, coworkers, peers, and others chosen by the individual. Natural supports are identified by the individual and engaged in services only with the individual's consent. For youth, natural supports shall include at minimum one caregiver or legally authorized representative.

One-to-one: means a service delivery method in which one or more qualified CPST team member(s) delivers services directly to one individual receiving services at a time. In one-to-one service provision, the provider's full attention, clinical focus, and billable time are directed exclusively to that individual throughout the encounter. One-to-one service provision may occur in-person or via telemedicine, consistent with the requirements set forth in this Appendix and the Telehealth Services Supplement and may take place in any approved service setting. One-to-one service provision does not include encounters in which services are delivered simultaneously to multiple individuals, such as group service delivery.

Part-time employment (PTE) means any staff person that averages 29 hours or less of work per week.

Serious Mental Illness (Adults) means an individual age 18 and older, having within the past year, a diagnosable mental, behavioral, or emotional disorder that substantially interferes with the individual’s life and ability to function.

Serious Emotional Disturbance (Youth) means an individual under the age of 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school or community activities.

School Setting (8VAC20-132-10): means a publicly funded institution where students are enrolled for all or a majority of the instructional day and those students are reported in fall membership at the institution or (§ 22.1-19) a privately funded institution recognized by Virginia Council for Private Education (VCPE) through the school’s accreditation with a VCPE approved accrediting association.

Section 2. Service Definition/Critical Features

Community Psychiatric Support and Treatment (CPST) is a team-based, trauma-informed service for youth in a school setting. CPST consists of assessment, counseling, therapeutic interventions, care coordination, and crisis and functional supports, grounded in principles of safety, trustworthiness, collaboration, and cultural humility.

Services are delivered in collaboration with the youth, their family, and the school, aligned with the youth's Individual Service Plan (ISP) and, where applicable, their Individualized Education Program (IEP). Interventions are individualized, strength-based, and solution-focused, supporting emotional regulation, natural support development, and the youth's

emotional, social, and personal growth. Family/caregivers or other legally authorized representatives are expected to have an active role in the youth's treatment.
The primary service location is the school setting. CPST may also be provided in the home when the ISP specifically identifies home-based goals directly related to improving the youth's functioning in the school setting.

CPST is delivered by a collaborative team of licensed mental health professionals and trained paraprofessionals under collaborative behavioral health services (as defined in § 54.1-3500). The licensed mental health professional leads assessment, ISP development, and IEP team collaboration, and oversees direct service delivery. Care coordination supports communication among school staff, families, and community providers to ensure continuity of care. All interventions are medically necessary, evidence-based, and tailored to each youth's needs.

The long-term goal of CPST is to achieve optimal school integration with minimal ongoing professional intervention.

2.1 CPST Teams

CPST is delivered by a team of two or more professional and paraprofessional staff under the definition of collaborative behavioral health services (§ 54.1-3500). Agencies shall ensure all team members serving an individual or family communicate and collaborate to meet supervision, oversight, and documentation requirements.

CPST Tier One (1) shall include a LMHP and may also include an additional LMHP, LMHP-type, QMHP or QMHP-T. Individuals will interact regularly with one or two team members face-to-face.

Each CPST Tier Two (2) team shall meet all Tier 1 team requirements and may additionally include a Behavioral Health Technician (BHT) to provide the rehabilitation skills practice component only. Individuals receiving CPST Tier 2 services will interact regularly with two team members on a face-to-face basis and may interact with three team members face-to-face. See Section 5 for required qualifications by service component.

2.2 Service Goals for CPST School Setting

The primary focus of CPST in a school-setting must include key developmental needs and protective factors such as:

1. Developing independent coping strategies and self-care practices
2. Supporting executive functioning skills (planning, organization, impulse control)
3. Developing problem-solving capabilities for life challenges
4. Developing prosocial peer relationships,
5. Creating opportunities for meaningful participation in school community
6. Restoration/stabilization of positive family/caregiver relationships,
7. Building positive relationships with trusted adults in the school
8. Teaching concrete life skills (communication, stress management, decision-making)

The goals of CPST school setting services include:

1. Restoration to a youth's best level of functioning by restoring the youth to their best developmental trajectory;
2. To ameliorate, restore and enhance the youth's functional skills necessary to:
    a. develop and maintain positive interpersonal relationships with peers, school staff and family;
    b. practice and implement skills that contribute to increased school community connectedness and social belonging;
    c. improve the use of daily living skills including, school attendance, behavior that contributes to loss of class time or school directed discipline, and coping strategies
    d. facilitate the youth's ability to participate fully and successfully in the school environment and the broader community.
    e. enhance the youth's functional stability and resilience and strengthen the family's capacity to assist the youth in achieving success within both the school setting and the broader community.

CPST – School Setting is an intensive, individually authorized clinical intervention for youth whose behavioral health needs exceed what universal and targeted school-based supports can address. It is delivered alongside, and does not replace, the supports the school division provides through its multi-tiered system of supports, its student services staff, or a youth's Individualized Education Program or Section 504 plan. Providers shall coordinate with school-based supports to avoid duplication and shall document in the Individual Service Plan how CPST interventions are distinguished from supports the school is separately providing.

Section 3. Required Evidence-Based Practices (EBP)

All agencies providing CPST Tier 1 and Tier 2 are required to incorporate trauma-informed and evidence-based principles, practices, and protocols into both treatment planning and service delivery. Evidence-based approaches fall within four categories:

1. **Evidence-Based Protocols** — Detailed procedural specifications of indicated treatments.
2. **Evidence-Based Principles** — Modular alternatives drawn from supported protocols, applied flexibly and dynamically.
3. **Evidence-Based Practices** — General practices shown to increase quality of care across behavioral health conditions, including routine outcome monitoring, feedback, supervision, and quality improvement.
4. **Evidence-Based Policies** — Mandates, differential reimbursement, or development of core competencies.

Each provider's policies and standard operating procedures must clearly identify which EBP protocols, principles, practices, and/or policies they are incorporating and how staff are trained in those elements.

3.1 Measurement-Based Care

3.1.1 CANS Lifetime Assessment and Treatment Planning

The CANS Lifetime assessment is the primary tool to inform the Level of Need (LON) identification and longer-term treatment planning and monitoring. It supports:

1. Treatment planning
2. Level of Need identification and updates
3. Outcome monitoring
4. Team communication
5. Linkage between the assessment process and ISP design, including the application of evidence-based practices

3.1.2 Additional Assessments

In addition to the CANS Lifetime, providers are strongly encouraged to use ongoing clinical assessments and symptom checklists to monitor progress and inform treatment modifications.

3.1.2.1 Recommended assessments for adults

i. Ask Suicide-Screening Questions (ASQ)
ii. Columbia Suicide Severity Rating Scale (C-SSRS)
iii. Daily Living Activities-20 (DLA-20)
iv. Patient Health Questionnaire (PHQ-9)
v. Post-Traumatic Stress Disorder (PTSD) Scale
vi. World Health Organization Disability Assessment Schedule (WHODAS)

3.1.2.2 Recommended assessments for youth

i. Ages and Stages Questionnaire (ASQ: SE-2)
ii. Alabama Parenting Questionnaire (APQ-SR and corporal punishment module)
iii. Ask Suicide-Screening Questions (ASQ)
iv. Brief Child Abuse Potential Inventory (BCAP)
v. Child PTSD Symptom Scale for DSM5 (CPSS-5)
vi. Client Satisfaction Questionnaire (CSQ-8)
vii. Clinical Global Impression Scale (CGI)
viii. Columbia Suicide Severity Rating Scale (C-SSRS)
ix. Conflict Tactics Scale (CTS)
x. Family Environment Scale (FES)
xi. Individual Goal Achievement Rating Scale (IGAR)
xii. Parenting Stress Index Short Form (PSI-36)
xiii. Pediatric Symptom Checklist (PSC)
xiv. Revised Child Anxiety and Depression Scale (RCADS)
xv. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
xvi. Strengths and Difficulties Questionnaire (SDQ)
xvii. World Health Organization Disability Assessment Schedule (WHODAS)

3.1.3 School Functioning Indicators

1. In addition to the CANS Lifetime, providers delivering CPST – School Setting shall document the following school functioning indicators at admission and at each 90-calendar-day ISP review:
    a. attendance rate for the preceding reporting period, including unexcused absences and tardies;
    b. number of disciplinary referrals and number of days of in-school and out-of-school suspension for the preceding reporting period;
    c. estimated instructional time lost to behavioral health–related removal from the classroom; and
    d. any change in educational placement or setting.
2. Indicators shall be obtained from school division records pursuant to the agreed upon MOU procedure regarding the exchange of information, in Section 7.4. Where school data are unavailable, the provider shall document the reason and record the indicator based on caregiver and youth report, identified as such.

3.2 Referral to Standalone EBPs

3.2.1 Purpose and Intent

The Virginia Medicaid behavioral health benefit includes several evidence-based practices available as standalone services. CPST is designed to serve individuals whose needs are not fully addressed by standalone EBPs, or for whom standalone EBPs are unavailable, inappropriate, or have been attempted and proven insufficient or maximum benefit has been achieved.

3.2.2 Required EBP Referrals

Prior to seeking authorization of CPST services or if the individual has remained at the same Level of Need for 18 calendar months or more, individuals must be assessed for and referred to any clinically appropriate standalone EBPs for which they may meet admission criteria, regardless of whether the agency completing the CANS Lifetime offers the EBP. Services that must be offered and referred to, if the individual meets admission criteria, include:

1. Assertive Community Treatment
2. Coordinated Specialty Care
3. Functional Family Therapy
4. Multisystemic Therapy

3.2.3 When a Standalone EBP Is Unavailable

If an individual meets criteria for a standalone EBP but cannot access it due to unavailability, or inappropriateness, or if the EBP has been attempted and proven insufficient or if maximum benefit from the EBP has been achieved, an authorization for CPST services may be pursued. In such cases, the provider shall:

1. Document in the individual's record which standalone EBP(s) the individual qualifies for and the specific barrier(s) to access
2. Notify the individual's MCO of the barrier and coordinate to address access as soon as practicable, with all care coordination contacts documented
3. Document all efforts to connect the individual with the standalone EBP, including referrals made and their outcomes
4. Include in the ISP a plan to transition to the standalone EBP if and when it becomes available and clinically appropriate

3.3 Required Provider Training and Documentation

Refer to **Attachment 1, Section 1** for required provider training for CPST – School Setting and **Attachment 1, Section 2** for required provider training for CPST – Adult.

Section 4. Required Service Oversight

4.1 LMHP Requirements

1. All CPST services shall be recommended, overseen, and supervised by the Clinical Director or a LMHP Clinical Supervisor.
2. All LMHPs, including the CPST Clinical Director and LMHP Clinical Supervisors, shall hold a current, active, and unrestricted Virginia license from the Department of Health Professions.
    a. DMAS shall allow the CPST Clinical Director and any LMHP Clinical Supervisor to hold an LMHP-type status with 50% or fewer of Board-approved supervision hours remaining before achieving independent licensure through DHP, through June 30, 2029. DMAS shall honor specific DBHDS variances regarding the Clinical Director through 06/30/2029.

4.2 CPST Clinical Director

1. Each CPST provider shall employ a full-time LMHP designated as the CPST Clinical Director, who provides clinical oversight of the CPST program.
2. The Clinical Director shall be able to provide in-person services, with agency policies documenting how in-person support will be arranged within a clinically appropriate timeframe and the ability to travel to an individual's location when clinically necessary.
3. The Clinical Director may also serve as the LMHP Clinical Supervisor.
4. DMAS shall honor specific DBHDS variances regarding the Clinical Director through 06/30/2029.

4.3 Required LMHP Face-to-Face Contact

The LMHP or LMHP-type responsible for assessment, treatment planning, and psychotherapy shall conduct a face-to-face contact with each individual at least once every 90 calendar days, documented in a progress note. This is a minimum standard; the ISP shall specify a clinically appropriate frequency based on the individual's Level of Need. Each contact shall include at least one of the following:

1. A formal review and update of the ISP

2. A clinical reassessment of functional status and progress toward ISP goals
3. A psychotherapy session addressing treatment goals

4.4 Roles of LMHP/LMHP-Type vs. QMHP

An LMHP/LMHP-type may delegate information gathering and documentation for assessments and treatment planning to a QMHP or QMHP-T. However, the LMHP/LMHP-type retains responsibility for the accuracy, completeness, and quality of all assessments, diagnoses, ISPs, and defined service goals and outcomes.

4.5 Crisis Consultation

Each CPST provider shall maintain policies and procedures ensuring that an experienced LMHP is available on-call for crisis consultation 24 hours per day, 7 days per week, 365 days per year, consistent with DBHDS licensing requirements. On-call consultation need not occur in every case; the policies must ensure availability when needed.

1. The on-call LMHP shall have at least one year of experience working with individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), consistent with 12VAC35-105.
2. The 24-hour availability requirement establishes a floor of consultation availability at all times. The required speed and modality of the LMHP's response is tiered according to the time of the request, as set forth in Section 5.3.3. The tiered structure does not reduce the hours of availability; an on-call LMHP shall be reachable at all hours.
3. **Availability during the instructional day.** For a youth receiving services in the school setting, the provider's policies shall ensure that any CPST team member delivering services in the school — including a QMHP, QMHP-T, or BHT — has an immediate, direct method of reaching the on-call LMHP, and that the LMHP is able to respond to a consultation request within a timeframe appropriate to an escalating in-person situation, not to exceed (15) minutes.
4. **Availability outside the instructional day.** At all other times, including evenings, weekends, school breaks, and periods when school is not in session, the on-call LMHP shall be reachable by telephone and able to respond to a consultation request, not to exceed (30) minutes and crisis response shall proceed under the youth's crisis mitigation plan and the tiered approach in Section 5.3.3.
5. The on-call LMHP providing consultation shall have access in real time to the youth's crisis mitigation plan, consistent with Section 5.3.2(C).
6. The provider's crisis consultation policies shall be referenced in each Memorandum of Understanding executed under Section 7.4, so that designated school personnel understand how and when CPST consultation is available during the instructional day.

4.6 Collaborative Behavioral Health Services, Supervision of Individual Staff, and Supervision of Cases

Refer to **Attachment 1, Section 3** for staff supervision requirements.

4.7 Staff Caseloads

Please refer to **Attachment 1, Section 4** for information on staff caseload requirements.

Section 5. Required Service Components

Covered service components shall primarily be provided in a school setting.

5.1 Assessment including the Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime)

Assessment means an in-person interaction in which the provider obtains information from the individual and family/caregivers, as appropriate, about the individual's current mental health status and symptoms as well as the history of the severity, intensity and duration of symptoms associated with a mental illness and behavioral and emotional issues and diagnosis of mental health conditions. Assessment includes assisting the individual and family/ caregivers, as appropriate with identifying strengths and needs, resources and natural supports used in developing individualized goals and objectives to address functional deficits associated with their mental illness.

1. A CANS Lifetime assessment shall be completed no more than 30 calendar days prior to submission of a preservice authorization for CPST. The CANS assessment process shall include a comprehensive assessment of the individual's treatment needs and strengths, identification of a Level of Need, differential service identification, confirmation that the individual meets admission criteria for the recommended CPST service tier, and information to support a request to authorize CPST Tier 1 or Tier 2
    a. A CANS Lifetime assessment completed by another DMAS-enrolled provider within the previous 12 calendar months shall be used to satisfy the assessment requirement in item 1 of this section, provided that:
        i. The individual provides written consent for release of the assessment;
        ii. The admitting LMHP reviews, and updates the assessment, by attesting in a progress note they have reviewed, agree with the Level of Need determination, added any additional information and documented any clinical disagreement, if applicable; and
        iii. The admitting LMHP documents whether any change in the individual's clinical status since the prior assessment warrants a new CANS Lifetime assessment. If the admitting LMHP determines a new assessment is clinically indicated, a new assessment shall be completed prior to admission.
2. The assessment shall be conducted by a LMHP or LMHP-type in person with the individual in the individual's home, school setting or another location of the individual's/family/caregiver's choice. Assessments completed by a LMHP-type require a LMHP review and co-signature.

3. The LMHP or LMHP-type completing the assessment shall be trained and certified to administer the CANS Lifetime.
4. QMHPs and QMHP-Ts trained and certified to administer the CANS Lifetime may assist the LMHP or LMHP-Type with assessment activities.
5. The CANS Lifetime shall be provided on a one-to-one basis.
6. Assessments inclusive of the CANS Lifetime, shall be performed at least once every 365 days until discharge.
7. Interventions shall be recommended based on the findings of the assessment and the individual needs and shall not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request.

5.2 Treatment Planning

Treatment Planning is the collaborative development of a person-centered Individual Support Plan (ISP) that is specific to the individual's unique treatment needs. Providers shall follow all ISP requirements outlined in Chapter IV of this Manual.

A. Treatment planning shall be provided by a Licensed Mental Health Professional (LMHP) or LMHP-type. The LMHP or LMHP-type responsible for an individual's treatment planning shall meet the face-to-face requirements described in Section 4.3 of this Appendix.
B. Treatment planning shall be conducted face-to-face and in collaboration with the individual, family, caregiver and natural supports.

5.2.1 Individual Service Plan

A. ISPs are required during the entire duration of services and shall be current.
B. The ISP shall be authorized and overseen by an LMHP who meets the oversight requirements of Section 4.1 of this Appendix.
C. The ISP shall be developed with the individual and in consultation with the individual's natural supports, through a team-based approach under collaborative behavioral health services.
D. The ISP directs collaborative behavioral health treatment and shall be actively utilized with the individual, family, and/or caregiver during each encounter.
E. The ISP shall document activities, trauma-informed, evidence-based interventions and the specific EBP protocols and principles incorporated into treatment, including any evidence-based practices or policies beyond those required by Medicaid, drawn from the categories described in Section 3, designed to prevent, correct, or ameliorate conditions identified during the initial CANS Lifetime assessment.
    i. Clinical documentation shall support the appropriateness of the selected interventions.
    ii. Subsequent assessments and emerging needs shall be reflected in updated ISPs with revised goals and objectives.

F. For each identified EBP protocol or practice, the ISP shall include documentation of:
    i. The professional type responsible for delivering and overseeing the approach; and
    ii. A brief clinical statement supporting the appropriateness of the selected approach for the individual's specific diagnosis, functional impairments, and treatment goals as identified in the CANS Lifetime assessment.
G. The service location shall be documented in the individual's ISP and associated with a specific goal or objective. Services shall be provided in locations that meet the individual's treatment needs, including settings that support the development and application of skills in natural environments.
H. The use of a Managing and Adapting Practice (MAP) ISP dashboard that includes the components of this section shall be considered to meet the criteria of this section.
I. The ISP shall be signed by, at minimum:
    i. The individual and the individual's legally authorized representative;
    ii. The Community Psychiatric Supportive Treatment (CPST) team members working with the individual; and
    iii. The LMHP Clinical Supervisor overseeing the services.
J. Where a youth has a current Individualized Education Program or Section 504 plan, the Individual Service Plan shall:
    i. identify each goal on the IEP or 504 plan related to behavioral, emotional, or social functioning;
    ii. state, for each such goal, whether the need is addressed by the IEP or 504 plan, by CPST, or by both;
    iii. document the clinical rationale for any goal addressed by both, including how the CPST intervention differs in scope, intensity, or method from the school-delivered service; and
    iv. identify the school personnel responsible for the school-delivered components and the mechanism for ongoing coordination.
K. The LMHP shall attend at least one IEP or 504 team meeting per service authorization period, or, where attendance is not practicable, shall submit written clinical input to the team and document both the submission and the reason attendance was not practicable. Documentation of attendance or written input shall be maintained in the youth's record.
L. Where a youth does not have an IEP or 504 plan and the CANS Lifetime assessment or ongoing clinical observation indicates that the youth's functional impairment may adversely affect educational performance, the LMHP shall, with parental consent, communicate that observation to the school team in writing. This appendix does not authorize the provider to initiate or conduct an evaluation for special education eligibility, which remains the responsibility of the local education agency.

5.2.2 ISP Reviews and Updates

1. Refer to Chapter IV for additional guidance and documentation requirements for the 90-calendar-day review and any additional quarterly review requirements.
2. ISPs shall be formally reviewed at least every 90 calendar days, or more frequently depending on the individual's needs.
3. The ISP review shall be completed face-to-face and shall include a LMHP/LMHP-type, additional CPST team members and the individual, and family/caregiver, if clinically appropriate.
4. The provider shall invite designated school personnel to participate in the development and review of the Individual Service Plan. The provider shall document each invitation extended, the personnel invited, whether participation occurred, and, where participation did not occur, the alternative method by which school input was obtained. Failure of school personnel to participate shall not constitute grounds for denial of admission, denial of service authorization, or discharge, provided the provider documents reasonable efforts to secure participation and obtains school input by alternative means.
5. Documentation of EBP protocols and practices selection shall be updated at each ISP review.
6. If it is determined that an individual is making limited or no progress, or is not engaged in treatment, the LMHP Clinical Supervisor, in collaboration with the CPST team, the individual, and the individual's natural supports, shall review and update the ISP to increase the likelihood that the individual will make progress toward identified goals and objectives.
    a. If the individual continues to make limited or no progress (remaining at the same Level of Need for 18 months), the LMHP Clinical Supervisor shall evaluate whether a referral to a different service may better support progress.
    b. In situations where limited or no progress involves a youth whose family or caregiver is not engaged or participating in treatment following initial authorization, the ISP shall be updated to ensure meaningful individual, family, and caregiver involvement before reauthorization of services is considered.

5.3 Crisis Support

Crisis Support means an intervention to assist the individual and their natural supports in developing the capacity to prevent, avoid, or reduce the severity of a crisis episode, including through crisis planning, crisis avoidance, and crisis intervention. CPST providers shall prioritize internal crisis support resources and preventative interventions as the primary response to behavioral health crises and shall deliver crisis support in a manner that builds the individual’s capacity to recognize distress, respond effectively, and seek help independently. Individuals shall be educated on how to access crisis resources directly, including the 988 Suicide and Crisis Lifeline (available by call, text, or chat), and

their capacity to self-initiate appropriate crisis contacts, including contacting 988 independently, is a core goal of crisis support that shall be reflected in the crisis mitigation plan. Crisis support also includes the development, ongoing review, and update of a crisis mitigation plan to assist the individual and their natural supports with identifying a potential behavioral health crisis and the steps needed to manage it and restore stability and functioning.

A. Crisis support shall be provided by a LMHP, LMHP-type, QMHP, or QMHP-T.
B. Crisis support shall be provided on a one-to-one basis with the individual and their natural supports.
C. Crisis support shall be available and accessible 24 hours per day, seven days per week, 365 days per year, to provide assistance to individuals experiencing acute behavioral health problems requiring immediate intervention to stabilize, prevent harm, and avoid a higher level of care. This availability is continuous and is not limited to the instructional day; for youth receiving services in the school setting, the modality and speed of response are tiered by time of day as set forth in Section 5.3.3.
    i. Crisis support may be provided through telehealth or in-person, consistent with the individual's documented needs and preferences, crisis mitigation plan, and the clinical requirements of the situation.
    ii. Any use of telehealth shall be for the clinical benefit of the individual, clinically justified, and documented.
    iii. In-person response shall be available when the individual's crisis mitigation plan indicates it is necessary or when the clinical situation requires it.
D. Providers shall collaborate with the individual and their natural supports to develop a crisis mitigation plan in accordance with Section 5.3.1 of this Appendix. The crisis mitigation plan shall identify the CPST provider as a primary crisis contact, and individuals shall be encouraged to contact their CPST provider prior to contacting 911 or emergency services when it is safe to do so.

5.3.1 Crisis Mitigation Plan

A crisis mitigation plan is a dynamic, individualized plan developed collaboratively with the individual and their natural supports to build the capacity to prevent, reduce the severity of, and manage behavioral health crises. The plan emphasizes proactive prevention and provider-delivered crisis support before escalating to external crisis resources.

The crisis mitigation plan shall:

A. Be completed and signed by all team members and the individual or legal representative no more than 30 calendar days after admission.
B. Be reviewed and updated regularly to reflect the individual's current needs and circumstances.

C. For a youth receiving services in the school setting, identify the response applicable during the instructional day and the response applicable outside the instructional day, consistent with the tiered approach in Section 5.3.3.
D. For youth receiving CPST – School Setting, the Crisis Mitigation Plan shall additionally address:
    a. identification of school-specific triggers, settings, and times of day associated with escalation;
    b. the youth's preferred de-escalation strategies and identified safe locations within the school building;
    c. the designated school personnel who will be informed of the plan and their agreed role;
    d. the sequence of response during the instructional day, identifying who is contacted, in what order, and the point at which CPST staff are engaged; and
    e. the circumstances under which contact with the parent or legally authorized representative occurs, and the method of contact.
E. The Crisis Mitigation Plan shall be shared with the school personnel pursuant to the MOU requirements regarding the exchange of information and consent, and shall be reviewed with those personnel at least annually and following any instructional day crisis event.
F. The Crisis Mitigation Plan shall be developed in a manner consistent with, and shall not conflict with, the school division's emergency, behavioral threat assessment, and student safety procedures. Nothing in this Appendix limits the authority of school officials to act under those procedures.

5.3.1.1 Preventative and Recovery Strategies

The plan shall prioritize proactive prevention and the individual’s capacity for self-directed crisis response. The plan shall:

A. Identify the individual’s precursors, triggers, and early warning signs of a behavioral health crisis, including, for youth in the school setting, any school-specific triggers, settings, and times of day associated with escalation.
B. Outline specific steps to prevent or avoid crisis episodes, including proactive skill-building, coping strategies, and enhanced support during high-risk periods, including transitions into and out of periods when school is not in session.
C. Document all crisis resources available to the individual, the individual’s preferred contact method for each, and the circumstances under which each resource is most appropriate.
D. Describe how the individual and their natural supports will manage the full continuum of crises from less intensive to acute situations, including independent contact with the 988 Suicide and Crisis Lifeline (available by call, text, or chat) as a self-initiated crisis option.

E. Establish the CPST provider as the primary crisis contact and document the individual's understanding that contacting the CPST provider or the 988 Suicide and Crisis Lifeline prior to calling 911 or emergency services is preferred when the situation safely allows.
F. Incorporate, where clinically appropriate, practice and rehearsal of self-initiated crisis contact into restorative life skills training and psychotherapy.
G. Educate school personnel, natural supports on recognizing and responding to warning signs and on supporting the individual's stability in school and community settings and restoration of functioning after a crisis.

Nothing in this section limits an individual's right to contact 911 or emergency services directly at any time when the individual believes there is an immediate risk to life or safety, and that decision shall never be discouraged. An individual's independent use of any crisis resource does not constitute a provider referral and shall not be counted against the provider's crisis support obligations.

5.3.2 Crisis Support Procedures

A. Before referring to any external crisis resource, the CPST provider shall attempt internal crisis support consistent with the individual's crisis mitigation plan, except when any of the following acute crisis conditions are present:
    i. The individual or another person is in immediate physical danger and emergency services (911) are required;
    ii. The individual is actively suicidal or homicidal with a plan and means, and the CPST provider has assessed that an in-person CPST crisis response cannot be initiated safely or within an appropriate timeframe;
    iii. The individual's clinical presentation requires an immediate medical assessment beyond the scope of CPST crisis support; or
    iv. The individual is in an unknown location and cannot be reached by phone or telehealth, and emergency location services are required.

B. If a provider-initiated referral to an external crisis resource is made (including 911, 988, Mobile Crisis Response, Emergency Room, CSB Emergency Services, 23-Hour Crisis Stabilization, or Residential Crisis Stabilization Unit), the CPST provider shall:
    i. Remain actively engaged with the individual, coordinate with responding providers to the extent clinically possible, and transmit the current ISP and crisis mitigation plan to the receiving provider at the time of referral.
    ii. Contact the individual's MCO.
    iii. Document in the individual's record:
        a. the crisis support interventions attempted prior to referral, or, if no attempt was made, the acute crisis condition that precluded it, and the clinical rationale for why internal crisis support was insufficient;
        b. the time, location, and specific interventions provided; and

c. actions taken to ensure continuity of care and the individual's timely transition back to CPST services, including a seamless transition back to community-based support.

iv. Follow up with the individual as soon as practicable after any crisis episode to review what occurred, update the crisis mitigation plan as needed, and reinforce the individual's capacity for self-directed crisis response. For a instructional day crisis event, follow-up shall proceed consistent with Section 5.3.3.

C. The CPST provider agency may utilize triage and coordination policies and procedures across other service areas (e.g., a single after-hours number), provided that crisis mitigation plans are available in real time to the individual answering the after-hours call.

D. The use of Comprehensive Crisis and Transition Services will be monitored by the individual's MCO to ensure appropriate utilization and continuity of care.

5.3.3 Tiered Crisis Response by Time of Delivery

The 24-hour, 7-day, 365-day crisis support obligation under Section 5.3(C) is continuous. For a youth receiving services in the school setting, the modality and required speed of response are tiered according to when the crisis arises. Tiering adjusts how the provider responds; it does not reduce the hours during which crisis support is available.

A. **Instructional day response.** When a crisis arises during the instructional day and a CPST team member is present in the school:

i. The team member shall initiate internal crisis support consistent with the crisis mitigation plan and shall have an immediate, direct method of reaching the on-call LMHP for consultation, who shall respond within the timeframe established in Section 4.5(3).

ii. Where CPST staff are present in the building, the provider shall make its qualified staff available to respond and to attempt de-escalation prior to activation of external crisis resources, unless the acute nature of the situation precludes it or school officials direct otherwise, consistent with Section 5.3.1.

iii. The response shall proceed consistent with the school division's emergency, behavioral threat assessment, and student safety procedures, and nothing in this Appendix limits the authority of school officials acting under those procedures.

B. **After-hours, weekend, and out-of-session response.** When a crisis arises outside the instructional day, on a weekend, during a school break, or during any period when school is not in session:

i. Crisis support shall proceed under the crisis mitigation plan, beginning with provider-delivered internal crisis support delivered by telephone or

telemedicine, and the on-call LMHP shall be reachable consistent with Section 4.5(4).

ii. Where an in-person response is clinically necessary and cannot be initiated by CPST staff within an appropriate timeframe, the crisis mitigation plan may designate Mobile Crisis Response, the Regional Crisis Hub, or 988 as the in-person response arm, provided the CPST provider remains actively engaged as the consultative and continuity contact consistent with Section 5.3.2. Designation of an external resource as the after-hours in-person responder does not relieve the CPST provider of its obligation to remain available, to coordinate, and to resume services.

iii. Designation of Mobile Crisis Response as the after-hours in-person response arm under this subsection is a coordination of response modality and is not a referral to a crisis provider as the crisis mitigation plan itself, which remains prohibited under Section 5.3.2.

C. In no case shall the tiered approach be applied so as to leave a youth without an available crisis response. Where Mobile Crisis Response or a Regional Crisis Hub is not reliably available in the youth's geographic area, the crisis mitigation plan shall identify an alternative in-person response resource, and the provider shall document the arrangement.

5.4 Restorative Life Skills Training

Restorative Life Skills Training means evidence-based therapeutic interventions designed to decrease symptoms of the mental health diagnosis, restore and strengthen the functional skills the youth needs to participate successfully in the school day, build natural supports, and achieve identified person-centered goals and objectives as set forth in the ISP. Restorative Life Skills Training shall be focused on the youth's ability to function and succeed in the school setting, including the ability to remain in and re-engage with instruction, manage the demands and transitions of the school day, and sustain relationships with peers and school staff. Encounters occur primarily in the school setting during the instructional day and, when needed to support generalization of skills or to maintain continuity when school is not in session, in the youth's home and other community settings.

Examples of Restorative Life Skills Training interventions include but are not limited to teaching:

A. Strategies such as motivational techniques, behavioral tailoring
B. Coping skills and stress management training
C. Specific mental health conditions, early warning signs, symptoms, recovery and relapse prevention
D. Self-monitoring and self-assessment skills
E. Communication skills and problem-solving skills

F. Skills for remaining in or returning to the classroom after a period of dysregulation, including use of an agreed calm or reset space and re-entry routines
G. Skills for managing the structure of the school day, including transitions between classes and activities, unstructured times such as lunch and recess, and navigating peer conflict and school personnel in school settings
H. Self-advocacy and communication skills for interacting with teachers and school staff, including requesting a break or support in a developmentally appropriate way

Requirements of Restorative Life Skills Training include:

1. Restorative life skills training shall be provided by a LMHP, LMHP-type, QMHP or QMHP-T.
2. Restorative life skills training shall be provided in accordance with the frequency identified in the ISP.
3. At least half of the Restorative life skills units rendered per service authorization shall be provided in-person.
4. Restorative life skills training may be provided via telemedicine if clinically appropriate for the individual, in consultation with the LMHP Clinical Supervisor and with the individual's documented agreement. The clinical rationale for telemedicine delivery of restorative life skills training shall be documented in the ISP and in the relevant progress note and shall not exceed half of the units billed for restorative life skills per week.
5. Restorative life skills training may be provided in a group if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor.
    a. The individual to team member ratio shall not exceed:
        i. One LMHP, LMHP-type, QMHP or QMHP-T to six youth
6. For CPST Tier 2 only, at least half of the Restorative life skills units rendered per service authorization shall be provided individually with one team member per individual receiving the service. The remaining units may be provided in a group as described in #5.

5.5 Care Coordination

Care Coordination means consultation, collaboration, and coordination among providers and others involved in the individual’s treatment including collateral contacts to improve the restorative care, identify and access needed activities and supports and align service plans. For youth receiving CPST - School Setting, care coordination shall include ongoing coordination with the youth’s school team including teachers, school counselors, school psychologists or social workers, and IEP or 504 team members as applicable — and shall include aligning the ISP with the youth’s Individualized Education Program or Section 504 plan consistent with Section 5.2.1.

1. Care coordination shall be provided by a LMHP, LMHP-type, QMHP or QMHP-T.

2. Providers shall follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
3. Care Coordination shall be provided on a one-to-one basis.
4. Care Coordination shall include the following but is not limited to:
    a. Consistent and regular communication with the individual's MCO Care Coordinator and Community Services Board Case Manager(if applicable), including updates on the individual's progress, any changes in Level of Need, and barriers to service access or goal achievement.
    b. Timely response to communication requested by an MCO Utilization Management Reviewer in connection with service authorization or concurrent review, including requests to communicate with the LMHP overseeing the case.
    c. When the CANS Lifetime assessment indicates that the individual meets criteria for a standalone EBP, but the EBP is not available due to geographic access barriers or extended waitlists the provider shall document:
        i. all efforts to refer the individual to a standalone EBP. Documentation shall include the specific barrier, the date referral was attempted, and the outcome.
        ii. coordination with the MCO to explore options for timelier access to the EBP, including identification of alternative EBP-qualified providers in the network.
        iii. coordination of a warm handoff to a standalone EBP provider when the service becomes available.
    d. If an individual has remained at the same Level of Need for 18 calendar months without improvement, the provider shall notify the individual's MCO and, in coordination with the MCO, develop a plan to refer the individual to an appropriate evidence-based practice, as set forth in Section 3.2 and Section 8.3 (Continued Stay Criteria). Documentation of this referral process shall be maintained in the individual's record, and the ISP shall be updated to reflect the plan.

5.6 Rehabilitation Skills Practice (CPST Tier 2 Only)

Rehabilitation skills practice means practice of skills through the collaborative behavioral health model as identified in the ISP. Activities include rehabilitation interventions and individualized, collaborative, hands-on training to build developmentally appropriate skills. The intent is to promote personal independence and autonomy through the restoration of skills in self-management, symptom management, interpersonal relationships, communication, and problem solving. For youth receiving CPST-School Setting, rehabilitation skills practice shall emphasize in-vivo practice of these skills within the school setting and the situations in which the youth actually applies them, such as the classroom, hallways, cafeteria, and transitions during the school day, so that skills are practiced and reinforced in the environment for which they are intended.

1. Rehabilitation skills practice shall be provided for all individuals receiving CPST Tier 2 services.
2. All Rehabilitation skills practice shall be provided in-person and cannot be provided via telehealth.
3. Rehabilitation skills practice shall be provided by a LMHP, LMHP-type, QMHP, QMHP-T or BHT.
4. Rehabilitation skills practice shall be provided in accordance with the frequency identified in the ISP.
5. Rehabilitation skills practice shall be provided on a one-to-one basis.

Section 6. Additional Covered Service Components

6.1 Psychotherapy

Psychotherapy means the application of principles, standards, and methods of the LMHP profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and assist in the recovery from mental, emotional, or behavioral disorders and associated distresses that interfere with mental health. Psychotherapy helps individuals find relief from emotional distress, seek solutions to problems in their lives, and modify ways of thinking and acting that are preventing the individual from working productively and enjoying personal relationships.

1. Psychotherapy shall be provided by a LMHP or LMHP-type acting within their scope of practice.
2. Psychotherapy shall be provided in accordance with the frequency identified in the ISP.
3. Psychotherapy may be provided in a group if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor and the individual. The LMHP or LMHP-type to individual ratio shall not exceed:
    a. One LMHP or LMHP-type to eight youth
4. Psychotherapy may be provided via telemedicine if deemed clinically appropriate and in consultation with the LMHP Clinical Supervisor and individual.

Section 7. Provider Qualification Requirements

CPST providers shall follow all general Medicaid provider requirements specified in Chapter II of this manual.

7.1 Department of Behavioral Health and Developmental Services (DBHDS) Licensing Requirements

1. Providers shall be licensed by the Department of Behavioral Health and Developmental Services with the following license:

   a. Community Psychiatric Support and Treatment – Youth/Community shall be licensed as 03-021 - MH Non-Center-Based Community Psychiatric Support and Treatment (CPST) Service for Children and Adolescents.
2. If a provider plans to provide services to youth ages 18-under 21 the following license is also required:
   a. Community Psychiatric Support and Treatment – Adult/Community shall be licensed as 03-020 – MH Non-Center-Based Community Psychiatric Support and Treatment (CPST) Service for Adults.
3. Provider's DBHDS license(s) shall be active and in good standing (conditional, annual or triennial).
4. DBHDS Corrective Action Plans shall be communicated to MCOs by the provider within 30 calendar days. The MCO may take network action if deemed appropriate.

7.2 DMAS Provider Enrollment

Prior to rendering CPST or claiming reimbursement providers are required to be enrolled with DMAS with the following:

1. Provider type:
   a. Behavioral Health Services (156) **or**
   b. Behavioral Health Clinic and Services (456) and
2. Provider specialty:
   a. Community Psychiatric Support and Treatment – School Setting (924)
3. Taxonomy: Community/Behavioral Health (251S00000X)
4. National Provider Identifier:
   a. Type 2: Organizational NPI associated with the 03-021 DBHDS License
   b. Type 2: Organizational NPI associated with the 03-020 DBHDS License, if applicable
5. Providers shall submit with their DMAS enrollment application all of the following:
   a. Appropriate 03-021 and/or 03-020 DBHDS License
   b. The Department of Health Professions license of the Clinical Director, which shall be kept up to date in the DMAS enrollment system.
      i. Providers shall have 30 calendar days to submit a new DHP license of the Clinical Director if changes occur.
   c. Evidence of their initiation of accreditation process or their formal accreditation.

7.3 Provider Accreditation

1. Providers shall be accredited 18 months from the effective date of the above provider specialties in the DMAS Provider Enrollment System.
2. Providers shall submit with their DMAS enrollment application evidence of their initiation of accreditation process or their formal accreditation.

3. Providers shall submit to the DMAS enrollment system any updates to their accreditation on an ongoing basis. Updates shall be submitted no more than 30 calendars after the update occurs.

7.4 School Division Requirements and Memorandum of Understanding

1. Providers delivering CPST – School Setting shall maintain a current Memorandum of Understanding (MOU) with each Virginia public school division, or with each private school recognized by the Virginia Council for Private Education, in which services are delivered. The MOU shall be reviewed and signed by both parties annually.
2. An MOU with a public-school division shall list the name and address of each school within the division at which services are delivered, and shall be amended to reflect the addition or removal of a school within 30 calendar days of the change.
3. At a minimum, the MOU shall address each of the following:
   a. designation of private, confidential space adequate for the delivery of clinical services, and the process for securing space when the designated space is unavailable;
   b. the scheduling protocol for service delivery, including the principle that services shall be scheduled to minimize loss of instructional time and shall not routinely remove a youth from the same class period;
   c. provider staff compliance with school division background check, fingerprinting, visitor identification, and building access requirements;
   d. the terms governing exchange of information between the provider and the division;
   e. the process by which the division will provide the school functioning indicators required at Section 3.1.3, and the frequency of that provision;
   f. coordination of crisis and emergency response, including the division's threat assessment and emergency procedures, the role of CPST staff during a instructional day crisis, and the notification sequence, consistent with Section 5.3.3 of this Appendix;
   g. clarification of mandated reporting responsibilities and the process for coordinated reporting where both provider and school staff hold the obligation;
   h. designation by the division of a school liaison for each school at which services are delivered, and designation by the provider of a corresponding point of contact;
   i. the division's commitment to make school personnel reasonably available to participate in treatment planning for enrolled youth;
   j. a dispute resolution process; and

k. terms governing termination, including a notice period of not less than [60] calendar days and the obligations of both parties to support continuity of care for enrolled youth during the notice period.

4. Where an MOU lapses, is terminated, or is not renewed, the provider shall notify the MCO of each affected youth, and the parent or legally authorized representative of each affected youth, within 5 business days. Services shall continue in the home or other community settings during the transition consistent with Section 9.4, and affected youth shall not be discharged solely by reason of the MOU lapse.

7.5 Other Qualifications

1. Refer to **Attachment 1, Section 1** for required provider training for CPST – Youth and **Attachment 1, Section 2** for required provider training for CPST – Adult.
2. Providers shall submit information pertaining to the qualifications of each staff person providing CPST to the Center for Evidence-Based Partnership CPST Finder and keep the information current and active.

Section 8. CPST – Youth, School Setting Medical Necessity Criteria

8.1 Tier One CPST-Youth, School Setting Admission Criteria

All of the following must be met:

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements (See MHS Chapter IV for requirements related to completing the CANS Lifetime assessment)**
    a. Individuals shall be assessed using the CANS Lifetime assessment within 12 calendar months prior to admission.
        i. If the CANS Lifetime assessment was completed more than 30 days prior to admission, the admitting LMHP shall review, and update the assessment, by attesting in a progress note they have reviewed, agree with the Level of Need determination, added any additional information and documenting any clinical disagreement, if applicable.
    b. The Level of Need (LON) for the individual shall be assessed at a LON 2 or LON 3 on the CANS Lifetime.
    c. The assessment shall document specific functional deficits requiring Community Psychiatric Support and Treatment – School Setting.

2. **Age requirement:**
    a. CPST - Youth, School Setting: Under 21 years of age

3. **Diagnostic Criteria: must meet a or b**
    a. The individual's current symptoms meet criteria for a primary ICD diagnosis that correlates to a DSM diagnosis and are not solely attributable to a Neurodevelopmental Disorder or to a Substance Use Disorder, with the

exception of Attention-Deficit/Hyperactivity Disorder (F90.0, F90.1, F90.2, F90.8, or F90.9).

b. For a period not to exceed 90 calendar days, individuals may have a provisional diagnosis developed by an LMHP, when no definitive diagnosis has been made.
    i. In instances where mental health needs have been identified but a diagnosis is not yet known and/or not specified, providers may use an unspecified ICD-10 diagnosis code, such as R69 (illness, unspecified), F99 (mental disorder, not otherwise specified), or an appropriate Z-code.

c. Individuals may also have a co-occurring diagnosis of a Substance Use Disorder or Neurodevelopmental Disorder.

4. **Functional Impairment Criteria: must meet a and b at least one (LON 2) or two (LON 3) additional domains (c-f)**

Tier	LON	Required Criterion	Functional Impairment Criteria Required	Total Domains Required
CPST Tier 1	LON 2	Symptom Management (a) and Academic/Educational Functioning (b)	At least 1 of (c), (d), (e), or (f)	3 domains minimum
CPST Tier 1	LON 3	Symptom Management (a) and Academic/Educational Functioning (b)	At least 2 of (c), (d), (e), or (f)	4 domains minimum

The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by moderate impairment in functioning.

a. Symptom Management – Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to manage symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
    i. Mental health symptoms often make it harder to do everyday activities and responsibilities
    ii. Has some understanding of their symptoms but is still learning ways to manage them effectively
    iii. Symptoms cause noticeable stress and make some areas of life more challenging

iv. Has some coping skills but they do not always work well or are not used consistently
v. Uses some healthy coping strategies but sometimes relies on less helpful ways of managing stress
vi. Has difficulty when daily routines change or when in new or unfamiliar situations

b. Academic/Educational Functioning - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in academic/educational functioning due to symptoms of mental illness. Examples of moderate impairment include, but are not limited to:
   i. Declining academic performance or chronic academic underachievement
   ii. School absences or tardiness related to the individual's mental illness symptoms
   iii. Difficulty completing assignments or participating in classroom activities
   iv. Problems with attention, concentration, or memory affecting learning
   v. Need for special education services or accommodations due to emotional/behavioral needs

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, LON 2 requires that the individual meet at least one of the following (c-f).

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, LON 3 requires that the individual meet at least two of the following (c-f).

c. Social/Interpersonal Functioning - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in social/interpersonal functioning. Examples of moderate impairment include, but are not limited to:
   i. Difficulty forming or maintaining peer relationships
   ii. Social withdrawal or isolation from classmates and school community
   iii. Conflicts with teachers, school staff, or authority figures
   iv. Inappropriate social behaviors that interfere with school participation
   v. Bullying behaviors (as perpetrator or victim) or social aggression
d. Emotional Regulation - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in emotional regulation. Examples of moderate impairment include, but are not limited to:

i. Occasional episodes of intense emotions in school setting
ii. Difficulty managing anger, frustration, or anxiety in school setting
iii. Mood lability affecting school performance and relationships

e. Behavioral Functioning - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in behavioral functioning. Examples of moderate impairment include, but are not limited to:
   i. Disruptive classroom behaviors interfering with school setting
   ii. Aggression toward peers, staff, or property in school setting
   iii. School avoidance or refusal behaviors
   iv. Risky or impulsive behaviors compromising safety at school
   v. Violations of school rules requiring disciplinary action
f. Family/Caregiver Relationships - Documentation submitted by the provider must indicate that the individual exhibits moderate impairment in the ability to sustain successful family and caregiver relationships. Examples of moderate impairment include, but are not limited to:
   i. Conflicts with family/caregivers affecting school performance
   ii. Family instability impacting youth's school functioning
   iii. Caregiver struggles to support youth's educational needs due to mental health concerns
   iv. Family trauma requiring coordinated intervention

5. **Intensity of Service Criteria: shall meet all criteria a though c**
   The interventions necessary to stabilize the individual's behaviors, symptoms, and ability to function require the frequency, intensity, and duration of contact provided by a CPST Tier 1 provider. Clinical documentation shall support the medical necessity for weekly intervention averaging 2-3 hours per week and demonstrate the need for:
   a. Direct observation and assessment of the individual's functioning in the school setting to identify environmental triggers and protective factors;
   b. Individualized skill-building interventions that require repetition, modeling, and hands-on practice across sessions to achieve skill acquisition and generalization; and
   c. Active engagement strategies for individuals who may require modified approaches delivered in the school setting.
6. **School-Setting Need Indicators: must meet at least one criteria (a or b) and provide documentation of the need.**
   a. Referral from school team due to concerns about youth's behavioral health that includes documentation of specific behavioral health related concerns and goals **or**
   b. Current IEP or 504 Plan with goals related to behavioral/emotional functioning.

7. **Additional CPST-School Setting criteria:** must meet **all** criteria
   There must be:
   a. An identified caregiver or legally authorized representative available and willing to participate.
      i. The caregiver shall be an adult who holds legal custody of, or primary caregiving responsibility for, the youth and who is responsible for engaging in family and caregiver psychotherapy and service-related activities to benefit the youth.
      ii. The caregiver shall commit to participating in an average of at least 30 minutes per week of CPST covered service components for CPST Tier 1, and at least one hour per week for CPST Tier 2.
      iii. Where no caregiver meeting the criteria at subsection (i) is available or willing to participate, a youth may be admitted where the LMHP documents all of the following:
         a. the specific circumstances precluding caregiver participation, including but not limited to foster or congregate care placement, housing instability, unaccompanied status, incarceration, or caregiver work schedule;
         b. the efforts made to engage a caregiver and the outcome of those efforts;
         c. an alternative adult support identified in collaboration with the youth, which may include a kinship caregiver not residing in the household, a foster parent, a local department of social services worker, a court-appointed special advocate, or a designated school staff member, and that individual's agreed role in the youth's plan; and
         d. a plan for continued outreach to secure caregiver participation, to be reviewed at each 90-calendar-day ISP review.
      iv. The MCO may not deny a service authorization solely on the basis that no caregiver meeting subsection (i) is participating, where the documentation required at subsection (iii) is present.

8.2 Tier Two CPST-School Setting Admission Criteria

1. **Standardized Comprehensive Assessment of Needs and Strengths (CANS Lifetime) Requirements (See MHS Chapter IV for requirements related to completing the CANS Lifetime assessment)**
   a. Individuals shall be assessed using the CANS Lifetime assessment within 12 calendar months prior to admission.
      i. If the CANS Lifetime assessment was completed more than 30 days prior to admission, the admitting LMHP shall review, and update the assessment, by attesting in a progress note they have reviewed, agree with the Level of Need determination, added any

additional information and documenting any clinical disagreement, if applicable.

b. The level of need for the individual shall be assessed at a LON 4 or greater on the CANS Lifetime.
c. The assessment shall document specific functional deficits requiring Community Psychiatric Support and Treatment – School Setting.

2. **Diagnostic Criteria:** must meet a and b
   a. The individual's current symptoms meet criteria for a primary ICD diagnosis that correlates to a DSM diagnosis and are not solely attributable to a Neurodevelopmental Disorder or to a Substance Use Disorder, with the exception of Attention-Deficit/Hyperactivity Disorder (F90.0, F90.1, F90.2, F90.8, or F90.9).
   b. Individual meets criteria for a Serious Emotional Disturbance, Early Serious Mental Illness, or Serious Mental Illness.
   c. Individuals may also have a co-occurring diagnosis of a Substance Use Disorder or Developmental Disability.

3. **Functional Impairment Criteria: must meet a and b and at least two (LON 4), three (LON 5) or all four (LON 6) additional domains (c-f).**

Tier	LON	Required Criterion	Functional Impairment Criteria Required	Total Domains Required
CPST Tier 2	LON 4	Symptom Management (a) and Academic/Educational Functioning (b)	At least 2 of (c), (d), (e), or (f)	4 domains minimum
CPST Tier 2	LON 5	Symptom Management (a) and Academic/Educational Functioning (b)	At least 3 of (c), (d), (e), or (f)	5 domains minimum
CPST Tier 2	LON 6	Symptom Management (a) and Academic/Educational Functioning (b)	At least 4 of (c), (d), (e), or (f)	6 domains (all)

The individual is unable to maintain an adequate level of functioning without CPST due to a mental illness as evidenced by significant impairment in functioning.

a. Symptom Management – Documentation submitted by the provider must indicate that the individual exhibits significant impairment in the ability to

manage symptoms of mental illness. Examples of significant impairment include, but are not limited to:

i. Mental health symptoms significantly interfere with everyday activities and responsibilities
ii. Has limited understanding of their symptoms and struggles to develop effective management strategies
iii. Regularly experiences mental health crises requiring intervention
iv. Symptoms cause significant distress and impair multiple areas of life functioning
v. Has limited coping skills that are inconsistently effective or not regularly utilized
vi. Infrequently uses healthy coping strategies and often relies on unhelpful or potentially harmful ways of managing stress
vii. Has great difficulty functioning when daily routines change and becomes very distressed in new or unfamiliar situations

b. Academic/Educational Functioning - Documentation submitted by the provider must indicate that the individual exhibits significant impairment in academic/educational functioning due to symptoms of mental illness. Examples of significant impairment include, but are not limited to:

i. Declining academic performance or chronic academic underachievement
ii. Frequent school absences or tardiness related to mental health symptoms
iii. Difficulty completing assignments or participating in classroom activities
iv. Problems with attention, concentration, or memory affecting learning
v. Need for special education services or accommodations due to emotional/behavioral needs

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, LON 4 requires that the individual meet at least two of the following (c-f).

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, LON 5 requires that the individual meet at least three of the following (c-f).

In addition to meeting impairment in symptom management (a) and academic/educational functioning (b) above, LON 6 requires that the individual meet all four of the following (c-f).

c. Social/Interpersonal Functioning - Documentation submitted by the provider must indicate that the individual exhibits significant impairment in

social/interpersonal functioning. Examples of significant impairment include, but are not limited to:

i. Difficulty forming or maintaining peer relationships
ii. Social withdrawal or isolation from classmates and school community
iii. Conflicts with teachers, school staff, or authority figures
iv. Inappropriate social behaviors that interfere with school participation
v. Bullying behaviors (as perpetrator or victim) or social aggression

d. Emotional Regulation - Documentation submitted by the provider must indicate that the individual exhibits significant impairment in emotional regulation. Examples of significant impairment include, but are not limited to:
   i. Frequent episodes of intense emotions in school setting
   ii. Difficulty managing anger, frustration, or anxiety in school setting
   iii. Panic attacks, flashbacks, or dissociative episodes during school hours
   iv. Intense and frequent mood lability affecting school performance and relationships
   v. Self-harm behaviors or suicidal ideation affecting school safety
e. Behavioral Functioning - Documentation submitted by the provider must indicate that the individual exhibits significant impairment in behavioral functioning. Examples of significant impairment include, but are not limited to:
   i. Disruptive classroom behaviors interfering with school setting
   ii. Aggression toward peers, staff, or property in school setting
   iii. School avoidance or refusal behaviors
   iv. Risky or impulsive behaviors compromising safety at school
   v. Violations of school rules requiring disciplinary action
f. Family/Caregiver Relationships - Documentation submitted by the provider must indicate that the individual exhibits significant impairment in the ability to sustain successful family and caregiver relationships. Examples of significant impairment include, but are not limited to:
   i. Significant conflicts with family/caregivers affecting school performance
   ii. Family crisis or instability impacting youth’s school functioning
   iii. Caregiver significantly struggles to support youth's educational needs due to mental health concerns
   iv. Family trauma requiring coordinated intervention

4. **Intensity of Service Criteria:** must meet all criteria (a-d)
   The interventions necessary to stabilize the individual's behaviors, symptoms, and ability to function require the frequency, intensity, and duration of contact provided

by a CPST Tier 2 provider. Clinical documentation must support the medical necessity for weekly intervention averaging 5-8 hours per week (based on Level of Need) and demonstrating or supporting the need for:

a. Weekly intervention that requires an average of 20 and 32 hours per calendar month (based on Level of Need) with a focus on skill building, school setting integration and crisis support; and
b. That the individual has previously received CPST Tier 1 services, clinical documentation demonstrates that CPST Tier 1 intensity was or is insufficient to achieve stabilization and the individual's LON warrants CPST Tier 2 services; **or**
    i. For individuals admitted directly to CPST Tier 2 without prior CPST Tier 1 services, clinical documentation demonstrates that the severity of functional impairment documented in the CANS Lifetime assessment requires CPST Tier 2 intensity from the outset and that a CPST Tier 1 approach would not meet the individual's clinical needs. In either case, the clinical rationale shall be documented in the CANS Lifetime assessment and the ISP.
c. Behavioral interventions requiring:
    i. Real-time crisis coaching and de-escalation
    ii. Environmental modifications and crisis mitigations plans
    iii. Intensive behavioral modeling and scaffolding
    iv. Skills training that shall occur in the school settings and
d. Care coordination with multiple service providers (psychiatry, case management, crisis services)

5. **School-Setting Need Indicators**: must meet at least one criteria (a or b) and provide documentation of the need.
    a. Referral from school team due to concerns about youth's behavioral health that includes documentation of specific behavioral health related concerns and goals or
    b. Current IEP or 504 Plan with goals related to behavioral/emotional functioning

6. **Additional CPST-School Setting criteria:** must meet **all** criteria
    There shall be:
    b. An identified caregiver or legally authorized representative available and willing to participate.
        i. The caregiver shall be an adult who holds legal custody of, or primary caregiving responsibility for, the youth and who is responsible for engaging in family and caregiver psychotherapy and service-related activities to benefit the youth.
        ii. The caregiver shall commit to participating in an average of at least 30 minutes per week of CPST covered service components for CPST Tier 1, and at least one hour per week for CPST Tier 2.

iii. Where no caregiver meeting the criteria at subsection (i) is available or willing to participate, a youth may be admitted where the LMHP documents all of the following:
   a. the specific circumstances precluding caregiver participation, including but not limited to foster or congregate care placement, housing instability, unaccompanied status, incarceration, or caregiver work schedule;
   b. the efforts made to engage a caregiver and the outcome of those efforts;
   c. an alternative adult support identified in collaboration with the youth, which may include a kinship caregiver not residing in the household, a foster parent, a local department of social services worker, a court-appointed special advocate, or a designated school staff member, and that individual's agreed role in the youth's plan; and
   d. a plan for continued outreach to secure caregiver participation, to be reviewed at each 90-calendar-day ISP review.

iv. The MCO may not deny a service authorization solely on the basis that no caregiver meeting subsection (i) is participating, where the documentation required at subsection (iii) is present.

8.3 Continued Stay Criteria

CPST is a recovery-oriented intervention. If the individual is not making significant progress after 180 calendar days, then the provider and MCO shall develop an alternative Individual Service Plan.

To meet continued stay criteria, all the following shall be met:

1. The individual continues to meet admission criteria.
2. Recovery requires a continuation of these services.
3. The individual and family/caregiver (as included in the ISP) are making progress toward goals and actively participating in the interventions. In the instance of limited or no progress, there shall be documented evidence of changes in the ISP, efforts to engage the individual and natural supports including family/caregiver for youth, consideration of alternative treatments and services, or some other action to address the lack of progress.
4. There is a reasonable likelihood of continued substantial benefit as a result of active continuation of services, as demonstrated by objective behavioral and functional measurements of improvement. For this criterion, objective evidence of continued benefit shall include at least **one** of the following:
   a. A documented reduction in the frequency, duration, or severity of behavioral health symptoms as measured on a standardized assessment tool administered in accordance with Section 3.1;

b. A reduction in the number of crisis contacts, emergency room visits, psychiatric hospitalizations, or law enforcement contacts attributable to behavioral health symptoms compared to the prior authorization period;
c. Documented improvement in LON score or in specific CANS Lifetime domain scores since the prior assessment;
d. Documented improvement in functional outcomes in at least one ISP goal domain (e.g., school attendance, employment, housing stability, medication adherence, social relationships) with specific data supporting the improvement;
e. Documented evidence of increased engagement with natural supports, self-initiated use of crisis resources, or other recovery milestones; or
f. For individuals who have not yet shown measurable improvement, documented clinical evidence that a specific change in the ISP or treatment approach has been implemented and that measurable improvement is clinically expected within the next 90 calendar days, with a specific outcome target.

8.4 Step-Down Criteria from Tier 2 to Tier 1

A step-down from CPST Tier 2 to CPST Tier 1 reflects the individual's clinical progress and reduced intensity of need. Step-down is a planned, clinically-driven transition and shall be based on objective evidence of functional improvement as documented in the CANS Lifetime assessment and the Individual Service Plan (ISP). The LMHP Clinical Supervisor/Clinical Director, in collaboration with the CPST team, the individual, and the individual's natural supports, shall determine readiness for step-down and document the clinical rationale in the individual's record.

All of the following criteria shall be met to support a step-down from Tier 2 to Tier 1:

1. **Reduction in Level of Need (LON).** A CANS Lifetime reassessment completed within the 30 calendar days prior to the step-down request documents that the individual's LON has decreased from LON 4, 5, or 6 to LON 2 or LON 3, indicating that the intensity of Tier 2 services is no longer required to maintain the individual's current level of stability and functioning.
2. **Reduction in Functional Impairment.** The individual's documented level of functional impairment has decreased from significant to moderate across the CANS Lifetime domains. Clinical documentation shall reflect measurable improvement in the Symptom Management domain and in any additional domains that previously supported Tier 2 admission, consistent with the criteria set forth in Sections 8.2 of this Appendix.
3. **Tier 1 Intensity is Clinically Sufficient.** Clinical documentation supports that the frequency, intensity, and duration of CPST Tier 1 services—averaging 2–3 hours of weekly intervention—are sufficient to maintain the individual's stability and continue progress toward ISP goals. The LMHP Clinical Supervisor shall document

that the Rehabilitation Skills Practice component of Tier 2 is no longer required at its current level to prevent deterioration or crisis.

4. **Stability of Crisis Support Needs.** The individual has demonstrated a sustained reduction in crisis episodes over the most recent authorization period, including a documented decrease in crisis contacts, emergency room visits, psychiatric hospitalizations, or law enforcement contacts attributable to behavioral health symptoms. The individual's crisis mitigation plan has been updated to reflect their current level of self-directed crisis response capacity and the reduced crisis support intensity of Tier 1.
5. **Updated Individual Service Plan.** The ISP shall be reviewed and updated prior to or concurrent with the step-down transition to reflect the individual's current goals, the reduced service intensity of Tier 1, and any changes to the team composition. The updated ISP shall be developed collaboratively with the individual and, for youth, the family or caregiver, and shall be signed by all required parties prior to the initiation of Tier 1 services.
6. **Individual and Family/Caregiver Engagement.** The individual, and for youth the family/caregiver, has been informed of and has participated in the step-down planning process. The individual's perspective on readiness for step-down shall be documented in the clinical record. Where the individual or family/caregiver expresses concern about step-down, the LMHP Clinical Supervisor shall document the clinical basis for the transition and the plan to monitor for any deterioration following the change in service intensity.
7. Documentation shall demonstrate measurable improvement in at least one school functioning indicator identified at Section 3.1.3(1) relative to the indicator recorded at admission or shall document the clinical basis for step-down notwithstanding the absence of such improvement.

Following a step-down to Tier 1, the CPST team shall monitor the individual's response to the reduced intensity of services. If clinical deterioration is observed within the first 90 calendar days following step-down, as evidenced by an increase in crisis contacts, a worsening of CANS Lifetime domain scores, or a clinical determination by the LMHP Clinical Supervisor that the individual is no longer maintaining stability at Tier 1 intensity, the provider shall reassess the individual using the CANS Lifetime and submit a service authorization request to return to Tier 2 if the individual meets Tier 2 admission criteria as set forth in Section 8.3 of this Appendix. Step-up back to Tier 2 shall not require a minimum period at Tier 1 and shall be based solely on clinical need as documented in the CANS Lifetime reassessment and updated ISP.

8.5 Discharge Criteria

Discharge is expected once the individual has met one of the following criteria:

1. The individual no longer meets admission criteria.
2. The individual has successfully met the specific goals outlined in the individual service plan for discharge.

3. Individual is not making progress on established service goals, nor is there expectation of any progress with continued provision of services.
4. The individual is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies.
5. The individual and/or family/caregiver(s) no longer need this service as they are obtaining a similar benefit through other services and resources.

Section 9. Exclusions and Service Limitations

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

9.1 General Non-Reimbursable CPST Activities

The following are not reimbursable:

1. Services not in compliance with the Mental Health Services Manual may not be billed to Medicaid.
2. The provider shall ensure that treatment is the active delivery of an intervention identified on an individual's treatment plan. Passive observation of an individual without an intervention is not a billable activity.
3. Telephone contacts for the purposes of reaching the individual to schedule, confirm, or cancel appointments are not reimbursable.
4. Completion of paperwork/documentation is not reimbursable.
5. Requiring the individual to be present to complete documentation to bill for services is not permitted or reimbursable.
6. Team meetings and collaboration exclusively with staff employed or contracted by the provider where the individual and/or their family/caregiver are not present.
7. Team member research on behalf of the individual.
8. Providers may not establish summer camps, after-school programs, or other group-based programming and bill that time as a mental health rehabilitation service. This provision does not restrict the delivery of individually authorized CPST covered service components to an enrolled youth during school breaks, recesses, or closures, as provided in Section 9.4.

9.2 Admission and Concurrent Services Limitations

1. Individuals with a sole diagnosis of a Neurodevelopmental Disorder or Substance Use Disorder without a co-occurring mental health disorder are not eligible for this service, with the exception of Attention Deficit Hyperactivity Disorder.
2. Comprehensive Crisis and Transition Services:
    a. The CPST provider or any affiliated provider or business of the CPST provider shall not provide Mobile Crisis Response, 23-Hour Crisis Stabilization or Residential Crisis Stabilization Unit to any individual receiving CPST.

i. This requirement does not include Community Services Boards that are licensed to provide 23-Hour Crisis Stabilization or Residential Crisis Stabilization Unit services.

3. Individuals that meet the admission criteria for Assertive Community Treatment, Coordinated Specialty Care, Functional Family Therapy, or Multisystemic Therapy, are not eligible to receive CPST, except when the standalone EBP services have failed to address the individual's treatment goals adequately, those services are not feasibly accessible for the individual, or the individual expresses reasonable preference to participate in CPST. Any of these exceptions require documentation.
    a. Early Periodic Screening Diagnostic and Treatment policies apply as well as exceptions if the MCO/FFS service authorization contractor determine CPST is the appropriate service.
4. Individuals receiving CPST may not be simultaneously serviced authorized to receive the following services:
    a. Mental Health Intensive Outpatient,
    b. Psychiatric Residential Treatment Facility (PRTF).
5. Service authorization overlaps of up to 30-calendar days are allowable as approved by the FFS service authorization contractor or MCO during transitions from one service to another for care coordination and continuity of care.
6. Early and Periodic Screening, Diagnostic and Treatment requirements apply to all admission and concurrent service limitations set forth in this section. Where the MCO or fee-for-service service authorization contractor determines that CPST – School Setting is the appropriate service for a member under 21 years of age, the limitations in this section shall not operate to deny medically necessary care.
7. The authorization of additional behavioral health services, not included in 9.2(4) is determined by the CANS Lifetime assessment/identified level of need in collaboration with the individual and their Managed Care Organization or FFS contractor.
8. CPST – School Setting shall not be billed for any service that the local education agency is obligated to provide at no cost to the family as a free appropriate public education under the Individuals with Disabilities Education Act, including counseling or other related services specified on the youth's Individualized Education Program.
    a. Where a youth's IEP specifies counseling or another related service that overlaps in whole or in part with a CPST covered service component, the Individual Service Plan shall identify the overlap, identify which entity is responsible for delivering the service, and document the clinical rationale for any CPST intervention delivered in the same domain.
    b. The determination required under subsection (a) shall be documented at admission and reviewed at each 90-calendar-day ISP review and at each service authorization renewal.

c. This section does not preclude CPST delivery where the youth's clinical need exceeds the scope, intensity, or duration of the related service specified on the IEP, provided the incremental need is documented.

9.3 Other Limitations

1. Group size is limited to a staff to individual ratio of one to six for youth.
    a. Group delivery of CPST services is limited to Psychotherapy and Restorative Life Skills Training
    b. For CPST Tier 2, group delivery of Restorative Life Skills Training may not exceed half of the units of restorative life skills training provided with the individual per week.
2. Covered service components provided in the provider's DBHDS licensed office location shall not exceed three (3) hours a week (Sunday-Saturday) per individual and shall be for the benefit of the individual.
3. As identified in the ISP, services may occur with a family or caregiver without the individual present when it is for the clinical benefit of the individual with the exception of Rehabilitative Skills Practice, which can only be provided in-person with the individual present.
4. Services are not provided in segregated, disability-specific, or institutional settings unless temporarily necessary to address acute safety concerns.

9.4 School Calendar Continuity

1. A service authorization for CPST – School Setting remains in effect during summer recess, scheduled school breaks, and unplanned school closures. Enrollment in CPST – School Setting shall not be terminated solely because school is not in session.
2. During any period in which school is not in session, covered service components may be delivered in the youth's home or in other natural, community-based settings, provided the interventions delivered address goals in the Individual Service Plan related to the youth's functioning in the school setting.
3. Not less than 15 calendar days prior to the start of summer recess, and prior to any scheduled break exceeding 10 consecutive instructional days, the LMHP shall document in the ISP a written continuity plan addressing:
    a. the anticipated frequency, duration, and location of services during the break;
    b. the covered service components to be delivered and the goals they address;
    c. anticipated risks associated with the loss of school routine and structure, and the mitigations planned; and
    d. the plan for resumption of school-based delivery, including re-engagement with the school team.

4. Where a youth transfers to a different school within the same division, the provider shall verify coverage under the existing Memorandum of Understanding and convene an ISP review within 10 business days of the transfer.
5. Where a youth transfers to a school in a different division or to a school not covered by a current Memorandum of Understanding, the provider shall notify the MCO within 5 business days, and shall either execute a Memorandum of Understanding with the receiving division or coordinate transfer to a provider holding one. Services may continue in the home or community during the transition, not to exceed 60 calendar days, and the youth shall not be discharged solely by reason of the transfer.

Section 10. Service Authorization (SA)

10.1 General requirements

1. Service authorization is required.
2. Providers shall submit service authorization requests within one business day of admission for preservice authorization requests and by the requested start date for concurrent service authorization requests. If submitted after the required time frame, the start date of the authorization will be based on the date of receipt.
3. The LMHP in collaboration with the individual, family/caregiver, and CPST team members, shall request services based on each individual's CANS Lifetime assessment/reassessment, treatment history, individual service plan, progress toward accomplishing goals/objectives, level of individual/family/caregiver engagement, individual choice/preference and Level of Need. The intensity, frequency, and duration for any requested service shall be individualized.
4. All service authorization requests will initially start with the standard 6 calendar month timeframe and the corresponding units required in the chart below.
5. If an individual remains at the same Level of Need or higher for 18 calendar months, the service authorization timeframe will decrease to 3 calendar months.
6. If a provider is requesting and providing services within the permissible amount based on the assessment and individuals are recovering, the MCO may waive the service authorization requirement.
7. Interventions recommended shall not be limited to the services delivered by the provider or provider agency conducting the assessment and submitting the authorization request.
8. The individual's MCO/FFS service authorization contractor conducting the service authorization review may approve the requested service(s) or may recommend a more clinically appropriate service based on their review.

Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

Information regarding our FFS service authorization contractor can be found here: Service Authorizations Home (Acentra Health/DMAS) | MES

10.2 Level of Need and CPST Service Authorization Requests

Service authorization requests shall follow the Level of Need standards below, including all provider requests and MCO/FFS approvals.

Level of Need	Service Type/Tier	CPST SA Timeframe	CPST Units per SA	Average Hours Weekly
2/3 with provisional diagnosis	CPST Tier 1	3 calendar months Example Start Date and End Date: 11/20/2025 to 02/19/2026	102 Units	Approximately 2 hours per week; approximately 8.5 hours per month
2	CPST Tier 1	6 calendar months Example Start Date and End Date: 11/20/2025 to 05/19/2026	204 Units	Approximately 2 hours per week; approximately 8.5 hours per month
3	CPST Tier 1	6 calendar months Example Start Date and End Date: 11/20/2025 to 05/19/2026	300 Units	Approximately 3 hours per week; approximately 12.5 hours per month
4	CPST Tier 2	6 calendar months	480 Units	Approximately 5 hours per week; approximately 20 hours per month
5	CPST Tier 2	6 calendar months	576 Units	Approximately 6 hours per week; approximately 24 hours per month
6	CPST Tier 2	6 calendar months	672 Units	Approximately 7 hours per week; approximately 28 hours per month

10.3 Level of Need and CPST Service Authorization Requests (with Psychotherapy)

Additional 16 units per calendar month shall explicitly be used for Psychotherapy.

Level of Need	Service Type/Tier	CPST SA Timeframe	CPST Units per SA with 16 units for Psychotherapy	Average Hours Weekly
2/3 with provisional diagnosis	CPST Tier 1	3 calendar months Example Start Date and End Date:	150 Units	Approximately 3 hours per week;

Level of Need	Service Type/Tier	CPST SA Timeframe	CPST Units per SA with 16 units for Psychotherapy	Average Hours Weekly
		11/20/2025 to 02/19/2026		approximately 12.5 hours per month
2	CPST Tier 1	6 calendar months Example Start Date and End Date: 11/20/2025 to 05/19/2026	300 Units	Approximately 3 hours per week; approximately 12.5 hours per month
3	CPST Tier 1	6 calendar months Example Start Date and End Date: 11/20/2025 to 05/19/2026	396 Units	Approximately 4 hours per week; approximately 16.5 hours per month
4	CPST Tier 2	6 calendar months	576 Units	Approximately 6 hours per week; approximately 24 hours per month
5	CPST Tier 2	6 calendar months	672 Units	Approximately 7 hours per week; approximately 28 hours per month
6	CPST Tier 2	6 calendar months	768 Units	Approximately 8 hours per week; approximately 32 hours per month

10.4 Preservice Authorization

The following information shall be submitted with the preservice authorization request:

1. Completed and signed, by an LMHP/LMHP-type, service authorization request form.
2. Initial Assessment including the completed CANS Lifetime.

10.5 Concurrent Authorization

The following information shall be submitted with the concurrent authorization request

1. Completed and signed, by an LMHP/LMHP-type, service authorization request form.
2. Updated ISP:

a. Shall include plan for telemedicine as described in the ISP section of Chapter IV, if applicable.
b. Youth: Following initial authorization, if an individual is not progressing and the family/caregiver is not engaged or participating in treatment, the ISP shall be updated to assure family/caregiver involvement before reauthorization is considered.
c. Adults: Following initial authorization, if an individual is not progressing and/or engaged, the ISP shall be updated to assure engagement and progress before reauthorization is considered.

Section 11. Additional Documentation Requirements and Utilization Review

1. An LMHP shall review documentation of non-licensed team members at least every 30 calendar days as evidenced by a progress note in the individual's chart written by the LMHP or a co-signature on the non-licensed team member's progress notes. Non-licensed team members include LMHP-types, QMHPs, QMHP-Ts and BHTs.
2. Refer to Chapter VI of this manual for additional documentation and utilization review requirements.

Section 12. CPST Billing Requirements

Services shall be billed with the modifier based on the staff level required for the service component:

12.1 General Billing Requirements

1. Providers shall only bill for time spent face-to-face with the individual or time spent face-to-face with the individual's family/caregiver when it is for the benefit of the individual.
    a. Exceptions to the face-to-face billing requirement include telehealth for the purposes of Care Coordination or Crisis Support.
2. Provider shall bill with a Place of Service (03) to represent services provided in a school setting. If the service is not provided in a school setting providers may use the following Place of Service codes:
    a. (02): Telehealth provided other than in Patient's Home
    b. (04): Homeless Shelter
    c. (10): Telehealth provided to a patient in their home
    d. (11): Office
    e. (12): Home
    f. (14): Group Home
    g. (27): Outreach Site/Street
    h. (99): Other Place of Service
3. A LMHP may provide Restorative Life Skills Training and shall bill using the procedure code/modifier combination associated with that service component.

4. A LMHP or QMHP may provide Rehabilitative Skills Practice and shall bill using the procedure code/Modifier combination associated with that service component.
5. An LMHP or LMHP-type may provide any component of CPST and shall bill using the procedure code and modifier combination associated with the service component.
6. Non-licensed staff (LMHP-types, QMHP, QMHP-T or BHT) shall not bill more than 750 CPST units in any calendar month (across all agencies in which they are employed).
7. Assessment and treatment planning service components allow for more than one staff person billing simultaneously. If clinically needed, an LMHP/LMHP type and a QMHP may bill simultaneously for Assessment or treatment planning service components. No other service components are allowed to be billed simultaneously by more than one staff person. Documentation shall support the need for simultaneous billing by an LMHP/LMHP-type and a QMHP.
8. For service authorizations that include the additional 16 units per month for psychotherapy, those additional 16 units shall only be billed for the provision of the psychotherapy service component.

12.2 CPST-School Setting

Service Component	Team Member Type	Rate Unit	CPST - Youth, School Setting Procedure Code and Modifier Combination
Assessment	LMHP, LMHP-type	Per 15 minutes	H0036, HO
Treatment Planning	LMHP, LMHP-type	Per 15 minutes	H0036, HO
Treatment Planning, if assisting the LMHP	QMHP, QMHP-T	Per 15 minutes	H0036, HN
Psychotherapy	LMHP, LMHP-type	Per 15 minutes	H0036, HO (individual) H0036, HO **and** TJ (group)
Care Coordination	LMHP, LMHP-type	Per 15 minutes	H0036, HO
Care Coordination	QMHP, QMHP-T	Per 15 minutes	H0036, HN
Crisis Support	LMHP, LMHP-type	Per 15 minutes	H0036, HO
Crisis Support	QMHP, QMHP-T	Per 15 minutes	H0036, HN

Service Component	Team Member Type	Rate Unit	CPST - Youth, School Setting Procedure Code and Modifier Combination
Restorative Life Skills Training	LMHP, LMHP-type, QMHP, QMHP-T All professional levels of staff shall bill with this procedure code and modifier combination.	Per 15 minutes	H0036, HN (individual) **or** H0036, HN **and** TJ (group)
Rehabilitative Skills Practice	LMHP, LMHP-type, QMHP, QMHP-T or BHT All professional levels of staff shall bill with this procedure code and modifier combination.	Per 15 minutes	H0036, HM Use of the GT (telehealth) modifier is not allowable.

Attachment 1 – Training, Supervision and Caseloads

Section 1: Required Training for CPST – Youth, Community and School Setting

1.1 Managing and Adapting Practice (MAP)

To provide CPST Youth Services (Community or School Setting) all youth serving agencies shall meet requirements for training and certification in Managing and Adapting Practice (MAP). MAP is a modular, flexible approach to guide treatment planning and leverage evidence-based principles for a range of common presenting problems. Training requirements by professional type for CPST-Youth serving agencies are as follows:

1. Each CPST agency shall have at least one LMHP who meets the criteria of a MAP Credentialed Therapist. A MAP Credentialed Therapist means an LMHP/LMHP Type that has successfully completed:
    a. The PracticeWise Direct Services Curriculum training,
    b. Six months of consultation with PracticeWise, and
    c. The MAP Therapist Portfolio review process
2. All LMHP/LMHP-Types who provide or supervise CPST services for youth shall be a MAP Credentialed Therapist or in the process of becoming a MAP Credentialed Therapist as described in (a) and (b).
    a. LMHPs/LMHP-types shall have 18 calendar months from the effective date of the agency's enrollment with DMAS for specialty 924/925 to successfully achieve their MAP Therapist Credential.
    b. A newly hired LMHP/LMHP type shall have 18 calendar months from their hire date to successfully achieve their MAP Therapist Credential.

The statewide requirement for training and application of Managing and Adapting Practice (MAP) does not limit professional staff from providing other clinically appropriate, evidence-based protocols in which they are trained to meet the needs of CPST clients. There are also a number of evidence-based group protocols which are appropriate and recommended for integration into programs offering Tier 1 CPST services and consistent with the broader MAP process, including: The Incredible Years, Parents as Teachers, Guiding Good Choices, and the Strengthening Families Program.

Clinical best practice guidelines shall be maintained and regularly updated in agency policy, particularly for the most common presenting problems to include, Neurodevelopmental Disorders, Anxiety Disorders, Trauma- and Stressor-Related Disorders, Depressive Disorders, Disruptive, Impulse-Control and Conduct Disorders and any other disorders commonly treated by the provider. Agencies that adopt all MAP process elements are not required to manage separate clinical best practice guidelines

1.2 Required Skills Training Curriculum (Youth)

All staff providing CPST services to youth shall complete the following training based on their professional credential.

Professional Type	Foundational Training Requirement	Role Specific Training Requirement
Licensed Mental Health Professionals (including all LMHP- types)	Foundational Skills Curriculum (FSC)	MAP Credentialed Therapist
Qualified Mental Health Professional (includes trainee)	Foundational Skills Curriculum (FSC)	CPST Intermediate Skills (IS) Curriculum
Behavioral Health Technician	DBHDS Behavioral Health Technician (BHT) Academy	CPST IS Curriculum

1. The Foundation Skills, Intermediate Skills Training and the Behavioral Health Technician Academy shall be accessed through DBHDS' Learning Management System.
2. All staff shall have 12 calendar months from the effective date of the agency's enrollment with DMAS for specialty 924/925, to successfully complete all training.
3. Newly hired staff shall have 12 calendar months from their hire date to successfully complete all training.

1.3 Required Documentation

Providers shall use a combination of the DBHDS Learning Management System, submitting documentation to the Center for Evidence-Based Partnerships (CEP-VA) at Virginia Commonwealth University (VCU) demonstrating compliance with statewide training requirements and clinical best practice policies outlined in this section.

Section 2 - Supervision

DMAS Mental Health Services Supervision is relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of a staff person. It is a structured professional relationship where a more experienced mental health professional (the supervisor) oversees the work of a less experienced or newer professional or paraprofessional (the supervisee), with the primary goal of fostering growth and learning. Supervision encompasses multiple roles where the supervisors are a teacher, coach, consultant, mentor, evaluator, and administrator; the supervisor provides support, encouragement, and education to staff while addressing an

array of psychological, interpersonal, physical, and spiritual needs of the individual participating in services.

The process involves regular meetings between supervisor and supervisee to discuss individual cases, treatment strategies, ethical considerations, professional development needs, and service decision-making. Supervision makes sure that the care provided meets the standards in terms of safety and effectiveness, and that any concerns related to the individual participating in services are addressed.

2.1 Core Functions of DMAS Mental Health Services Supervision

For the CPST service, supervision serves three primary functions. This does not include administrative supervision functions which are not required to be provided by the clinical supervisor for the purpose of this service. If agencies have a separate compliance/quality assurance role that meets the regulatory/compliance function of supervision for CPST, the clinical supervisor does not have to directly carry out those tasks so long as there is evidence that those tasks are completed by agency staff. The three primary functions and the activities that may be considered supervision time are:

Educational/Clinical Function: Supervisors are responsible for imparting knowledge, refining skills, and promoting professional development. The supervisor teaches therapeutic skills and helps the staff and collaborative behavioral health team develop self-awareness to better the therapeutic interactions with individuals participating in services.

Regulatory Compliance Function: Objectives of the agency/organization's policy and public accountability are transformed into practice standards. This ensures compliance with regulations, documentation requirements, and organizational protocols, including ensuring supervisees maintain required licenses, certifications, and continuing education.

Supportive Function: Daily work with individuals experiencing symptoms of a mental illness can be inherently distressing, so a key aspect of supervision is often helping staff to learn to manage the emotional demands of the work. Supervision has been found to increase provider competence and decrease stress.

2.2 Supervision-Related Activities

Supervision-Related Activities include:

Individual supervision sessions - One-on-one meetings between supervisor and supervisee to review cases, discuss treatment approaches, and address professional development needs

Group supervision - Sessions facilitated by the supervisor with multiple supervisees to discuss cases, share learning, and develop skills collectively

Case consultation - Reviewing specific client cases, treatment plans, diagnoses, and interventions to ensure appropriate care and competency

Clinical documentation review - Examining and providing feedback on progress notes, treatment plans, assessments, and other required clinical records

Clinical case oversight for collaborative behavioral health services means education, two-way communication, collaborative treatment planning and collaborative monitoring of outcomes between a team member who provides the assessment, treatment planning, and psychotherapy components of CPST and team members who provides rehabilitative skill building, care coordination, crisis support, and/or rehabilitative skills practice components of CPST.

Rehabilitative skills practice planning means education, two-way communication, and collaborative treatment activity planning between a team member who provides the restorative life skill training, care coordination and crisis support components of CPST with a team member who provides the rehabilitative skills practice components of CPST.

Direct observation - Watching supervisees conduct sessions (live, recorded, or through one-way mirrors) to assess skills and provide feedback

Co-treatment sessions - Supervisor and supervisee working together with clients to model interventions and provide real-time guidance

Performance evaluation - Formal assessment of supervisee competencies, skills, and professional development progress

Training and education - Providing instruction on techniques, ethical standards, legal requirements, and evidence-based practices

Crisis intervention oversight - Being available for consultation during emergencies and reviewing crisis response procedures

Ethical and legal guidance - Discussing ethical dilemmas, legal obligations, confidentiality, and professional boundaries

Professional development planning - Setting goals and creating pathways for supervisees' career advancement and skill enhancement

2.3 Collaborative Behavioral Health Services and Supervision of Individual Staff

1. The CPST Clinical Director and all LMHP Clinical Supervisors shall ensure non-licensed staff practice within their scope and do not provide services requiring licensure.
2. All supervision and supervision related-activities shall be documented and accessible upon request.
    a. The provider shall provide ongoing supervision of staff consistent with the requirements of 12VAC35-105 in addition to the requirements stated in Section 3.3 of this Appendix.

DMAS Mental Health Services Supervision shall be provided in accordance with the chart below:

Credential and weekly hours worked	Minimum frequency	Minimum total individual and group supervision per calendar month	Minimum total individual, group and supervision related activities[1] per calendar month
LMHPs full time[2]	monthly	1 hour	1 hour
LMHP-types, QMHPs, QMHP-Ts, BHTs full-time or part-time with 10 or more cases	weekly	2 hours monthly (minimum one hour of individual supervision)	4 hours monthly
LMHP-types, QMHPs, QMHP-Ts, BHTs part-time with less than 10 cases	weekly	1 hour monthly	2 hours monthly

[1] See supervision related activities section of this attachment

[2] Does not apply to LMHPs working for agencies as sole LMHP serving as clinical director and providing all LMHP required services.

2.4 DHP Board required supervision for LMHP Residents/Supervisees:

1. LMHP-types shall receive supervision in accordance with the requirements established by their respective professional licensing board.
2. Official documentation from the Department of Health Professions of the board approved supervision and supervisor shall be maintained in a secure file at the DBHDS licensed CPST location and available upon request.
3. Official documentation of the board approved supervision sessions shall be maintained in the staff employment record.
4. The supervision-related activities listed in this Appendix do not replace the supervision requirements established by the relevant professional licensing board under the Department of Health Professions (DHP). Where DHP board-required supervision exceeds the minimums set forth in this Appendix, the higher DHP standard shall govern. Where this Appendix establishes a higher standard than DHP board requirements, this Appendix shall govern.
5. Supervision provided under board requirements shall satisfy the CPST supervision requirements in Section 3.3 of this Appendix only if provided by an LMHP employed by or under contract with the CPST agency.

Section 3 - Staff Caseloads/Supervision of Cases

3.1 Staff Caseloads

1. Appropriate caseloads will vary based on team composition, Level of Need score of the individuals, and the experience and skills of the staff and shall be monitored by a LMHP Clinical Supervisor or CPST Clinical Director.
2. CPST agencies shall have policies and procedures regarding caseloads that take into account the experience level of staff members, coverage of cases between staff during staff leave, and when staff leave the agency. Policies shall clearly articulate how staff at the agency shall be protected from high caseloads, even if there is staff turnover.
3. All CPST agencies shall require all employees to disclose outside employment that includes the provision of Medicaid-billed services. If an employee discloses outside employment providing Medicaid-billed services, the CPST agency shall document the outside employment and provide this information upon any CPST audit.
4. For staff providing the primary components (Restorative Life Skills Training, Care Coordination, and/or Crisis Supports), weighted caseload shall not exceed 20. In general, blended caseloads of CPST Tier 1 and CPST Tier 2 services are recommended. Weighted caseloads are calculated as follows and the caseload shall not exceed 20.
    a. Caseload = (# CPST Tier 2 Clients * 2.5) + (# CPST Tier 1 Clients)
5. For license-eligible staff only providing the service components of Assessment, Treatment Planning (and 90-day follow up), and Psychotherapy, agencies shall follow #1 and #2 of this section.
6. The CPST provider shall keep an ongoing formal log of each staff's caseload. An average, per month, over a six-month period shall be used to demonstrate compliance with caseload limits.
7. Individual non-licensed staff may bill no more than 750 CPST units per calendar month, to include total caseload across all agencies in which they are employed. Compliance with this limit will be assessed on a rolling 6-month average basis and is subject to audit accordingly.

3.2 LMHP Supervision of Cases

1. A single LMHP shall not provide clinical oversight of more than 120 (unweighted) cases in a calendar month. The CPST Clinical Director shall determine how many cases can be managed with appropriate attention to quality and safety. The following maximum limits apply based on team composition:
    a. Where the LMHP is providing oversight primarily to other fully-licensed LMHPs or LMHP-types who are completing the assessment, treatment planning, and psychotherapy components of CPST, a single LMHP shall not provide oversight of more than 120 total cases per calendar month.
    b. Where the LMHP is providing oversight primarily to QMHPs, QMHP-Ts, or BHTs who are completing the restorative life skills, rehabilitation skills

practice, care coordination, and crisis support components, and is directly providing the assessment and treatment planning components, a single LMHP shall not provide oversight of more than 75 total cases per calendar month.

c. Where the LMHP's oversight responsibilities involve a mixed team including both LMHP-types, QMHPs and BHTs, the CPST Clinical Director shall determine the appropriate caseload cap based on documented team composition, not to exceed 100 cases per calendar month.

Section 4 – Additional Reference Charts

This document contains reference charts derived from the CPST Provider Manual draft:

#	Chart Title	Manual Section Reference
Chart 1	**Functional Impairment Criteria**	*Sections 8.1 & 8.2*
Chart 2	**Level of Need & Service Authorization**	*Section 10.2*
Chart 3	**Staff Supervision Requirements**	*Attachment 1, Section 2*
Chart 4	**Staff Caseload Calculation**	*Attachment 1, Section 3*
Chart 5	**Staff Types by Service Component and Tier**	*Sections 2.1 & 5*

Chart 1 — Functional Impairment Criteria

Sections 8.1 & 8.2 — Unified Tier 1 and Tier 2 Domain Requirements

Tier	LON	(a) Symptom Management	(b) Academic/ Educational Functioning	Functional Impairment Criteria	Total Domains
Tier 1	**LON 2**	**✓ Required**	**✓ Required**	At least 1 of (c), (d), (e), or (f)	3 min
	LON 3	**✓ Required**	**✓ Required**	At least 2 of (c), (d), (e), or (f)	4 min
Tier 2	**LON 4**	**✓ Required**	**✓ Required**	At least 2 of (c), (d), (e), or (f)	4 min
	LON 5	**✓ Required**	**✓ Required**	At least 3 of (c), (d), (e), or (f)	5 min

Tier	LON	(a) Symptom Management	(b) Academic/ Educational Functioning	Functional Impairment Criteria	Total Domains
	LON 6	**✓ Required**	**✓ Required**	**✓ Required**	6 (all)

★ *Domain (a) Symptom Management is ALWAYS required at every LON. The number of additional domains required increases with LON severity. Tier 2 LON 6 is the only level requiring ALL four domains.*

★ *Impairment level: Tier 1 = moderate impairment; Tier 2 = significant impairment.*

Chart 2 — Level of Need & Service Authorization

Section 10.2 — SA Timeframes, Units, and Average Hours by LON

Chart 2A - Level of Need & Service Authorization (Standard)

LON	Tier	SA Timeframe	Units per SA	Avg Hours/Week	Avg Hours/Month	Special Condition
LON 2/3 (provisional)	**Tier 1**	3 months	**102**	~2 hrs/wk	~8.5 hrs/mo	*Provisional Dx only*
LON 2	**Tier 1**	6 months	**204**	~2 hrs/wk	~8.5 hrs/mo	—
LON 3	**Tier 1**	6 months	**300**	~3 hrs/wk	~12.5 hrs/mo	—
LON 4	**Tier 2**	6 months	**480**	~5 hrs/wk	~20 hrs/mo	—
LON 5	**Tier 2**	6 months	**576**	~6 hrs/wk	~24 hrs/mo	—
LON 6	**Tier 2**	6 months	**672**	~7 hrs/wk	~28 hrs/mo	—

Chart 2B — Level of Need & Service Authorization (with Psychotherapy)

LON	Tier	SA Timeframe	Units per SA	Avg Hours/Week	Avg Hours/Month	Special Condition
LON 2/3 (provisional)	**Tier 1**	3 months	**150**	~3 hrs/wk	~12.5 hrs/mo	*Provisional Dx only*
LON 2	**Tier 1**	6 months	300	~3 hrs/wk	~12.5 hrs/mo	—
LON 3	**Tier 1**	6 months	**396**	~4 hrs/wk	~16.5 hrs/mo	—
LON 4	**Tier 2**	6 months	**576**	~6 hrs/wk	~24 hrs/mo	—
LON 5	**Tier 2**	6 months	**672**	~7 hrs/wk	~28 hrs/mo	—
LON 6	**Tier 2**	6 months	**768**	~8 hrs/wk	~32 hrs/mo	—

★ *If an individual remains at the same LON or higher for 18 calendar months, the SA timeframe drops to 3 months regardless of tier.*

★ *Units are billed per 15 minutes. 1 hour = 4 units.*

Chart 3 — Staff Supervision Requirements

Attachment 1, Section 2.3 — Minimum Supervision by Credential and Caseload

Credential & Case Load	Min. Frequency	Min. Individual + Group Supervision / Month	Min. Total (incl. Related Activities) / Month	Notes
LMHP (full-time)	Monthly	1 hr/month (ind. or group)	**1 hr/month total**	*Footnote 2*
LMHP type, QMHP, QMHP-T, BHT (full-time OR part-time ≥10 cases)	Weekly	2 hrs/month (min 1 hr individual)	**4 hrs/month total**	—

Credential & Case Load	Min. Frequency	Min. Individual + Group Supervision / Month	Min. Total (incl. Related Activities) / Month	Notes
LMHP-type, QMHP, QMHP-T, BHT (part-time <10 cases)	Weekly	1 hr/month	**2 hrs/month total**	—

★ *Footnote 2: Does not apply to LMHPs working as the sole LMHP serving as Clinical Director and providing all LMHP-required services.*

★ *'Related Activities' include case consultation, documentation review, direct observation, co-treatment, performance evaluation, crisis oversight, and training. See Section 3.2 for full list.*

★ *Where DHP board-required supervision exceeds these minimums, the higher DHP standard governs. Where this Appendix sets a higher standard, this Appendix governs.*

Chart 4 — Staff Caseload Calculation

Attachment 1, Section 3 — Caseload Formula and LMHP Oversight Caps

5A — Non-Licensed Staff Caseload Limits

Staff Type	Caseload Formula	Maximum Caseload
Non-licensed staff (LMHP-type, QMHP, QMHP-T, BHT)	(Tier 2 clients × 2.5) + Tier 1 clients	**20 cases (weighted)**
Non-licensed staff — Billing cap	Across ALL employing agencies/total caseload	**750 CPST units / calendar month**

★ *Compliance is measured as an average per month over a six-month period. Agencies must maintain a formal ongoing log of each staff member's caseload.*

5B — LMHP Clinical Oversight Caps

LMHP Team Composition	Max Cases / Calendar Month	Description
Primarily LMHP/LMHP-types	**120 (unweighted) cases**	Oversight of fully-licensed or resident-level staff completing assessment, treatment planning & psychotherapy

LMHP Team Composition	Max Cases / Calendar Month	Description
Mixed team (LMHP-types + paraprofessionals)	**Up to 100 (unweighted) cases**	Clinical Director determines appropriate cap based on documented team composition
Primarily QMHPs, QMHP-Ts, or BHTs	**75 (unweighted) cases**	LMHP directly provides assessment & treatment planning while overseeing paraprofessionals delivering rehab, care coordination, and crisis support

★ *Blended caseloads of Tier 1 and Tier 2 are recommended. A single LMHP shall never provide oversight of more than 120 cases/month under any configuration.*

Chart 5 — Staff Types by Service Component and Tier
Sections 2.1 & 5 — Who Can Deliver Each Component

Service Component	Tier	LMHP	LMHP-type	QMHP / QMHP-T	BHT
Assessment	Tier 1 & 2	✓	✓	Assist only (must be CANS certified)	—
Treatment Planning	Tier 1 & 2	✓	✓	Assist only	—
Psychotherapy	Tier 1 & 2	✓	✓	—	—
Restorative Life Skills Training	Tier 1 & 2	✓	✓	✓	—
Care Coordination	Tier 1 & 2	✓	✓	✓	—
Crisis Support	Tier 1 & 2	✓	✓	✓	—
Rehabilitation Skills Practice	***Tier 2 Only***	✓	✓	✓	✓

★ *'Assist only' for QMHP/QMHP-T means they may gather information and assist documentation under LMHP direction; LMHP retains full clinical responsibility.*

★ *Rehabilitation Skills Practice (Tier 2 only) is the sole component where BHTs may bill; all BHT billing uses the same procedure code/modifier as higher-level staff for this component.*

★ *A QMHP may provide BHT-level services and shall bill using the procedure code/modifier associated with BHTs.*