

SECTION 2

POLICIES AND PROCEDURES

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PROGRAM OVERVIEW

COMMUNITY MENTAL HEALTH SERVICES OVERVIEW

The purpose of this manual is to provide pertinent information to community mental health service providers for successful participation in the South Carolina Medicaid program. This manual provides a comprehensive overview of the program, standards, policies and procedures for Medicaid compliance. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of, and promotes access to, “evidence-based” practices, and “emerging best practices” in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis, and treatment planning; and fosters improvement in the delivery system of mental health services to children and adults in the most effective and cost-efficient manner.

Community mental health service providers shall provide clinic services as defined in federal regulations 42 CFR 440.90. This section describes these services, legal authorities, and the characteristics of the providers of services.

Community mental health services are provided to adults and children diagnosed with a mental illness as defined by the current edition of the Diagnostic Statistical Manual (DSM).

Clinic Services

Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that meet **all** of the following criteria:

- Services provided to outpatients
- Services provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients
- Services furnished by or under the direction of a physician

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PROGRAM OVERVIEW

General Definitions

- **SCDHHS** – South Carolina Department of Health and Human Services
- **DMH** – South Carolina Department of Mental Health
- **DSM** – Current edition of the Diagnostic and Statistical Manual of Mental Disorders
- **ICF/MR** – Intermediate Care Facility for People with Mental Retardation
- **IMD** – Institutions for Mental Diseases
- **MUSC** – Medical University of South Carolina
- **SNF** – Skilled Nursing Facility
- **Client** – Any Medicaid beneficiary who is receiving services from the service provider
- **Community Mental Health Center (CMHC)** – A free-standing facility of the Department of Mental Health or Medical University of South Carolina having as its primary function the diagnosis, treatment, counseling, and/or rehabilitation involving mental, emotional, and behavioral problems, disturbances or dysfunction (Services are provided to clients on an outpatient basis.)
- **Collaterals** – Persons who are significant others or members of the client’s family or household, academic or workplace setting who regularly interact with clients and are directly affected by, or have the capability of affecting, their conditions and are identified in the client’s Plan of Care (POC) as having a role in treatment and/or are identified as being necessary for participation in the evaluation and assessment of the client prior to admission
- **Contact** – A face-to-face interaction between a staff member and a client or collateral

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PROGRAM REQUIREMENTS

PHYSICIAN DIRECTION AND SUPERVISION FOR CLINIC SERVICES

Clinic services require that services be provided to clients under the direction of a physician, whether or not the clinic itself is administered by the physician. That is, the physician must at least be affiliated with the clinic in accordance with Section 1908(a) of Title XIX of the Social Security Act.

Although the physician does not have to be on the premises when his or her client is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate and that clients are getting services in a safe, efficient manner in accordance with accepted standards of medical practice.

PHYSICIAN RESPONSIBILITIES

To comply with the above requirements, the physician/psychiatrist must see all Medicaid clients within the first 90 days from the date of admission to a CMHC or earlier, based on the individual client's needs. Physicians should prescribe the type of care to be provided and periodically review the need for continued care.

Physicians must include a properly completed Physician Medical Order (PMO) form in the medical record to confirm the initial contact with the client.

The physician/psychiatrist's signature is required on the client's Plan of Care (POC) to confirm diagnosis, medical necessity of the treatment, the appropriateness of care, and authorization of all services that are required to be listed on the POC. Refer to the heading "Plan of Care (POC)" in this section of the manual for more detail.

The physician/psychiatrist must evaluate all clients' needs for continued service at least once every 12 months. This evaluation will be confirmed by the physician/psychiatrist's signature and date on the POC.

STAFF-TO-CLIENT RATIO

Staff-to-client ratios must be met and maintained at all times during hours of operation. Ratios must be maintained in accordance with each individual service standard. Staff involved in the treatment delivery must have direct contact with clients; staff present but not

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PROGRAM REQUIREMENTS

STAFF-TO-CLIENT RATIO (CONT'D.)

involved in the treatment delivery cannot be included in the ratio.

If at any time during the delivery of a service, the staff-to-client ratio is not in accordance with the service standard, billing for clients in excess of the required ratio should be discontinued. Appropriately credentialed staff must be substituted or group sizes must be adjusted to meet the service standard requirements before billing may resume.

MEDICAL NECESSITY

All services are required to meet medical necessity. A service is medically necessary when it meets **all** of the following conditions:

- It is required to diagnose, treat, cure, or prevent an illness that has been diagnosed or is reasonably suspected, to relieve pain, improve and preserve health, or be essential to life.
- It is consistent with a client's symptoms, diagnosis, and level or ability to function in his or her roles and not be in excess of the client's needs.
- It is consistent with generally accepted medical standards and is not experimental or investigational.
- It is not primarily provided for the convenience of a client, the client's caretaker, or the provider.

COORDINATION OF CARE

Coordination of care must occur for clients who are being served by multiple agencies/providers. During the intake process, each provider is responsible for attempting to identify whether a client is already receiving treatment from another Medicaid provider and notifying any other involved Medicaid providers of the client's need for services. Needed services should never be denied to an individual because another provider has been identified as the service provider. Each provider should also notify other involved agencies or providers immediately if an individual in an overlapping situation discontinues his or her services.

OUT-OF-HOME PLACEMENT SERVICES

Some children in out-of-home placements have specific treatment needs that cannot be adequately addressed by the out-of-home placement provider's staff. If a child requires therapeutic interventions beyond the clinical scope of the out-of-home placement providers' treatment capacity, the out-of-home placement provider may seek the services of

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PROGRAM REQUIREMENTS

OUT-OF-HOME

PLACEMENT SERVICES (CONT'D.)

an outside provider.

Community mental health service providers may provide services to children of which there is no duplication of services with the out-of-home placement provider. Community mental health services may provide the following services where there is clearly no duplication of services: Psychiatric Medical Assessment, Injectable Medication Administration, and Nursing Services.

Since there is no way to address all of the possibilities that may arise, each situation must be judged on its own merit. Those most clinically knowledgeable of the child's treatment needs and/or direct care staff, as well as the Case Manager from the state agency that placed the child, should discern the appropriateness for the need of an outside provider. Emergency situations do not require approval from the child-placing agency.

Services must be documented in the child's clinical record, in accordance with the requirements of this manual, and must clearly show no duplication of services.

It is NEVER appropriate for an out-of-home placement provider to seek the service of an outside provider to replace his or her required treatment services.

Regardless of the special needs of any one child, it is inappropriate for the out-of-home placement provider to rely on an outside provider to render most or all of the treatment service to any child.

PROVIDER QUALIFICATIONS

The community mental health service provider may bill for only those services rendered by clinical staff who hold the credentials required by each covered, billable service. The community mental health service provider is responsible for the appropriate billing for services administered by staff members who possess the credentials required by each covered, billable service.

The CMHC shall have a credentials folder on file for each clinician that includes **all** of the following:

- Curriculum vitae or resume
- Copy of diploma or transcripts representing the highest degree attained
- Copy of licenses or certification, including current renewals or required training

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS (CONT'D.)

Each community mental health service provider shall also maintain a file that lists the clinical staff, their professional titles, and the services each staff member is privileged to render.

General Staff Requirements

The following information describes the credentialing requirements for staff delivering services in community mental health service programs. Prior to delivery of services, each staff member should be appropriately credentialed and privileged by the authorizing community mental health service provider. Each community mental health center shall adhere to the standards of qualification of service provider credentials as defined below.

Community mental health services must be rendered by, or under the supervision of, a Mental Health Professional (MHP) as outlined in the individual service standard and in accordance with their respective scope of practice as allowed under SC Law.

Mental Health Professional (MHP)

The following professionals are considered to be MHPs:

- A **Psychiatrist** must be a licensed Doctor of Medicine or Doctor of Osteopathy who has completed a residency in psychiatry and who is licensed to practice medicine in South Carolina.
- A **Physician** must be licensed to practice medicine in South Carolina.
- A **Psychiatric Nurse** or **Advanced Practice Registered Nurse** must be a registered nurse, licensed in South Carolina, with a minimum of a master's degree in nursing.
- A **Psychologist** must possess a doctoral degree from an accredited university or college, and be licensed in the state of South Carolina in the clinical, school, or counseling areas.
- A **Social Worker** must possess a master's degree in social work from an accredited university or college and be licensed by the State Board of Social Work Examiners.
- A **Clinical Chaplain** must possess a Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister, or rabbi and one year of Clinical

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PROGRAM REQUIREMENTS

Mental Health Professional (MHP) (Cont'd.)

Pastoral Education that includes a provision for supervised clinical services.

- A **Mental Health Counselor (MHC)** must possess a master's or doctoral degree from a program that is primarily psychological in nature from an accredited university or college (*e.g.*, counseling, guidance, or social science equivalent).
- A **Mental Health Professional with a Master's Equivalent** must possess a master's degree in a closely related field that is applicable to the bio-psycho-social treatment of the mentally ill. Included in this category are those appropriate Ph.D. candidates who have bypassed the master's degree but have more than enough hours to satisfy a master's requirement.

Other Qualified Professionals

The following qualified professionals may provide community mental health services as outlined in the individual service standards and in accordance with State Law and their respective scope of practice:

- A **Registered Nurse (RN)** must be licensed in South Carolina and at a minimum must possess an associate's degree in nursing from a Board-approved nursing education program and one year of experience working with the population to be served
- A **Licensed Practical Nurse (LPN)** must be licensed in South Carolina with the completion of an accredited program of nursing approved by the Board of Nursing and one year of experience working with the population to be served
- A **Physician's Assistant (PA)** must be licensed in South Carolina with the completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs
- A **Non-Mental Health Professional** must possess a bachelor's degree from an accredited university or college; or must have three years experience in the direct care of persons with serious mental illness. They must also have completed an approved curriculum program as specified by the authorizing community mental health service provider

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PROGRAM REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

MEDICAL RECORDS

Each client shall have a medical record that includes sufficient documentation to justify Medicaid participation and permit a clinician not familiar with the client to evaluate the course of treatment.

The client's medical record should contain the following:

- A written comprehensive bio-psycho-social examination or initial clinical assessment conducted by an MHP
- A Psychiatric Medical Assessment
- All plans of care, reviews, and addenda
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered)
- Clinical Service Notes
- Copies of any testing performed on the client
- Copies of all written reports
- Consents and eligibility information, and any other documents relevant to the care and treatment of the client

The medical record must be arranged in a logical order to facilitate the review, copy, and audit of the clinical information and course of treatment.

Medical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1.

CONSENT TO EXAMINATIONS AND TREATMENT

A "Consent to Examinations and Treatment" form [hereinafter referenced as "Consent form"], dated and signed by the client or representative, must be obtained at the onset of treatment from all clients except in the circumstances indicated below.

If the client cannot sign the Consent form due to a crisis, and is accompanied by a next of kin or responsible party, that individual may sign the Consent form. If the client is

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DOCUMENTATION REQUIREMENTS

CONSENT TO EXAMINATIONS AND TREATMENT (CONT'D.)

alone and unable to sign, a statement such as “client unable to sign and requires emergency treatment” should be noted on the Consent form and must be signed by the physician or MHP and one other staff member. The client should sign the Consent form as soon as circumstances permit.

A new Consent form should be signed and dated each time a client is readmitted to the system after discharge.

Consent forms are not necessary to conduct designated examinations ordered by probate court. However, a copy of the probate court order must be kept in the medical record.

ABBREVIATIONS AND SYMBOLS

Community mental health service abbreviations on the Plan of Care (POC) and/or Clinical Service Notes (CSNs) must use only the approved abbreviation for services. Approved abbreviations for services can be found in the “Medicaid Billable Services” chart in Section 4 of this manual. Service providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation.

LEGIBILITY

All clinical documentation must be typed or handwritten using only black or blue ink, legible, and filed in chronological order. All clinical records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order so they can be easily and clearly reviewed, copied, and audited.

Original legible signature and credential (*e.g.*, Registered Nurse) or functional title (*e.g.*, MHP) of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service and/or co-signature, when required, are not acceptable.

ERROR CORRECTION

Medical records are legal documents. Staff should be extremely cautious in making alterations to the records. In the event that errors are made, adhere to the following guidelines:

- Draw one line through the error, and write “error,” “ER,” “mistaken entry,” or “ME” to the side of the error in parenthesis.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

ERROR CORRECTION (CONT'D.)

- Enter the correction, sign or initial, and date it.
- Errors cannot be totally marked through; the information in error must remain legible.
- No correction fluid may be used.

LATE ENTRIES

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in documentation. Late entries should rarely be used, and then only to correct a genuine error of omission or to add new information that was not discovered until a later time. When late entries are made, adhere to the following guidelines:

- Identify the new entry as a “late entry.”
- Enter the current date and time.
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible.
- When using late entries, document as soon as possible.

RECORD RETENTION

Medical records must be retained for a period of five years after the last payment date. If any litigation, claims, or other actions involving the records are initiated prior to the expiration of the five-year period, the records shall be retained until completion of the action/resolution of all issues which arise from it, or until the end of the five-year period, whichever is later.

INITIAL CLINICAL ASSESSMENT

An MHP shall perform an initial clinical assessment or comprehensive bio-psychosocial examination for each client at the onset of treatment.

Initial Clinical Assessments or bio-psychosocial examinations are provided to evaluate a client’s mental condition, establish medical necessity, and, based on their diagnosis, determine the appropriate treatment. The initial assessment or comprehensive bio-psychosocial examination must be completed within the first three non-emergency visits and shall include, at least, the following areas:

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

INITIAL CLINICAL ASSESSMENT (CONT'D.)

- Presenting problem/history
- Psychiatric history/care
- Integrated Substance Abuse Disorder Assessment (as appropriate)
- Medical history/care/current medications
- Personal history/developmental/family/social/occupational
- Mental status examination
- Diagnosis

PLAN OF CARE (POC)

The Plan of Care (POC) is an individualized comprehensive plan of care to improve the client's condition developed in collaboration with a client and/or significant other(s). Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the POC. The signature of the MHP responsible for the POC is required. The signature of a physician is required to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care.

POC Due Date

The initial POC must be formulated, signed, and dated by the MHP and the reviewing physician within 90 calendar days from the day a client enters services at the mental health center.

For beneficiaries receiving retroactive coverage, and for whom a Psychiatric Medical Assessment (PMA) has not been rendered during a retroactively covered period, the PMA must occur within 45 days from the date that a client is determined Medicaid eligible. The initial POC must be developed, signed, and dated by the MHP and reviewing physician/psychiatrist within 45 calendar days from the day the client becomes retroactively eligible. A note indicating the date the client became retroactively eligible should be placed in the medical record.

Duration of the POC

The maximum duration of a POC is 12 months from the date of the physician/psychiatrist's signature on the POC. If the POC is reformulated prior to its expiration, the maximum duration is 12 months from the reviewing physician's signature.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

POC Requirements

The POC must be in writing or print and include the following:

1. The client's name and Medicaid ID number
2. The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the Diagnostic Statistical Manual (DSM)

For individuals who have more than one diagnosis regarding mental health, substance use, and/or medical conditions, all diagnoses should be recorded.

3. Justification for treatment, frequency of services, and continuation of treatment statement based on the diagnosis and needs of the client

For individuals who have concurrent substance abuse disorders, the other diagnoses should be integrated into the POC. A list of specific goals and objectives, and as appropriate, interventions coordinated with substance abuse service providers, should also be included.

4. Authorized treatment process including the following:
 - Goals (stated by the client as possible) that are relevant to treatment
 - Objectives that are outcome oriented and individualized
 - Interventions which include a list of specific services used to meet the stated goals and objectives must be included
 - Services necessary to meet each objective
 - The appropriate frequency of the services that are required in the POC
 - The frequency of services must be listed on the POC. Each service should be listed by its name or approved abbreviation with either a planned frequency or, if allowable, PRN (as necessary for client needs). Services cannot be listed as both. Services which may be listed as PRN are

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DOCUMENTATION REQUIREMENTS

POC Requirements (Cont'd.)

PMA, MH Assessment by Non-Physician, Injectable Medication Administration, Nursing Services, Crisis Intervention Services, MH Service Plan Development by Non-Physician

- Expected dates to meet each objective, which should not exceed the duration of the POC
 - The type of staff who will be rendering the service and professional title (MD, MHP, RN, etc.)
5. Client signature (If a client refuses to sign the POC or it is not deemed clinically appropriate to obtain the client's signature, the reason the client's signature was not obtained must be documented.)
 6. The signature(s) and title(s) of the MHP that developed the POC

Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the POC. The signature of the MHP responsible for the POC is required. The signature of a physician is required to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care.

7. The physician/psychiatrist's signature and date is required to confirm the medical necessity and appropriateness of care.

Services Required to be Listed on the POC

The following services must be listed in the POC to receive reimbursement:

- Family Therapy
- Group Therapy
- Individual Therapy

The following services may be listed in the POC, but are not required. However, when a combination of these services are to be provided due to the medical needs of a client it is recommended that these services be included on the POC to maintain the integrity of the plan of care.

- Injectable Medication Administration
- MH Assessment by Non-Physician
- Psychiatric Medical Assessment

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DOCUMENTATION REQUIREMENTS

Services Required to be Listed on the POC (Cont'd.)

- Crisis Intervention Services
- MH Service Plan Development by Non-Physician
- Nursing Services

POC Additions or Changes

Services added or frequencies of services changed in an existing POC must be signed or initialed and dated by the reviewing physician. Clients are not required to have face-to-face contact with physicians/psychiatrists for the addition of services or changes in service frequency. All additions to the POC should be listed in chronological order.

When additions or changes are authorized without face-to-face contact with the physician, the contact should be documented in the record and should be signed and/or initialed by the physician immediately upon return. Should the service be provided before the physician signature is obtained, the record must contain a CSN justifying the change.

Addendum POC/Goal Sheet

An addendum POC and/or Goal Sheet, used in conjunction with an existing POC if the space is insufficient on the current POC, must be labeled “Addendum POC” or “Addendum Goal Sheet(s)” and must accompany to the existing POC. The addendum must include the signature and title of the MHP who formulated the addendum(s), and the date it was formulated. The addendum(s) must also be signed by the reviewing physician. In order to avoid duplication or repeating unchanged information from the original POC, the addendum can state, “see POC of [appropriate date].”

Progress Summaries

Progress summaries are periodic reviews to evaluate a client’s progress toward the treatment objectives, appropriateness of the services being furnished and need for the client’s continued participation in the community mental health service program. A review of the client’s participation in all services must be conducted at least every 90 calendar days from the date clients begin receiving services, and must be summarized by the MHP and documented in the POC Progress Summary Report. The MHP will review the following areas:

- The client’s progress toward treatment objectives

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DOCUMENTATION REQUIREMENTS

Progress Summaries (Cont'd.)

and goals

- The appropriateness of the services provided and their frequency
- The need for continued treatment
- Recommendations for continued services

POC Review

Upon termination or expiration of the treatment period, the MHP must review the POC, preferably with the client, and evaluate the client's progress in reference to each of the treatment objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the POC. The signature of the MHP responsible for the review is required. The clinician should also assess the need for continued services and the specific services needed based on the progress of the client. Newly recommended services will either be added to the existing POC, or a new POC can be developed that includes needed services. The physician signature is required to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care for newly recommended services.

The POC must include the signature and title of the MHP, and the date when the review was completed.

Continued Treatment

In situations where it appears necessary to continue treatment beyond the initially authorized duration, the POC can be reviewed up to 30 days prior to its expiration date without altering the due date of the initial POC. The physician must sign and date the POC, and then state an effective date, which is presumably consistent with the current POC expiration date. Failure to list an effective date will result in the POC expiring 12 months from the physician's signature date. At this time, the MHP should meet with the client to discuss the continuation of treatment and make the necessary changes on the POC.

Physician Signature on the POC

For services to be eligible for Medicaid reimbursement, the POC must be signed by the reviewing physician within 90 calendar days of a client's admission to a CMHC.

The physician signature is required to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care. The physician must sign a

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Physician Signature on the POC (Cont'd.) continued POC immediately after the MHP reviews it and prior to any delivery of services. This is crucial when the POC is not reviewed until its expiration date.

Clinical Service Note (CSN) All community mental health services provided to Medicaid beneficiaries shall be documented on a CSN. PMA services rendered by a physician/psychiatrist may be documented on a PMO. Each service should be documented on a separate CSN or PMO. CSNs and PMOs must also be typed or handwritten using only black or blue ink, legible, and filed in chronological order. Additionally, CSNs must be dated, legibly signed, and include professional titles of appropriately credentialed staff. CSNs should be completed immediately after the delivery of a service.

Only approved abbreviations and symbols may be used in the clinical documentation. An Abbreviation Key must be maintained to support use of abbreviations and symbols in entries.

The CSN must reflect the following:

- Delivery of specific billable services as identified on the POC
- Documentation that services correspond to billing in type, amount, duration, and date
- A pertinent clinical description of the service
- The date and actual time the service was rendered
- A signature, with the name and title, of the appropriate service provider
- The duration of the service rendered

When two or more staff members write on the same CSN, the individual responsible for that segment must sign each entry.

Generic Notes Generic notes may be used as an extension of the CSN. These notes should be filed adjacent to the corresponding CSN and kept in chronological order. It is preferable that generic notes be used rather than writing on the back of the CSN to prevent destruction of critical information concerning a client.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Referenced Information

Additional information, for example test results and interview information that is located within the medical record, must be referenced on the CSN, and the CSN should clearly identify where this information can be located.

When a physician/psychiatrist renders services to clients, the documentation on the CSN should reference the PMO.

Availability of Clinical Documentation

A CSN or PMO should be completed and placed in the medical record immediately after the delivery of a service. If this is not possible due to the nature of the service, the CSN must be placed in the medical record no later than ten working days from the date of the service, unless otherwise indicated in the service standard.

If a CSN or PMO is dictated, the transcription must occur within one working day from the date of the service. The note must be placed in the medical record no later than ten working days from the date the service was provided.

Clinical Service Note Billing Information

The following billing information should be included in the documentation:

- The specific service that was rendered or its approved abbreviation
- The date, start time, and bill time that the service was rendered (Bill time is defined as time spent face-to-face with clients providing direct care.)
- The signature and title of the clinician who renders the service
- The place of service as appropriate for the particular service provided

See the “Billable Places of Service” heading for each service under “Program Services” in this manual section. The following list provides the codes most commonly used:

- o 03 – School
- o 11 – Doctor’s Office
- o 12 – Client’s Home
- o 21 – Inpatient Hospital
- o 22 – Outpatient Hospital

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Clinical Service Note Billing Information (Cont'd.)

- o 23 – Emergency Room
- o 51 – Inpatient Psychiatric Facility
- o 53 – Community Mental Health Center
- o 99 – Other Unlisted Facility

For billing purposes, services provided in the client's natural/community environment, school, Community Residential Care Facility, nursing facility, other approved community mental health facility, or other allowable places of service will use the place of service code 99 - Other Unlisted Facility.

Clinical Documentation on the CSN

The documentation of services must provide a pertinent clinical description, assure that the service conforms to the service description, and authenticate the charges.

The documentation of the CSNs should include the information outlined in the next two subsections of this manual, with the exception of the following services:

- Psychiatric Medical Assessment
- Injectable Medication Administration
- Crisis Intervention
- MH Assessment
- MH Service Plan Development by a non-physician

The content of the CSNs for the excepted services is detailed under their individual service descriptions.

Content of Service Notes

Clinical service notes must document:

- The focus or reason for the session/intervention (This should be related to a treatment objective or goal listed on the POC.)
- The intervention(s) provided by the clinician
- The response of the client to the clinician's intervention(s)
- The results of tests or measurements, if applicable
- The general progress and status of the client in reference to the treatment goals and objectives
- The plan for the next session

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Content of Service Notes (Cont'd.)

For individuals with co-occurring disorders receiving billable mental health interventions for a mental health diagnosis, attention to the substance use disorders or other medical disorders should be documented on the CSN using the criteria listed above. This is in addition to the documentation relating to the mental health diagnosis.

MEDICAL MANAGEMENT ONLY

Medical Management Only is a level of care provided to clients who due to their level of functioning and psychiatric stability do not require ongoing psychotherapeutic intervention. Clients that are eligible for Medical Management Only require only the prescription of appropriate medications and continued monitoring for side effects. Based on the judgment of the physician, these identified clients who can benefit from medical management to maintain therapeutic gains and emotional stabilization will be managed by medical staff with the exception of situations of crisis when the client may be seen by a qualified MHP and if client is receiving Targeted Case Management to be assisted in assessing resources to meet general needs. Services may be provided by physicians, Advanced Practice Registered Nurses (APRNs), Registered Nurses (RNs), Physician Assistants (PAs), and Licensed Practical Nurses (LPNs). The physician must determine that a patient is appropriate for Medical Management Only level of care.

Clients meeting Medical Management Only criteria, as determined by the physician, may only receive the following services:

- Nursing Services
- Mental Health Service Plan Development by Non-Physician (SPD)
- Injectable Medication Administration
- Mental Health Assessment by a non-physician
- Psychiatric Medical Assessment (PMA)
- Psychiatric Medical Assessment Advanced Practice Registered Nurse

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

MEDICAL MANAGEMENT ONLY (CONT'D.)

- Crisis Intervention services (up to two contacts per year)

The physician will perform the initial PMA to determine the appropriateness of the client for the program. The physician will assign the client to the program and prescribe the plan of care to be followed. The physician must include a properly completed Physician's Medical Order (PMO) form in the record that clearly identifies the client to be appropriate for this level of care. The physician must sign and date the PMO. All eligible clients will be assessed at least annually to determine ongoing appropriateness of this level of care. When subsequent assessments are performed by an APRN, the physician must co-sign the note, thereby authorizing the plan of care and continued participation in this level of care. Thereafter, medical staff may see the client and must document the client's need to remain at this level of care. An assessment of each client in this level of care must be conducted at least annually by a physician or an APRN.

Participation in the Medical Management Only level of care must be clearly documented in the client's medical record. In addition to general documentation requirements and those specified in the individual service standard, the PMO or the Clinical Service Note must contain the following:

- Intervening services since the last PMA
- Assessment of whether the client is meeting his or her goal(s) and any desire to change the goal(s). Examples of goals may include "take my medicine and stay out of the hospital," or "continue to work," or "learn more about my medicine."
- An indication of any change in the client's goal(s) and that the client verbally agrees to continue this level of care
- Justification of treatment

The client's progress and any significant changes in the client's treatment shall be documented in the client's record every 90 days. The summary may be documented in the PMO note or a CSN. If a client has not been seen by a physician, an APRN, or a RN during the preceding 90-day period, and does not have sufficient clinical information to evaluate the treatment prescription, a progress summary

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

MEDICAL MANAGEMENT ONLY (CONT'D.)

must be completed during the first contact thereafter. If the physician determines that the client needs additional Community Mental Health Services other than those allowed under this level of care, the client no longer meets the Medical Management Only criteria and all Medicaid standard Community Mental Health Services requirements shall apply.

All Medicaid billing requirements as set forth in the "Billing Requirements" section of Section 2 of this manual must be maintained.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Medicaid community mental health services are billed in units of 15 or 30 minutes, depending on the service. Units billed must be substantiated by the clinical documentation.

Each procedure code has a unit time and maximum frequency limit. All services must be billed in units, not to exceed the maximum number of units allowed per day. A billable unit of time is defined in increments of 15 or 30 minutes of service time with an eligible client. Service time is defined as the actual time the service provider spends “face-to-face” with clients and/or time spent working on behalf of clients while providing a community mental health service. Service time does not include any “non-billable” activities, to include preparation time, and travel time. The heading “Non-Billable Medicaid Activities” below outlines additional activities that fall under this category.

Service time must be converted to units and the total number of units is required to be submitted on the claim form. In all instances, service documentation must justify the number of units billed. See the “Documentation” heading in this manual section.

In some cases, service time may exceed the allowable billing time. For billing purposes, only the converted bill time (total number of units) is required on the documentation, up to the maximum number of units allowed per day.

NON-BILLABLE MEDICAID ACTIVITIES

The following is a list of activities that are not Medicaid-reimbursable under the Community Mental Health Service Program guidelines. Professional judgment should be exercised in distinguishing between billable and non-billable activities. This list is not exhaustive, but serves as a guide to non-billable activities.

- Travel time
- Attempted phone calls, home visits, and face-to-face contacts
- Record audits

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Completion of any specially requested information regarding clients from the state office or from other agencies for administrative purposes
- Recreation or socialization with a client
- Documentation of service notes
- Completion of Management Information System (MIS) reports and monthly statistical reports
- Unstructured client time (Inactivity, free, and unstructured time may be necessary for a client, but is not part of a billable service.)
- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (GED, Adult Development), or tutorial services in relation to a defined education course
- Education interventions that do not include individual process interactions
- Filing and mailing of reports
- Medicaid eligibility determinations and re-determinations
- Medicaid intake processing
- Prior authorization for Medicaid services
- Required Medicaid utilization review
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) administration
- “Outreach” activities in which an agency or a provider attempts to contact potential Medicaid recipients
- Participation in job interviews
- The on-site instruction of specific employment tasks
- Staff supervision of actual employment services
- Assisting clients in obtaining job placements
- Assisting clients in filling out applications (*i.e.*, job, disability, etc.)

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Assisting clients in performing the job or performing jobs for clients
- Drawing client's blood and/or urine specimen, and/or taking the specimen(s) to the lab
- Visiting clients while in another mental health service program, unless for a special treatment activity
- Retrieving medications for a client kept at the CMHC and handing out prescriptions or medications
- Scheduling appointments with the physician or any other clinician at the CMHC
- Providing non-authorized services to children placed in high or moderate management group homes
- Staffing between clinicians in the same clinical unit within the mental health center for the purpose of supervision
- Transporting clients to appointments or waiting for clients in waiting rooms
- Respite care

TELEPSYCHIATRY

To qualify for Medicaid reimbursement, interactive audio and video equipment must be involved that permits two-way – real-time (synchronous) or near-real-time (asynchronous) – communication between the client, consultant, interpreter, and referring clinician.

Please note the following requirements:

- Reimbursement requires the “real-time” presence of the client.
- Reimbursement is available for all community mental health services except; injectables, Crisis Intervention (if there is no other MH staff with the client), Group Therapy and Psychological Testing which require “hands on” encounters. GT modifier must be used when billing these services.
- All equipment must operate at a minimum communication transfer rate of 384 kbps.

SECTION 2 POLICIES AND PROCEDURES
BILLING REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PSYCHIATRIC MEDICAL ASSESSMENT (PMA), PSYCHIATRIC MEDICAL ASSESSMENT -ADVANCED PRACTICE REGISTERED NURSE (PMA-APRN), AND PSYCHIATRIC MEDICAL ASSESSMENT - TELEPSYCHIATRY (PMA-T)

Service Description

Psychiatric Medical Assessments are face-to-face clinical interactions between a client and a physician (PMA), or advanced practice registered nurse (PMA-APRN), or Telepsychiatry (PMA-T) to assess and monitor the client's psychiatric and/or physiological status for one or more of the following purposes:

- Assess the mental status of a client and provide a psychiatric diagnostic evaluation, including the evaluation of concurrent substance use disorders
- Provide specialized medical, psychiatric, and/or substance use disorder assessment
- Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent substance use disorders
- Provide or review information on which to base a psychiatric evaluation and establish the medical necessity for care
- Assess or monitor a client's status in relation to treatment
- Assess the need for a referral to another health care, substance abuse, and/or social service provider
- Diagnose, treat, and monitor chronic and acute

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)	<p>health problems. This may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays.</p> <ul style="list-style-type: none"> • Plan treatment and assess the need for continued treatment <p>Delivery of this service may include contacts with collateral persons for the purpose of securing pertinent information necessary to complete an evaluation of the client.</p>
Telepsychiatry	<p>When provided by a physician, PMAs can be rendered via interactive telecommunication. All other requirements must be met to render this service.</p>
Eligibility	<p>All Medicaid clients admitted to a mental health facility are eligible to receive PMA service and must receive this service at least once within the first 90 days from the date of admission to the mental health center or as the first service thereafter. PMAs may be repeated as often as is medically necessary.</p> <p>If a PMA has not been rendered during a retroactively covered period, the PMA must be rendered within 90 calendar days from the date a client is retroactively determined Medicaid eligible.</p> <p>Clients receiving psychotropic medications are strongly encouraged to receive a PMA every six months at a minimum.</p> <p>Clients who have not had a face-to-face treatment service during a six-month period will require a new PMA completed by a physician or an Advanced Practice Registered Nurse (APRN) within 90 calendar days.</p>
Staff Qualifications	<p>Any physician or APRN who is deemed suitable under the provider qualification's provisions may render PMA services.</p>
APRN Restriction	<p>An APRN may render subsequent PMA services only after a physician has conducted the initial or first psychiatric assessment.</p>

SECTION 2 POLICIES AND PROCEDURES**PROGRAM SERVICES**

Service Documentation PMA's are not required to be listed on the POC. The physician or APRN who renders the service must include a properly completed PMO form in the record. The physician or APRN must sign and date the PMO. A Clinical Service Note (CSN) must be entered in the record that references the PMO.

A community mental health services provider may obtain a copy of a PMA performed by another provider for the purpose of the initial PMA requirement, provided there are no clinical indications that necessitate another PMA. In these cases, under all circumstances, the receiving service provider is responsible for ensuring that clients receive PMA's as clinically necessary and for Medicaid billing purposes, in accordance with Medicaid requirements.

Billing/Frequency Limits PMA's are billed in unit increments of 15 minutes for a maximum of six units per day.

Any services rendered after 90 calendar days from the day a client enters service and before the rendering of a PMA may not be billed. Once the PMA has been completed, billing may resume.

Billable Places of Service PMA's may be provided in a client's home, an inpatient or outpatient general hospital, a Community Mental Health Center, school, nursing facility, or other approved facility.

**INJECTABLE MEDICATION
ADMINISTRATION
(MED. ADM.)**

Service Description Injectable Medication Administration is the injection of a medication in response to the order of a licensed physician. It is used as an adjunctive treatment to primary mental health services to restore, maintain, or improve a client's role performance or mental status.

Eligibility All Medicaid clients in need of this service that have been identified by a physician or an APRN are eligible for this service.

Staff Qualifications A physician licensed to practice medicine in the state of South Carolina may render Medication Administration

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Staff Qualifications (Cont'd.)

Services. A Registered Nurse (RN), Licensed Practical Nurse (LPN), or licensed Physician Assistant (PA) under the supervision of a physician or APRN may also render this service. However, when an RN, LPN, or PA renders this service, the supervising physician must be accessible in case of an emergency.

Service Provision

Medication Administration is rendered in response to a physician or APRN order documented on a PMO. The physician or APRN must assure the form is properly completed and included in the medical record to confirm the initial and any subsequent contacts with the client.

Only the provision of administration of those injectable procedure codes listed below are reimbursable under this service:

REIMBURSABLE MEDICAID CODES FOR INJECTIONS	
J2060	Ativan, to 4 mg
J1200	Diphenhydramine, up to 50 mg
J0515	Benztropine, up to 1 mg
J1630	Haldol, up to 5 mg.
J1631	Haldol Decanoate to 50 mg. IM.
J1990	Librium, up to 100 mg.
96372	Therapeutic, Prophy, DX Inj, Subcut/Intramuc
J2680	Prolixin Decanoate, Fluphenazine, up to 25 mg
J3230	Torazine, Chlorpromazine, up to 50 mg
J3310	Perphenazine, up to 5 mg
J3360	Valium, up to 5 mg
J3410	Vistaril, up to 25 mg
J2794	Risperidone, 0.5 mg
J3486	Ziprasidone Mesylate, 10 mg

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Service Documentation	<p>Injectable Medication Administration is not required to be listed on the POC. A CSN will be used to document this service. This service must be entered as the service to be rendered on the CSN. The provider of the service should include the following items in order to provide a relevant clinical description, assure the service conforms to the service description, and authenticate the charges:</p> <ul style="list-style-type: none">• The medication administered• The dosage given (quantity and strength)• The route (I.M., I.D., I.V.)• The injection site• The side effects or adverse reactions noted
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Billing/Frequency Limits	<p>Only the injectable procedure codes listed in the table on the previous page are reimbursable under this service. Injections must be billed using the appropriate procedure code. Injection codes include both the cost and the administration of the drug.</p>
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Billable Places of Service	<p>Medication Administration may be provided at a client's home or natural environment, CMHC, or a Community Residential Care Facility.</p>
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Relationship to Other Services	<p>No restrictions</p>
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NURSING SERVICES (NS)

Service Description	<p>Nursing Services offer a variety of face-to-face or telephonic interventions to a client. When providing this service, RNs utilize a holistic approach that addresses the medical, physical, and psychiatric needs of a client, recognizes the interaction of the two, and prevents unnecessary psychiatric hospitalization. Services are designed to:</p> <ul style="list-style-type: none">• Provide limited or comprehensive medically necessary nursing care intervention to address the physical and/or mental health needs of a client to promote positive psychiatric treatment outcomes, and/or
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SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Promote health education/intervention regarding coexisting conditions that affect psychiatric symptomatology and functioning and promote client competence. This includes education about psychiatric medications and concurrent substance use in accordance with national practice guideline standards, and/or
- Determine and evaluate the nutritional status of mentally ill clients in support of improved treatment outcomes when it medically interferes with the psychiatric status of clients, and/or
- Provide follow-up nursing care to address identified problems and assess progress, and/or
- Promote the consistent use of health/medical services designed to promote positive psychiatric treatment outcomes.

Medication Monitoring is provided to do any or all of the following:

- Assess the need for clients to see the physician
- Determine the overt physiological effects related to the medication(s)
- Determine psychological effects of medications
- Monitor clients' compliance to prescription directions
- Educate clients as to the dosage, type, benefits, actions, and potential adverse effects of the prescribed medications
- Educate clients about psychiatric medications and substance abuse in accordance with nationally accepted practice guidelines

Eligibility

All Medicaid beneficiaries who physicians and APRNs, within the scope of their medical or nursing practice, believe will benefit from this service are eligible.

Staff Qualifications

Any RN, under the supervision of a physician or an APRN, may render Nursing Services. The physician must be accessible in case of emergency.

An RN or a Licensed Pharmacist, under the supervision of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Staff Qualifications (Cont'd.)	a physician or an APRN, may render medication-monitoring activities. The physician or the APRN must be accessible in case of emergency.
Special Restrictions	<p>Telephone contacts between an RN and clients are not Medicaid reimbursable under the following circumstances:</p> <ul style="list-style-type: none">• Brief conversations to inform clients about appointment times• Monitoring a client's general condition• Billing more than two units per day <p>Telephonic contact may occur between a client and/or collateral to assess the client's physiological or psychological response to a medication order, but cannot be billed for more than two units per day.</p>
Service Documentation	<p>Nursing Services are not required to be listed on the POC. A CSN will be used to document this service. Nursing Services shall be entered on the CSN as the service to be rendered.</p> <p>Medication Monitoring services require that the provider of the service also include the following items in addition to those required in the general CSN requirements:</p> <ul style="list-style-type: none">• The medications the client is currently taking, or reference to the physician's order or other document in the medical record that lists all the medications prescribed to the client• The side effects or adverse reactions experienced by the client• Whether the client is refusing or unable to take medications as ordered, or is compliant in taking medications as prescribed• How effective the medication(s) is in controlling symptoms• Any issues relating to concurrent substance use, documentation of education to the client, and support for the rationale for continuing the necessary medication

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing/Frequency Limits	Nursing Services are billed in units of 15 minutes for a maximum of seven units per day.
Billable Places of Service	Nursing Services may be rendered at a client's home, natural environment, or at a CMHC.
Relationship to Other Services	No restrictions.

CRISIS INTERVENTION (CI) SERVICE

Service Description Crisis Intervention (CI) is a face-to-face or telephonic, time-limited, intensive therapeutic intervention with the client provided by an MHP or a RN.

Face-to-face interventions are intended to:

- Stabilize the client
- Identify the precipitant(s) or causal agent(s) that triggered the crisis
- Reduce the immediate personal distress felt by the client
- Reduce the chance of future crises through the implementation of preventive strategies

Telephonic interventions are provided either to the client or on behalf of the client. Telephonic interventions are intended to:

- Stabilize the client
- Prevent a negative outcome
- Link the necessary services to assist the client

Eligibility All clients who experience an abrupt substantial change in their role function and/or emotional state resulting in a marked increase in personal distress that results in an emergency for the client and/or the client's environment are eligible.

Individuals in crisis who require this service may commonly be using substances during the crisis.

Substance use should be recognized and addressed in an

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Eligibility (Cont'd.)	integrated fashion, as it may add to risk, increasing the need for engagement in care.
Staff Qualifications	CI services shall be rendered by an MHP or a RN within their scope of practice.
Special Restrictions	Telephonic interventions are limited to a maximum of four units per day.
Service Documentation	<p>CI services are not required to be listed on the POC. A CSN must be completed daily on contact and should include the following:</p> <ul style="list-style-type: none"> • The focus of the session or the nature of the crisis • The content of the session • The intervention of the staff • The response of the client to the intervention(s) of the staff • The client's status at the end of the session • The disposition at the end of the session
Billing/Frequency Limits	CI services are billed in units of 15 minutes for a maximum of 20 units per day. Face-to-face interventions may be billed in units of 15 minutes for a maximum of 16 units per day. Telephonic interventions may be billed in units of 15 minutes for a maximum of four units per day.
Billable Places of Service	CI services may be provided at the CMHC, client's home or natural environment, Doctor's office, nursing facility, or outpatient hospital.

MENTAL HEALTH ASSESSMENT BY NON- PHYSICIAN (ASSMT)

Service Description	<p>Mental Health Assessment by a Non-Physician is a face-to-face clinical interaction between a client and an MHP that determines the following:</p> <ul style="list-style-type: none"> • The nature of the client's problems • Factors contributing to those problems • The client's strengths, abilities, and resources to
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SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)	<p>help solve the problems</p> <ul style="list-style-type: none"> • One or more of the client's diagnoses • The basis upon which to develop a POC for a client <p>When a client is unable to supply the information detailed above, the MHP may use this service when securing information from collaterals who have reason to know information pertinent to the status of the client.</p> <p>The Initial Clinical Assessment or comprehensive bio-psychosocial examination must be completed for all clients within the first three non-emergency visits.</p>
Eligibility	<p>All Medicaid clients requesting mental health services, including those who present with co-occurring substance abuse symptomatology, are eligible.</p>
Staff Qualifications	<p>Assessment services shall be rendered by an MHP.</p> <p>Other qualified professional staff time, if used while assisting the MHP, may be added to the MHP's bill time when the other qualified professional participates in the evaluation process. Staff time includes only face-to-face service time.</p>
Service Provision	<p>Assessments may be provided at different times during the treatment, to include:</p> <ul style="list-style-type: none"> • At the beginning of treatment, when the client first requests services at the clinic • At any time during the treatment when it is necessary to ascertain the client's progress, response to treatment, need for continued participation in treatment, or change in behavior and/or condition • At the time of the review of the POC to reassess the client's progress, response to treatment, and need for continued participation in treatment. The reassessment must be documented separately on a CSN and comply with the service documentation requirements. • At the end or termination of treatment, to justify discontinuing treatment • To conduct a court-ordered evaluation and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Provision (Cont'd.)

designated examinations that meet Medicaid reimbursement requirements

- For screening a client for placement in an outpatient setting, only once per inpatient admission to a general hospital, to assess the services necessary for the client's treatment modality after discharge

Assessment Components

The following activities are considered an assessment:

- **Initial Clinical Assessment or Comprehensive Bio-psychosocial Evaluation** that is conducted at the beginning of treatment when a client first request services: It serves as the basis for the POC and includes a clinical history, as well as any substance abuse history. The service establishes one or more diagnoses and the medical necessity of treatment.
- **Psychological Testing** conducted by a psychologist or MHP within the scope of their qualifications: This test is used to assess the client's interests, ability, personality, or level of function as related to the medical and/or psychiatric diagnosis.
- **Integrated Substance Use Disorder Assessment** that provides the MHP with past patterns of substance use. This assessment includes the following:
 - o When the substance disorder occurred in relation to the mental health symptoms
 - o The specific abuse or **dependence diagnoses**
 - o **An identification of periods of abstinence** or reduced use
 - o A description of mental health symptoms, functioning, and treatment
 - o Successful substance treatment during those periods
 - o The client's current patterns of use, diagnoses, treatment participation, withdrawal risk, and the impact of substance use on the client's current mental health symptoms

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PROGRAM SERVICES

Assessment Components (Cont'd.)

- **Diagnostic Interview** that is conducted at the beginning of treatment or at any other time during treatment as deemed necessary by members of the treatment team: It is used to clarify a diagnosis or diagnoses and plan a course of treatment.

Service Documentation

Mental Health Assessment is not required to be listed on the POC, but shall be documented daily upon contact.

Billing/Frequency Limits

Assessment services are billed in units of 30 minutes for a maximum of eight units a day.

Billable Places of Service

Assessment services may be provided in a client's home or natural environment, an inpatient hospital, nursing facility, or a CMHC.

INDIVIDUAL THERAPY (IND. TX.)

Service Description

Individual Therapy involves face-to-face, planned therapeutic interventions. These interventions focus on the enhancement of a client's capacity to manage his or her emotions and behaviors through effective decision making, developing and acquiring coping skills, making better choices and decisions regarding co-occurring substance abuse, achievement of personal goals, and development of self-confidence and self-esteem.

Individual Therapy may be psychotherapeutic and/or therapeutically supportive in nature. The client's needs and diagnosis – including substance abuse, strengths, and resources – determine the extent of the issues addressed in treatment, as well as the psychotherapeutic modalities used by the clinician.

Individual Therapy is directed toward the solution of problems and learning new adaptive behavior. Psychotherapeutic modalities include, but are not limited to, non-experimental therapies such as cognitive, dynamic, behavioral, humanistic, existentialist, psychoanalytical, and other recognized specialized psychotherapeutic practices. Individuals with severe disabilities are likely to benefit from interventions that are cognitive and behavioral in nature but are simplified to accommodate their level of functioning. Interventions should also be designed to

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)	<p>achieve specific behavioral targets, such as improving medication adherence or reducing substance abuse.</p> <p>This service does not include educational interventions without therapeutic process interaction or any experimental therapy not generally recognized by the profession.</p>
Eligibility	<p>All clients who physicians, within the scope of their clinical practice, believe would benefit from this service are eligible, including those with co-occurring disorders.</p> <p>Clients who are able to engage in personal exploration and who have no, or minimal, impairment of cognitive functions will benefit from more dynamic psychotherapeutic interventions. As noted above, clients with more severe cognitive disabilities will benefit from more cognitive and behavioral interventions with emphasis on decisions, choices, and skills.</p> <p>Clients experiencing an acute crisis or those with severe mental illness who need ongoing support are good candidates for supportive psychotherapy. These clients may also benefit from learning new skills that help them to manage the crisis and prevent recurrence.</p>
Staff Qualifications	Individual Therapy shall be rendered by an MHP.
Service Documentation	Individual Therapy is required to be listed on the POC with a planned frequency and must be documented daily on contact.
Billing/Frequency Limits	Individual Therapy may be billed in units of 30 minutes for a maximum of six units per day.
Billable Places of Service	Individual Therapy may be provided in a client's home or natural environment, nursing facility, or in a CMHC.
FAMILY THERAPY (FAM. TX.)	
Service Description	Family Therapy includes interventions with the client's family unit (<i>i.e.</i> , immediate or extended family or significant others) with or on behalf of a client to restore, enhance, or maintain the function of the family unit.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

Family Therapy promotes and encourages the family support to facilitate a client's improvement. Services include the identification and resolution of conflicts arising in the family environment – including conflicts that may relate to substance use or abuse on the part of the client or family members; and the promotion of the family understanding of the client's mental disorder, its dynamics, and treatment. Services may also include addressing ways in which the family can promote recovery for the client from mental illness and/or co-occurring substance use disorders.

Family Therapy may be rendered to family members of the identified client as long as the identified client is the focus of the session. Only issues pertinent to the active client may be addressed under this service. When the focus changes to a family member other than the client, a new client record must be opened. Within this context, it is appropriate to work within the family to provide motivational and decisional strategies to family members whose substance abuse is adversely affecting the client. The goal of this therapy should be having that family member begin to recognize and address the problem; including, if indicated, seeking treatment for themselves to provide a more supportive environment for the client.

This service does not include educational interventions without psychotherapeutic process interaction or any experimental therapy not generally recognized by the profession.

Eligibility

All clients who physicians, within the scope of their clinical practice, believe would benefit from this service are eligible.

Staff Qualifications

Family Therapy shall be rendered by an MHP.

Service Documentation

Family Therapy is required to be listed on the POC with a planned frequency and documented daily on contact.

Billing/Frequency Limits

Family Therapy may be billed in units of 30 minutes for a maximum of six units per day.

Billable Places of Service

Family Therapy may be provided in a client's home or natural environment, a CMHC, or a general hospital.

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GROUP THERAPY (GP. TX.)

Service Description

Group Therapy involves face-to-face, planned, therapeutic interventions directed toward the restoration, enhancement, or prevention of deterioration of role performance levels. Group Therapy allows the therapist to address the needs of several clients at the same time and mobilize group support for the client. The group therapy process provides commonality of client therapy experience and utilizes a complex of client interaction under the guidance of a therapist. The participants benefit from a commonality of experiences, ideas, and group support and interaction.

These services can be therapeutic, psychoeducational, or supportive in orientation.

- **Group psychotherapy** is intended to help clients improve and manage their emotions and behaviors. Further, it helps clients change behavior and learn how to cope with problems in their lives, as well as encouraging personal development through the dynamics generated by the group.
- **Stage-specific groups for co-occurring substance use disorders** are an evidence-based, best-practice integrated treatment approach that may be incorporated into any program that offers an array of group services. These motivational or persuasion groups utilize a framework of support of peers to either help the client make better choices and decisions regarding substance use, or help the client develop or maintain skills to reduce or eliminate substance use (active treatment or relapse prevention groups).
- **Medication Compliance Group Therapy** focuses on increasing reality orientation, decreasing disorientation, and improving the physical skills of the client. Issues addressed by this service are:
 - o The orientation of a client to the psychiatric medical prescription and treatment
 - o Increasing client awareness to medication effect

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Service Description (Cont'd.)

- o Concerns for undesirable side effects and the process of their disease through client instruction

Structured activities are the core of this service. These may include medication usage, oral dosage, timing, route, frequency, special instructions and side effects, personal safety when taking medications or experiencing a medical condition, and procedures for increasing compliance with medication.

- **Caregiver Groups** are direct services provided to persons serving in primary caregiver roles for community mental health clients. Caregiver groups are intended to promote effective support from the caregivers to facilitate the improvement and/or recovery of the clients. These groups are psychoeducational in nature. They provide information and education to the participants about the nature of the severe mental illness or serious emotional disturbance that the clients experience. They allow and promote the participants to process the information, ventilate their feelings, share their experiences in caring for the clients, and receive support from the group.
- **Multiple Family Group Therapy** is directed toward the restoration, enhancement, or prevention of deterioration of role performance of families. Multiple Family Group Therapy allows the therapist to address the needs of several families at the same time and mobilizes group support for the families. The Multiple Family Group Therapy process provides commonality of Family Therapy experience – including experiences with co-occurring substance use disorders – and utilizes a complex of family interaction under the guidance of a therapist. The intended outcome of such family-oriented, psychotherapeutic services is the management, reduction, or resolution of the identified mental health problems, thereby allowing the client/family units to function more independently and competently in daily life.

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Special Restrictions	<p>This service does not include educational interventions that do not include psychotherapeutic process interactions, or experimental therapy not generally recognized by the profession.</p> <p>Caregiver and Multiple Family Therapy Groups are rendered to caregivers or family members of the identified client as long as the identified client is the focus of the session. Both caregiver and staff must be actively involved in the group during the time to be billed.</p>
Eligibility	<p>All clients who physicians, within the scope of their clinical practice, believe would benefit from this service, including those who may have co-occurring substance use disorders, are eligible. The eligibility of participants for group, versus individual, therapy is the same. The advantage of the group over individual therapy is the commonality of experiences shared by the participants and the support received by the group. Further, when interpersonal relations play a role in triggering, maintaining, or worsening the client's symptoms and problems, group therapy may be more effective than individual therapy. Group interventions have been demonstrated to have particular value for individuals with co-occurring disorders.</p> <p>Caregivers or family members of Medicaid eligible clients are also eligible to participate in either Caregiver Groups or Multiple Family Group Therapy as deemed appropriate by the physicians, within the scope of their clinical practice.</p>
Staff Qualifications	<p>Group Therapy shall be rendered by an MHP.</p> <p>A RN or bachelor's level qualified professional may be privileged to provide caregiver groups or medication compliance groups, only under the supervision of an MHP and with appropriate training. A Licensed Practical Nurse (LPN) under the supervision of an MHP may be privileged to provide Medication Compliance Group Therapy.</p>
Staff-to-Client Ratio	<p>The staff-to-client ratio requires one staff member and a group of up to 12 clients, or groups of up to six family units, but no more than 12 family members per group.</p>
Service Documentation	<p>Group Therapy is required to be listed on the POC with a planned frequency and documented daily on contact.</p>

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Billing/Frequency Limits	For Caregiver Groups, both caregiver and staff must be actively involved in the group during the time to be billed. Group Therapy is billed in unit increments of 30 minutes for a maximum of eight units per day.
Billable Places of Service	Group Therapy may be provided at a CMHC, nursing facility, or other approved community mental health facility.

BEHAVIORAL HEALTH SCREENING (ALCOHOL/DRUG) BHS

Service Description	<p>The purpose of this service is to provide early identification of behavioral health issues and to facilitate appropriate referral for a focused assessment and/or treatment. Behavioral Health Screening is a process designed to quickly assess the severity of behavioral health issues and/or substance use and to identify the appropriate level of treatment for individuals who have and/or are at risk of developing a behavioral health or substance use problem.</p> <p>This service requires completion of a valid, brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized, DHHS approved tool, through interviews or self-report. Some of the common tools used for screenings are GAIN, AUDIT, ASSIST, DAST, ECBI, SESBI, CIDI. Screenings should be scored utilizing the tool's standardized scoring methodology and referrals made based on the interpretation of the results.</p> <p>Screenings should focus on patterns of behavior and associated factors such as legal problems, mental health status, educational functioning, and living situation. The client's awareness of the problem, feelings about his or her behavior, mental health or substance use and motivation for changing behaviors may also be integral parts of the screen. Prior to the screening, attempts should be made to determine whether another screening had been conducted in the last 30 days. If a recent screening has been conducted, efforts should be made to access those records. A screening should be repeated, only if a significant change in behavior or functioning had been noted.</p>
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Service Description (Cont'd.)	<p>This screening creates a professional, helping atmosphere while gaining client information that will be used to make an appropriate referral, utilizing minimal client/staff time. The service is intended to encourage individuals to change their behavior and refers them for further assessment and/or treatment as appropriate.</p> <p>A positive screen results in a brief intervention or a referral for behavioral health or substance use treatment.</p>
Eligibility	<p>All Medicaid eligible beneficiaries are eligible for this service.</p>
Staff Qualifications	<p>Behavioral Health Screening must be provided by qualified clinical professionals who have been specifically trained to review the screening tool and determine the level of referral.</p>
Service Documentation	<p>Behavioral Health Screenings should be documented upon contact with the client. The completed screening tool and its interpretation results must be filed in the client's record within three working days from the date of the service. Documentation must include the outcome of the screening and support the number of units billed.</p>
Billing/Frequency Limits	<p>Behavioral Health Screening is billed in unit increments of 15 minutes for a maximum of two units per day.</p>
Billable Places of Service	<p>Behavioral Health Screenings may be provided in a community mental health center, substance abuse facility, office, an inpatient or outpatient general hospital, or an approved community setting.</p>

MH SERVICE PLAN DEVELOPMENT BY NON- PHYSICIAN

Service Description	<p>MH Service Plan Development by Non-Physician is a face-to-face or telephonic interaction between a physician and a Mental Health Professional (MHP) or Registered Nurse (RN) to jointly assess the client's mental and physical strengths, weaknesses, social history, and support systems; and to establish treatment goals and treatment services to reach those goals.</p>
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Eligibility	All clients are eligible for MH Service Plan Development by Non-Physician.
Staff Qualifications	A physician, MHP or a RN may render this service.
Service Documentation	<p>The CSN shall document the physician and MHP/RN's involvement in the following:</p> <ul style="list-style-type: none"> • The development, staffing, review and monitoring of the POC • Outcome data as it impacts diagnosis, treatment discharge plans, frequency and focus of types of service (may include progression through stages of change reduction in use, reduction in risky or harmful behavior associated with use, reduction in acute service utilization, as well as achievement of abstinence if the client has a co-occurring disorder) • Confirmation of medical necessity • Establishment of one or more diagnoses, including co-occurring substance abuse or dependence if present • Recommended treatment <p>The MHP/RN and the physician are required to sign and date the CSN corroborating the delivery of the service.</p>
Service Content	<p>MH Service Plan Development by Non-Physician is the joint interaction between a physician and MHP or a physician and a RN, designed to:</p> <ul style="list-style-type: none"> • Assess the client's mental and physical history, mental status examination, symptoms, strengths, weaknesses, social history and support systems, etc. • Establish treatment goals and treatment services to reach these goals <p>The physician shall establish one or more diagnoses, including co-occurring substance abuse or dependence if present; confirm medical/psychiatric necessity of treatment; determine the appropriateness of treatment services – including the need for integrated treatment of co-occurring disorders; and upon periodic review, determine progress towards goals and justify continuation of treatment.</p>

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Service Content (Cont'd.)	The MHP and/or RN shall provide multidisciplinary input and assure effective linkage and continuity of care.
Billable Places of Service	MH Service Plan Development by Non-Physician may be provided at the community mental health center, inpatient hospital or other approved community mental health facility.
Billing/Frequency Limits	MH Service Plan Development by Non-Physician is billed in unit increments of 15 minutes for a maximum of two units per day.

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