

July 31, 2007

MHRC-MHC 07-12

MEDICAID BULLETIN

TO: Community Mental Health Services Providers

SUBJECT: Policy Revisions to the Medicaid Manual for Community Mental Health Services (CMHS)

This bulletin transmits additions to and changes in existing policy requirements for providers of Community Mental Health Services effective **August 1, 2007**.

The following revisions have been made to **Section 2** of the Community Mental Health Services Manual:

1. Under Physician Responsibilities, the following language has been added: Targeted Case Management (TCM) may be provided as a stand-alone service. Clients receiving only TCM, Case Management and/or Mental Health Assessment by a Non-Physician are not required to see a physician.
2. In addition, the definition of a Non-Mental Health Professional (Non-MHP) has been revised to state that a Non-MHP 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. Also, they must have completed an approved curriculum program as specified by the authorizing community mental health service provider. Language has been updated to reflect this change throughout **Section 2** of the manual.
3. The definition for Non-Lead Clinical Staff as listed in the Mental Health Services Not Otherwise Specified Staff Qualifications, has also been added under the Lead Clinical Staff section.
4. Under the Plan of Care (POC) Section, the following language has been added: 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 Plan of Care is required. The signature of a physician is required to confirm the diagnosis, the medical necessity of the treatment and the appropriateness of care. This language has also been added to the POC Requirements and Physician Signature on the POC sections of this manual.
5. Under the POC Requirements section:
 - The third bullet of number 4 (Clinical interventions that are appropriate to achieve the objectives) has been deleted. This information should be evident in the clinical documentation, but is not a required part of the POC.

- Under the POC Requirements (Continued), the language in item number 5 has been revised to state: 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. Under the Addendum POC/Goal Sheet section, language has been revised to state that Addendum POC/Goal sheet(s) must accompany the existing POC.
- 7. Under the Progress Summaries section, the following language has been added to clarify policy requirements for progress summaries: For new clients entering services, the process of assessment and treatment planning culminating with the initial Plan of Care may satisfy the requirement for the first 90-day progress summary. For these clients, a distinct Progress Summary is required within at least 180 calendar days from the date clients begin receiving services. Thereafter, Progress Summaries will be conducted every 90 days and must be summarized by the MHP and documented in the POC Progress Summary Report.
- 8. Under the POC Review section, language has been revised to add expiration of the treatment period. In addition the following language has been added: Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the POC. However, the signature of the MHP responsible for the review is required.
- 9. Under the Continued Treatment section, the policy has been revised to state that a POC that does not list an effective date will expire in twelve (12) months rather than six (6) months.
- 10. Under the Clinical Service Note Billing Information section, 03 - School has been added as a billable place of service.
- 11. The following policy language has been added for Medical Management Only clients:

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. Services may be provided by physicians, Advanced Practice Registered Nurse (APRNs), and/or Registered Nurses (RNs). The physician must determine that a patient is appropriate for Medical Management level of care.

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

- *Nursing Services*
- *Injectable Medication Administration*
- *Mental Health Assessment by a non-physician*
- *Psychiatric Medical Assessment (PMA)*

- *Psychiatric Medical Assessment Advanced Practice Registered Nurse*
- *Crisis Intervention services (up to two contacts per year)*
- *Targeted Case Management/Case Management*

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 on-going 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 by an APRN.

Participation in the Medication 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 Clinical Service Note must contain the following:

- *Intervening services since the last PMA*
- *Assessment of whether the client is meeting his/her goal(s) and any desire to change the goal(s). Example of goals may include "take my medicine and stay out of the hospital" or "continue to work" or "continue to take care of my family" or "not hear voices" or "learn more about my medicine."*
- *Indication of any change in client's goal(s) and that client verbally agrees to continue in this level of care*
- *Justification for 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 an RN during the preceding 90-day period, and does not have sufficient clinical information to evaluate the treatment prescription, a progress summary 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 policy, 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.

12. Under the Service Documentation section of Nursing Services a heading for Medication Monitoring has been added to clarify the additional documentation requirements when Medication Monitoring is provided.
13. Under the Definition of the Crisis Intervention Service, language has been added to clarify that face-to-face interventions must be provided "with the client."
14. Under the Crisis Intervention Mental Health Service, the policy has been revised to allow Psychiatric Medical Assessment to be billed as a separate service.

The following language has been added to the Comprehensive Community Support standard: For services rendered to clients that are residing in a Community Residential Care Facility, activities must be above and beyond structured activities required daily by the Department of Health and Environmental Control (DHEC) licensure requirements. This delineation must be clearly defined, documented and accessible in the client record.

15. The billing/frequency limit for Comprehensive Community Support has been changed from 48 units per day to 32 units per day.
16. Under the Service Documentation section of Behavioral Health Prevention Education Services, the following language has been added: Documentation must be placed in the medical record within 5 working days from the date of service.

Should you wish to order a printed copy of your provider manual, or a replacement compact disk, please call the South Carolina Medicaid Provider Outreach at (803) 264-9609. Charges for printed manuals are based on actual costs of printing and mailing. The manual is also available on the South Carolina Department of Health and Human Services web site www.scdhhs.gov and click on "Provider Manuals" under the heading "Providers."

Questions regarding this bulletin should be directed to your program representative at (803) 898-2565. Thank you for your continued support of the South Carolina Medicaid Program.

/s/

Susan B. Bowling
Acting Director

SBB/mmj

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