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**POLICIES AND PROCEDURES**

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## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### OVERVIEW

Effective July 1, 2010, the South Carolina State Medicaid Plan was amended to allow an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130,(d). Rehabilitative Services are medical or remedial services that have been recommended by a physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South Carolina State Law and as further defined by SCDHHS for maximum reduction of a physical or mental disability and restoration of a beneficiary to their best possible functional level.

The purpose of this manual is to provide pertinent information to Rehabilitative Behavioral Health Service (RBHS) providers for successful participation in the South Carolina Medicaid program. This manual provides a comprehensive overview of the RBHS policy and procedure for licensed independent practitioners rendering behavioral health services.

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 “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. Evidence-based practices are defined as preferential use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. The National Registry of Evidence-based Programs and Practices and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

RBHS is available to all Medicaid beneficiaries with a behavioral health disorder, as defined by the current edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (DSM) or the

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### PROGRAM REQUIREMENTS

#### OVERVIEW (CONT'D.)

*“International Classification of Diseases” (ICD)* who meet medical necessity criteria. Rehabilitative Services are provided to, or directed exclusively toward the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

This section describes these services, legal authorities, and the characteristics of the providers of services. To participate in the South Carolina Medicaid program, LIP providers of RBHS must meet appropriate state licensure and general requirements outlined in this section. This manual describes three different options under which LIP providers may receive RBHS referrals and service authorizations.

RBHS services must be determined medically necessary to be eligible for Medicaid reimbursement and some services must be authorized prior to service delivery.

The requirements for prior authorization are articulated later in this section. Failure to obtain authorization prior to provision of service when required will result in non-payment.

**Enrollment in the Medicaid program does not provide a guarantee of referrals or a certain funding level. Failure to comply with all Medicaid policy requirements may result in termination of Medicaid enrollment.**

**As a condition of participation in the Medicaid program, the provider must ensure that adequate and correct fiscal records shall be kept to disclose the extent of services rendered and ensure that claims for funds are in accordance with all applicable laws, regulations, and policies.**

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

## PROGRAM REQUIREMENTS

### PROVIDER QUALIFICATIONS

In addition to the conditions for participation in the Medicaid program outlined in Section 1, the following licensed independent practitioners allowed by South Carolina State Law to practice independently are eligible to enroll directly with the Medicaid program:

- **A Licensed Psychologist** with the following qualifications:
  - Ph.D. or Psy.D. from an accredited college or university
  - A valid and current professional license with a specialty in Clinical, Counseling, or School Psychology as approved by the South Carolina Board of Examiners in Psychology
- **A Licensed Psycho-Educational Specialist** with the following qualifications:
  - Master's, specialist, or doctorate degree from a degree program approved by the National Association of School Psychologists or the American Psychological Association or from a degree program that the Board finds to be substantially equivalent based on criteria established by the South Carolina Board in regulation
  - Certified by the South Carolina Department of Education as a school psychologist level II or III and served successfully for at least two years as a certified school psychologist in a school psychology or comparable setting (at least one year of which must have been under the supervision of a licensed psycho-educational specialist) and a satisfactory score on PRAXIS Series II exam
  - A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### PROVIDER QUALIFICATIONS (CONT'D.)

- **A Licensed Independent Social Worker-Clinical Practice (LISW-CP)** with the following qualifications:
  - Master's or doctorate degree from a board-approved social work program
  - One year of experience working with the population to be served
  - A valid and current professional license as approved by the South Carolina Board of Social Work Examiners
- **A Licensed Marriage and Family Therapist (LMFT)** with the following qualifications:
  - Master's, specialist, or doctorate degree from a degree program accredited by the Commission on Colleges of the Southern Association of Colleges and Schools, one of its transferring regional associations, the Association of Theological Schools in the United States and Canada, a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education, or a regionally-accredited institution of higher learning
  - A minimum of 48 graduate semester hours or 72 quarter hours in Marriage and Family Therapy.
  - A minimum of three semester hour graduate level courses with a minimum of 45 classroom hours or 4.5 quarter hours for each course. One course cannot be used to satisfy two different categories.
  - A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists
- **A Licensed Professional Counselor (LPC)** with the following qualifications:
  - A minimum of a 48 hour master's degree or higher in counseling or in a related discipline
  - All coursework, including any additional core coursework, must be taken at a college or university accredited by the Commission on the

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### PROVIDER QUALIFICATIONS (CONT'D.)

Colleges of the Southern Association of Colleges and Schools, or one of its transferring regional associations; or the Association of Theological Schools in the United States and Canada; or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education; or a regionally accredited institution of higher learning subsequent to receiving the graduate degree

- o A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists

LIP providers of RBHS must fulfill all the requirements for South Carolina licensure and/or certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation.

Professionals with appropriate education and experience who have passed prerequisite examinations as required by the applicable state laws and licensing and/or certification board and additional requirements as may be further established by SCDHHS, may qualify to provide RBHS according to the policy herein.

The presence of licensure and/or certification means the established licensing board in accordance with South Carolina Code of Laws has granted the authorization to practice in the state. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State of South Carolina and must be operating within their scope of practice.

#### LIP Enrollment Guidelines

All Medicaid Provider Enrollment is completed through an online enrollment application process. Please refer to the resources available on the Provider Enrollment webpage at <https://www.scdhhs.gov/ProviderRequirements> for complete instructions. Prior to completing the online Enrollment application, LIP applicants must complete the following steps to become enrolled as a Medicaid provider:

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### LIP Enrollment Guidelines (Cont'd.)

1. Obtain a National Provider Identifier (NPI) number. An NPI number is required to enroll directly with the Medicaid program. Information about the NPI number is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <https://nppes.cms.hhs.gov>.
2. Register for the Pre-Enrollment Orientation at <https://training.scdhhs.gov/academy/course/view.php?id=5>. The pre-enrollment orientation is available online 24 hours per day, seven days per week. The orientation is designed to provide the LIP with knowledge about RBHS policy and procedures and prevent potential Medicaid recoupment as a result of a post payment review. Following the orientation, the LIP will be prompted to complete a questionnaire.
3. Complete the online Provider Enrollment application. On the application, providers must select "New Enrollment" and the following options depending on whether enrolling an individual or a group:

<b>LIP Enrollment Options - Individual</b>	
<b>Enrollment Type</b>	Individual
<b>Provider Type Description</b>	Other Medical Professionals
<b>Specialty Description</b> <i>(Select only one specialty.)</i>	LISW-CP, LPC, LMFT, LPES, or Psychologist
<b>Subspecialty Description</b>	No Subspecialty

LIP group practices must enroll separately and receive a Medicaid Group Legacy ID number. Please refer to the Provider Enrollment Manual for information on fees associated with this type of enrollment. Each LIP wishing to render Medicaid reimbursable services through a group practice must also be enrolled individually with Medicaid and can affiliate themselves during their online application process with a currently enrolled group practice.

To enroll as a LIP Group, select "New Enrollment and the following options:

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

**LIP Enrollment Guidelines  
(Cont'd.)**

LIP Enrollment Options – Organization	
<b>Enrollment Type</b>	Organization
<b>Provider Type Description</b>	Groups
<b>Specialty Description</b> <i>(Select only one specialty.)</i>	LISW-CP, LPC, LMFT, LPES, Psychologist, or Multiple Specialty Group
<b>Subspecialty Description</b>	No Subspecialty

Entering the Medicaid Group NPI number on the Medicaid billing form (CMS-1500) will ensure that payment is made to the group rather than to the individual LIP.

Please refer to Section 3 of this manual for instructions regarding billing procedures.

**MANAGED CARE ORGANIZATIONS**

Effective April 1, 2012, behavioral health services are covered for beneficiaries enrolled in Medicaid Managed Care Organizations (MCO). If the beneficiary is enrolled in a Medicaid MCO the provider must request prior authorization and claim reimbursement from the MCO directly. The policy herein does not apply to services covered by an MCO. Providers are encouraged to visit the SCDHHS Web site at <https://msp.scdhhs.gov/managedcare/> for additional information regarding MCO coverage.

**Billing Requirements**

LIPs may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Medicaid will generally pay the lower of the established Medicaid reimbursement rate.

**Quality Improvement Organization (QIO) — Physician and Self-Referrals Process**

Medicaid Fee-for-Service beneficiaries must receive prior authorization from a Quality Improvement Organization (QIO) and reimbursement from SCDHHS.

SCDHHS contracts with a Quality Improvement Organization (QIO) for utilization review and prior authorization services. The current QIO is Keystone Peer Review Organization, Inc. (KEPRO). No prior authorization is necessary for Behavioral Health Screening, Comprehensive Assessment (initial or follow up), Service Plan Development, or Crisis Management. Please refer to

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Quality Improvement Organization (QIO) — Physician and Self-Referrals Process (Cont'd.)

Section 4 of this manual for frequency limits for these services.

The following services may be authorized by the QIO to the enrolled LIP once medical necessity has been established:

- Psychological Testing and Evaluation
- Psychotherapy
- Group Psychotherapy
- Family Psychotherapy

The LIP should use the SCDHHS LIP Prior Authorization Request Form (located in the Forms section of this manual) to request prior authorization for the above services. For initial requests, the Comprehensive Assessment, which documents medical necessity, should be submitted along with this form. For Psychological Testing and Evaluation, please provide the reason for testing and the referral source (physician, school, LPHA, etc.).

If the initial number of visits authorized is deemed inadequate to address the identified goals, reauthorization of services will be required. For Continued Treatment Review, the most recent Individualized Plan of Care and Progress Summary should be submitted with the SCDHHS LIP Prior Authorization Request Form. Continued Treatment requests must be submitted two weeks prior to the expiration of authorized visits. Failure to obtain reauthorization prior to the provision of services will result in recoupment of payment.

To receive reimbursement from Medicaid, all prior authorization requests must be submitted to KEPRO using one of the following methods:

Fax: 1-855-300-0082

Web Portal: <http://scdhhs.kepro.com>

If the authorization request is approved by KEPRO, the LIP will be notified via QIO approval letter and prior authorizations will only be indicated for a six-month period. If using the web portal, the LIP must download the approval document(s). The approval document(s) must be placed in the beneficiary's clinical record prior to or at the time of the appointment for treatment. A faxed copy is acceptable.

The LIP provider may contact KEPRO using one of the following methods:

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Quality Improvement Organization (QIO) — Physician and Self-Referrals Process (Cont'd.)

Customer Service: 1-855-326-5219  
 Fax: 1-855-300-0082  
 Provider Issues Email: [atrezzoissues@Kepro.com](mailto:atrezzoissues@Kepro.com)

LIP providers must ensure that only authorized amounts of services are provided and submitted for reimbursement and that all services are provided in accordance with all SCDHHS policy requirements. If SCDHHS or its designee determines that services were reimbursed when there was not a valid QIO approval letter in the beneficiary's file, the provider payments will be subject to recoupment.

#### QIO Approval Letter

The QIO must include the following information on the approval letter:

- The beneficiary's Medicaid member number
- The LIP's name
- The LIP's NPI number
- The Prior Authorization number assigned by the QIO which is mandatory for billing purposes
- The authorization (beginning) date and the expiration (ending) date, which establishes the treatment period
- The specific service(s) authorized to be provided
- The maximum authorized amount (number of units)

#### Requirements for Participation in Rehabilitative Behavioral Health Services

LIPs or group providers are responsible for ensuring that all professionals rendering RBHS must maintain current licensure and appropriate standards of conduct. While the group may receive Medicaid payments, the individual practitioner who rendered the service directly to a beneficiary is responsible for ensuring the quality and extent of services delivered.

Providers must have a policy for definition of confidentiality issues, record security and maintenance, consent for treatment, release of information, beneficiary's rights and responsibilities, retention procedures, and code of ethics.

#### Business Termination Guidelines

In the event the LIP provider closes his or her practice, the provider will adhere to all of the following applicable state laws, rules and regulations:

- In cases of voluntary termination or closure, the provider shall provide written notification 30 days

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Business Termination Guidelines (Cont'd.)

- prior to the closure to SCDHHS and other appropriate agencies.
- Notification shall include the location where beneficiary and administrative records will be stored.
  - The responsible party must retain administrative and beneficiary records for five years.
  - Prior to closure, the LIP provider will notify all beneficiaries and assist them with locating appropriate service providers.
  - When a provider closes, the owner is responsible for releasing records to any beneficiary who requests a copy of his or her records. The owner is also responsible for the transfer of records to the appropriate state agencies if applicable.
  - Even if a provider closes, the provider may be responsible for repayment of any overpayments that occurred during the time the provider rendered treatment to Medicaid beneficiaries.
  - If the provider is terminated involuntarily by Medicaid, the provider is responsible for all beneficiary and administrative records in the event of a post-payment review.

#### ELIGIBILITY FOR SERVICES

The determination of eligibility for RBHS should include a comprehensive assessment or evaluation of the beneficiary.

Unless otherwise specified in the specific service description, Medicaid-eligible beneficiaries may receive RBHS when there is a primary psychiatric diagnosis from the current edition of the DSM and/or ICD, (excluding irreversible dementias, intellectual disabilities or related disabilities, developmental disorders, unless they co-occur with a serious mental disorder that meets current edition DSM criteria) and services are determined medically necessary. Developmental disabilities should not be confused with mental disorders. Persons with a developmental disability should be carefully assessed to determine if there are co-occurring behavioral problems and if those problems could be addressed with RBHS. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of RBHS.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### ELIGIBILITY FOR SERVICES (CONT'D.)

Providers are strongly encouraged to verify current eligibility status prior to service delivery. Gaps in Medicaid eligibility may result in a referred beneficiary being ineligible for Medicaid coverage at the time of treatment. Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing a Point of Sale (POS) device, the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool), or an eligibility verification vendor. Additional information on these options is in Section 1 of this manual.

#### REFERRAL PROCESS

There are three ways that A LIP may receive a referral to provide services:

1. A Medicaid-enrolled physician may refer an eligible beneficiary to the LIP via the SCDHHS Behavioral Health Referral & Feedback Form (located in the Forms section of this manual). To ensure coordination of care, the feedback portion of this form should be completed by the LIP and returned to the referring physician within 30 calendar days of the assessment date. There is no prior authorization needed for the LIP to conduct a Comprehensive Assessment.
2. A state agency can provide a referral. If the state agency is making a referral to a LIP, they may furnish the receiving provider the assessment, IPOC, list of services to render, and any other clinical documentation. To ensure coordination of care, the completed clinical service notes must be forwarded to the state agency by the referring entity.
3. An eligible Medicaid beneficiary may self-refer for RBHS provided by a LIP. There is no prior authorization needed for the LIP to conduct a Comprehensive Assessment in order to determine medical necessity for RBHS services.

**Note:** Referrals (provider-to-provider or self-referred) can be done via phone, email, fax, and hard copy mail. Providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MEDICAL NECESSITY

RBHS must be medically necessary to be covered under the Medicaid program. Medical necessity means the need for treatment services is necessary in order to diagnose, treat, cure, or prevent an illness, or which may reasonably be expected to relieve pain, improve and preserve health, or be essential to life.

All Medicaid beneficiaries must meet specific medical necessity criteria in order to receive RBHS services.

#### Documenting Medical Necessity

RBHS must be medically necessary to be covered under the Medicaid program. Medical necessity means the need for treatment services is necessary in order to diagnose, treat, cure, or prevent an illness, or which may reasonably be expected to relieve pain, improve and preserve health, or be essential to life.

All Medicaid beneficiaries must meet specific medical necessity criteria in order to receive RBHS services.

When an assessment has not been received, the LIP must certify and document through a Comprehensive Assessment that the beneficiary meets the medical necessity criteria for services. The following guidelines shall be used to determine medical necessity:

- Medical necessity must be based on information provided by the beneficiary, their family, or others who are familiar with the beneficiary.
- Medical necessity must be based on current clinical information. If the diagnosis has not been reviewed in a 12-month or more period of time, the diagnosis must be confirmed immediately.
- Medical necessity must be made within SCDHHS's standards for timeliness.

#### **For dates of service on or before September 30, 2015**

- Medical necessity based on V-codes is allowed but is considered temporary and may not be used for longer than six-month duration. V-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. V-codes may not be used for ages 7 and up for longer than six-month

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Documenting Medical Necessity (Cont'd.)

duration. The use of V-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

#### **For dates of service on or after October 1, 2015**

- Medical necessity based on Z-codes is allowed but is considered temporary and may not be used for longer than six-month duration. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. Z-codes may not be used for ages 7 and up for longer than six-month duration. The use of Z-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

Once a referral is received, the LIP shall conduct a Comprehensive Assessment in order to:

- Establish one or more diagnoses, including co-occurring substance use or dependence if present in accordance with the current edition of the ICD
- Determine the appropriateness of treatment services, including the need for integrated treatment of co-occurring disorders
- Upon periodic review, determine progress towards goals and justify continuation of treatment
- Confirm medical and/or psychiatric necessity of treatment

In order to document medical necessity, the Comprehensive Assessment must include the following information and must be maintained in the beneficiary's clinical record:

- The beneficiary's name, date of birth and Medicaid member number or social security number. The state agency or referring physician must furnish the Medicaid member number to the LIP provider.
- A psychiatric diagnosis from the current edition of the DSM or the ICD (excluding irreversible dementias, intellectual disabilities or related disabilities, developmental disorders, unless they co-

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Documenting Medical Necessity (Cont'd.)

occur with a serious mental disorder that meets current edition DSM criteria)

- Identification of the beneficiary's problem areas and specific treatment goals that need to be addressed by the service provider
- The LIP's name, professional title, signature, and date
- All required components as listed in "Core Rehabilitative Behavioral Health Service Standards" in this section.

Medical necessity is valid for 12 months and must be confirmed annually if the beneficiary needs continuing rehabilitative service(s). The initial signature date on the Comprehensive Assessment stands as the date to be used for all subsequent annual confirmations.

The diagnostic assessment must include the date of admission to the program. The diagnostic assessment must be completed within 14 calendar days of the admission to the program.

The IPOC must be completed within 45 calendar days of the admission to the program.

If the beneficiary has not received RBHS for 45 **consecutive** calendar days, the medical necessity must be re-established by completing a follow-up assessment and/or IPOC.

If SCDHHS or its designee determines that services were reimbursed when there was no valid medical necessity components listed in the assessment and/or IPOC the provider payments will be subject to recoupment.

#### Retroactive Coverage

When a beneficiary receives retroactive Medicaid coverage, the QIO approval letter must be provided to the LIP provider within 10 business days from the date of the Medicaid eligibility determination.

For beneficiaries receiving retroactive coverage, all other Medicaid service and documentation requirements must be met in order to receive Medicaid reimbursement for the covered period.

#### MAINTENANCE OF LIP CREDENTIALS

All LIP providers must be properly qualified and trained and must comply with all other applicable state and federal requirements.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MAINTENANCE OF LIP CREDENTIALS (CONT'D.)

LIP providers must maintain and make available upon request, appropriate records and documentation of such qualifications, trainings and investigations. If these records are kept in another location or a central corporate office, the LIP will be given five business days to retrieve the records for the agency that is requesting them.

LIP(s) shall ensure that all interns, and other individuals that require supervision, and are under the authority of the provider who come into contact with beneficiaries are properly qualified, trained, and supervised.

All Medicaid enrolled groups must maintain a file substantiating each practitioner's qualifications and training. This shall include employer verification of the LIP's licensure and work experience. The group must maintain a signature sheet that identifies all professionals providing services by name, signature, and initial.

In addition to documentation of LIP credentials and training, the group must keep the following specific documents on file:

- A completed employment application form
- Copies of advanced degrees
- A copy of all applicable licenses
- Letters or other documentation of verification of previous employment/volunteer work to document experience with the population to be served
- A copy of the individual's criminal record check form from an appropriate law enforcement agency. The criminal record check must be updated annually
- Verification must be updated annually from the child abuse registry that there are no findings of abuse or neglect against the individual
- Verification must be updated annually from the state and national sex offender registries that there are no findings of sexual charges against the individual

LIP(s) must be licensed to practice in the state where they are providing services and must **not exceed their licensed scope of practice under state law.**

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#### EMERGENCY SAFETY INTERVENTION

The Emergency Safety Intervention (ESI) policy applies to any community-based provider(s) that has policies prohibiting the use of seclusion and restraint but who may have an emergency situation requiring staff intervention.

Providers must have a written policy and procedure for emergency situations and must ensure that the practitioners are trained and prepared in the event of an emergency situation.

If the provider intends to use restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring beneficiary safety. For more information on selecting training models, see Section 7 of the *Project Rest Manual of Recommended Practice*, available at <http://www.frdsn.org/rest.html>.
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion or restraints are being used that adheres to all state licensing laws and regulations (including all reporting requirements).

Failure to have these policies and staff training in place at the time services are rendered will result in termination from the Medicaid program and possible recovery of payments.

#### Staff-to-Beneficiary Ratio

Staff-to-beneficiary ratios are established for safety and therapeutic efficacy concerns. Ratios must be met and maintained at all times during hours of operation.

Staff should be in direct contact and be involved with the beneficiary during service delivery. Ratios must be maintained in accordance with the requirements of each individual service description array.

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### PROGRAM REQUIREMENTS

**Out of Home Placement** Rehabilitative Behavioral Health Services in this manual are intended to be delivered in an outpatient and community setting only. In accordance with the Code of Federal Regulations, 42 CFR 435.1009-1011, RBHS is not available for beneficiaries residing in an Institution of Mental Disease. Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive an all-inclusive, per diem rate for services. RBHS provided to beneficiaries in these settings are not Medicaid reimbursable.

**Transition/Discharge** The authorizing entity is responsible for determining the duration of treatment based on the individual needs of the beneficiary. Beneficiaries should be considered for discharge from treatment when they meet the following criteria:

- Level of functioning has significantly improved with respect to the goals established in the Individual Plan of Care (IPOC)
- Beneficiary requests discharge (and is not imminently dangerous to self or others)
- Beneficiary requires a higher level of care (*i.e.*, inpatient hospitalization or PRTF)

### CLINICAL RECORDS AND DOCUMENTATION REQUIREMENTS

Each LIP provider shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The beneficiary's name and Medicaid number should be on **all** clinical documentation and billing records. The clinical record must contain documentation sufficient to justify Medicaid reimbursement and should allow an individual not familiar with the beneficiary to evaluate the course of treatment.

The absence of appropriate and complete records may result in recoupment of payments by SCDHHS. An Index as to how the clinical record is organized must be maintained and made available to Medicaid reviewers/auditors at the time of request.

Each provider shall have the responsibility of maintaining accurate, complete, and timely records and should always adhere to procedures to ensure confidentiality of clinical data.

The beneficiary's clinical record must include, at a minimum, the following documentation:

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### CLINICAL RECORDS AND DOCUMENTATION REQUIREMENTS (CONT'D.)

- A Comprehensive Diagnostic Assessment, which establishes medical necessity
- SCDHHS Behavioral Health Referral & Feedback Form, if applicable
- QIO approval letter
- Signed/titled and dated Individual Plan of Care (IPOC), progress summaries, and reformulations
- Signed releases, consents, and confidentiality assurances for treatment
- Signed/titled and dated clinical service notes (CSN)
- Court orders, if applicable
- Copies of any evaluations and or tests, if applicable
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered) if applicable
- Copies of all written reports, and any other documents relevant to the care and treatment of the beneficiary

#### Consent for Treatment

A consent form dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor), or legal representative must be obtained at the onset of treatment from all beneficiaries and placed in the beneficiary's file. If the beneficiary, parent/guardian or legal representative cannot sign the Consent form due to a crisis, and the beneficiary is accompanied by next of kin or responsible party, that individual may sign the Consent form.

If the beneficiary is alone and unable to sign, a statement such as "beneficiary unable to sign and requires emergency treatment" should be noted on the Consent form and must be signed by the LIP. The beneficiary, parent/guardian or legal representative should sign the Consent form as soon as circumstances permit. A new Consent form should be signed, a new service is added, and dated each time a beneficiary is readmitted to services after discharge. Consent forms are not necessary to conduct court ordered examinations. However, a copy of the probate court order must be kept in the clinical record.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Coordination of Care

SCDHHS encourages coordination of care and continued communication between the referring physician or state agency and the LIP. There should be evidence in the record of coordination between the LIP and the referring entity regarding treatment. Interim progress reports should be provided to the referring entity as warranted supporting the ongoing medical necessity of the services rendered. The LIP may provide the referring entity with clinical service documentation describing the services rendered, outcomes achieved, and any recommendation for continued or additional services. These reports are not separately reimbursable but considered part of the beneficiary's overall care.

#### CLINICAL SERVICE NOTES (CSNs)

All Rehabilitative Behavioral Health Services (RBHS) must be documented in clinical service notes (CSNs) upon the delivery of services and filed in the beneficiary's record. Each discrete service should have its own CSN capturing service and bill time. The purpose of the CSN is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status. Documentation must justify the amount of reimbursement claimed to Medicaid.

The documentation for individual, family, and group psychotherapy shall address the following items in order to provide a pertinent clinical description, to ensure that the service conforms to the service description, and to authenticate the charges:

- The specific objective(s) from the IPOC toward which the session is focused
- The structured activities of the beneficiary in the session
- The beneficiary's response to the intervention/treatment
- The specific intervention(s) used
- The beneficiary's progress or lack of progress made in treatment
- Recommendation and future plans for working with the beneficiary

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### CLINICAL SERVICE NOTES (CSNs) (CONT'D.)

Medicaid requires that the LIP provider attest to the accuracy of the diagnoses, treatment modalities, and claims submitted for all Medicaid beneficiaries.

Additionally, the following requirements must be met in order for a LIP to be in compliance with Medicaid documentation policy for RBHS. LIP(s) should review each requirement listed below to ensure that services are not left vulnerable to the recoupment of funds in the event of a Medicaid audit. All CSN's must include:

- The beneficiary's name and Medicaid ID
- Date of service
- Name of the service provided (psychotherapy, family psychotherapy, group psychotherapy, etc.)
- Place of service
- Duration of service (start and end time for each service delivered)
- Separate documentation for siblings
- Documentation must be legible and abbreviations decipherable. If abbreviations are used, the provider must maintain a list of abbreviations and their meanings. This list must be made available to SCDHHS.
- Be typed or handwritten using only black or blue ink
- Be legible and kept in chronological order
- Reference individuals by full name, title and agency/provider affiliation at least once in each note
- Be signed, titled and signature dated (month/date/year) by the LIP responsible for the provision of services. The signature verifies that the services are provided in accordance with these standards
- Be completed and placed in the clinical record following service delivery but no later than five business days from the date of service

All documentation must support the number of units billed.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

**Billing Information/Location of Service** 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:

- 03 – School
- 11 – Doctor’s Office
- 12 – Beneficiary’s Home
- 19 – Off Campus Hospital
- 22 – Outpatient Hospital
- 23 – Emergency Room
- 99 – Other Unlisted

**Record Retention** Clinical records shall be retained for a period of five years. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five-year period, records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the five-year period, whichever is later.

In the event of an entity’s closure, providers must notify SCDHHS regarding storage of and/or access to medical records.

The clinical record must be arranged in a logical order to facilitate the review, copy and audit of the clinical information and course of treatment. Clinical records will be kept confidential in conformance with HIPPA regulations and safeguarded as outlined in Section 1.

Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at <http://scdhhs.gov/contact-us> to request additional information.

All Protected Health Information (PHI) stored on portable devices must be encrypted. Portable devices include all transportable devices that perform computing or data storage manipulation or transmission including, but not limit to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberries, cell phones, portable audio/video devices (such as iPods, MP3 and MP4 players), and personal organizers.

**Abbreviations and Symbols** Abbreviations may be used in the CSN or IPOC. Service providers shall maintain a list of abbreviations and symbols used in the clinical documentation which leaves no doubt as

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

<b>Abbreviations and Symbols (Cont'd.)</b>	to the meaning of the documentation. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.
<b>Error Correction</b>	<p>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:</p> <ul style="list-style-type: none"><li>• Draw one line through the error, and write “error,” “ER,” “mistaken entry,” or “ME” to the side of the error in parenthesis. Enter the correction, sign or initial, and date it</li><li>• Errors cannot be totally marked through; the information in error must remain legible</li><li>• No correction fluid may be used</li></ul>
<b>Late Entries</b>	<p>Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in the documentation.</p> <p>Late entries should rarely be used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:</p> <ul style="list-style-type: none"><li>• Identify the new entry as a “late entry.”</li><li>• Enter the current date and time.</li><li>• Identify or refer to the date and incident for which late entry is written.</li><li>• If the late entry is used to document an omission, validate the source of additional information as much as possible.</li><li>• When using late entries, document as soon as possible.</li></ul>
<b>INDIVIDUALIZED PLAN OF CARE (IPOC)</b>	<p>The Individualized Plan of Care (IPOC) is a comprehensive plan of care outlining the service delivery that will address the specific strengths and needs of the beneficiary. The IPOC must be individualized and specify problems to be addressed. Excluding screening, assessment, and crisis services, an IPOC should be developed prior to the delivery of a service with the full participation of the beneficiary and his or her</p>

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### INDIVIDUALIZED PLAN OF CARE (IPOC) (CONT'D.)

family, if appropriate, except in the case of an emergency.

Services required to be on the IPOC may be provided following the completion of the diagnostic assessment. If the IPOC is not completed and signed within 45 days, services rendered are not Medicaid reimbursable. The LIPs signature is required to confirm the appropriateness of care.

The IPOC will be person/family centered and the beneficiary must be given the opportunity to determine the direction of his or her treatment. If reunification or avoidance of removing the beneficiary from the home is a treatment goal, families/legal guardian/representative/primary caregiver must be encouraged to participate in the treatment planning process.

Documentation of compliance with this requirement must be located in the beneficiary's record. If the family/legal guardian/representative/primary caregiver will not be involved in the treatment planning process, the provider must provide justification. Evidence of this justification must be located in the beneficiary's clinical record. For adults, family/legal representative should be included as appropriate.

**The IPOC must contain the signature and title of the LIP and the date signed.** The beneficiary must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC.

If the beneficiary does not sign the IPOC or if it is not considered appropriate for the beneficiary to sign the IPOC, the reason the beneficiary did not sign the IPOC must be documented in the IPOC and clinical record.

The IPOC must address the following:

- Goals and objectives of treatment
- Types of interventions
- Planned frequency of service delivery
- Criteria for achievement
- Estimated duration of treatment
- Long-term or discharge goals

#### INDIVIDUAL PLAN OF CARE (IPOC) DUE DATE

The IPOC must be reviewed and updated as needed according to the beneficiary's progress, but at a minimum every 90 days through the progress summary process

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### INDIVIDUAL PLAN OF CARE (IPOC) DUE DATE (CONT'D)

described later in this section. If the provider determines during treatment that additional services are required, these services should be added to the treatment plan. The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and reformulations.

If the IPOC is not completed and signed within 45 days, services rendered are not Medicaid reimbursable.

#### IPOC Reformulation

A new IPOC must be developed every 12 months. If services are discontinued, the LIP must indicate the reason for discontinuing treatment on the IPOC. The IPOC must include the date it was reformulated, the signature, title and signature date of the LIP. When the IPOC is developed at least two months prior to the expiration date, the new plan is effective with the anniversary date. Please refer to the documentation format example in the Forms section of this manual.

#### Services Not Listed on the IPOC

The following services are not required to be listed on the IPOC: Crisis Management, Service Plan Development, Behavioral Health Screening, Psychological Testing and Evaluation, and Comprehensive Assessment.

#### IPOC Changes

Services added or frequencies of services changed in an existing IPOC must be signed or initialed and dated by the LIP. Beneficiaries are not required to have face-to-face contact with the LIP for the addition of services or changes in service frequency. All additions to the IPOC should be listed in chronological order.

If changes and updates are made to the original IPOC, an updated copy must be provided to the referring state agency within 10 calendar days. A copy of the updated IPOC must be made available to the beneficiary. A faxed copy is acceptable.

#### PROGRESS SUMMARY

The 90-day progress summary is a periodic evaluation of a beneficiary's progress toward the treatment objectives, appropriateness of the services being furnished and need for the beneficiary's continued participation in treatment.

The progress summary of the beneficiary's participation in RBHS will be conducted at least every 90 calendar days from the signature date on the IPOC and at a minimum, each 90 days thereafter.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### PROGRESS SUMMARY (CONT'D.)

The progress summary must be summarized by the LIP and documented on the IPOC and identified as the progress summary.

The LIP will review the following areas:

- The beneficiary's progress toward treatment objectives and goals
- The appropriateness of the services provided and their frequency
- The need for continued treatment
- Recommendations for continued services

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**PROGRAM REQUIREMENTS**

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## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE BEHAVIORAL HEALTH SERVICE STANDARDS

#### BEHAVIORAL HEALTH SCREENING (BHS)

The purpose of Behavioral Health Screening is to provide early identification of behavioral health issues and to facilitate appropriate referral for a more focused assessment and/or treatment. BHS is designed to quickly identify behavioral health issues and/or risk of development of behavioral health problems and/or substance abuse.

This service requires completion of a brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized or SCDHHS-approved tool, through interviews or self-report. Some common tools used are:

- GAIN- Global Appraisal of Individual Needs-Short Screener
- ECBI- Eyberg Child Behavioral Inventory
- DAST-Drug Abuse Screening Test

Screenings should be scored utilizing the tool's scoring methodology and referrals made based on the interpretation of the results.

Reimbursement for BHS is only available for the interpretation and/or scoring of the screening tool and does not include time spent administering the tool.

#### Service Documentation

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's record no later than 10 working days from the date of the service.

Documentation must :

- Include the outcome of the screening
- Identify any referrals resulting from the screening
- Support the number of units billed

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

**Service Location** The only excluded settings for BHS services are Psychiatric Residential Treatment Facilities and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

**Special Restrictions Related to Other Services** BHS cannot be billed on the same date of service as 90791 and/or H2000.

#### COMPREHENSIVE ASSESSMENT – INITIAL AND FOLLOW-UP

The purpose of an Initial Comprehensive Assessment is to determine the need for RBHS by establishing medical necessity, to establish and/or confirm a diagnosis, and to provide the basis for the development of an effective course of treatment. The Initial Comprehensive Assessment may include but is not limited to, psychological assessment/testing to determine accurate diagnosis or to determine differential diagnosis. The diagnostic assessment must be completed within 14 calendar days of the admission to the practice.

Initial assessments must include face-to-face time with the beneficiary and include an evaluation of the beneficiary for the presence of a behavioral health disorder. The initial assessment is used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

Initial assessments include a clinical interview with the beneficiary and/or family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths and history, including past psychological assessment reports and records.

Components of an assessment include:

- Date of the assessment
- Beneficiary demographic information
- Presenting complaint, source of distress
- Medical history and medications
- Family history
- Psychological and/or psychiatric treatment history including previous psychological assessment/testing reports, etc.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### COMPREHENSIVE ASSESSMENT – INITIAL AND FOLLOW-UP (CONT'D.)

- Substance use history
- Mental status
- Current edition DSM or ICD diagnosis
- Age-appropriate functional assessment
- Beneficiary and/or family strengths and support system
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events
- Recommendations for additional services, support, or treatment based on medical necessity criteria, including specific rehabilitative services

Follow-up assessments occur at any time after an initial assessment, to reevaluate the status of the beneficiary, identify any changes in behavior and/or condition and to monitor and ensure appropriateness of treatment. Follow up assessments may also be rendered to assess the beneficiary's progress, response to treatment, the need for continued treatment and establish medical necessity.

The LIP should attempt to determine whether another Comprehensive Assessment (initial or follow-up) has been conducted in the last 90 days and efforts should be made to access those records. An assessment should be repeated only if a significant change in behavior or functioning has been noted. Delivery of this service may include contacts with family and/or guardians for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

#### CALOCUS Assessment – PRTF and Community Support Services

South Carolina Department of Health and Human Services requires the use of the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized pre-admission criteria for all beneficiaries being considered for placement in a psychiatric residential treatment facility (PRTF). The CALOCUS may also be used to establish medical necessity for children and adolescents age 6-21 who are entering into community support services of Psychosocial Rehabilitation, Behavior Modification, and Family Support. The assessment must be a face-to-face assessment with the beneficiary.

The Child and Adolescent Level of Care Utilization System (CALOCUS) links a clinical assessment with standardized criteria that describes the level of intensity of services needed for a beneficiary. The CALOCUS rating can be done for any

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### PROGRAM SERVICES

#### CALOCUS Assessment — PRTF and Community Support Services (Cont'd.)

beneficiary in any setting, regardless of the diagnosis or service agency with which the beneficiary is involved.

CALOCUS must be administered by a Licensed Practitioner of the Healing Arts that has successfully completed training on CALOCUS and passed a competency test with prior written approval from SCDHHS.

CALOCUS training and certification will be offered by SCDHHS. All training information will be posted on the Medicaid provider Web site at: <https://training.scdhhs.gov/moodle/login/index.php>.

The CALOCUS tool considers four distinct types of potential co-morbid areas: psychiatric, substance use, developmental and medical.

CALOCUS ranges from Level 1 to Level 6 where the frequency, intensity, location and duration of treatment are correlated to the severity of the child or adolescent's condition.

The level of care system can be viewed as a continuum ranging from medical maintenance or minimal treatment in a minimally restrictive environment to a PRTF, a more restrictive treatment environment.

The child or adolescent is evaluated and rated in the following six dimensions:

- Risk of Harm
- Functional Status
- Co-Morbidity
- Recovery
- Resiliency and Treatment History
- Treatment Acceptance and Engagement

Treatment and/or services are recommended based on the composite score of the dimensions and the corresponding level of care. Services may be provided in a community mental health system, a private therapist, an interagency community-based system of care, or other providers of mental, psychiatric or behavioral health services. It is always preferable to keep children in their communities, when this is an option, and clinical professionals should determine if enhanced community services could be provided to support the child and his or her family as an alternative to placement.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

<p>CALOCUS Assessment — PRTF and Community Support Services (Cont'd.)</p>	<p>The levels of care are:</p> <ul style="list-style-type: none"> <li>Level 1—Recovery Maintenance and Health Management</li> <li>Level 2—Outpatient Services</li> <li>Level 3—Intensive Outpatient Services</li> <li>Level 4—Intensive Integrated Service without 24-Hour Psychiatric Monitoring</li> <li>Level 5—Non-secure 24-Hour Services with Psychiatric Monitoring</li> <li>Level 6—Secure 24-Hour Services with Psychiatric Management</li> </ul> <p>When CALOCUS score indicates a Level 4, 5, or 6, PRTF placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered.</p> <p>For more detailed information regarding the CALOCUS screening and process, refer to the Psychiatric Hospital Manual.</p>
<p>Staff-to-Beneficiary Ratio</p>	<p>The staff-to-beneficiary ratio for the Comprehensive Assessment (initial and follow-up) requires one LIP for each beneficiary.</p>
<p>Service Documentation</p>	<p>Assessments must be documented in a manner which addresses all of the necessary components and clearly establishes medical necessity. When submitting a claim for the CALOCUS assessment, documentation of the scoring instrument and supporting clinical documentation is required.</p> <p>Effective with dates of services on or after February 1, 2015, conducting and scoring the CALOCUS assessment is billed using procedure code H2000 with the appropriate modifier. Effective with dates of service on or after February 1, 2015, conducting an Initial Comprehensive Diagnostic Evaluation without medical will be billed using procedure code 90791 with the appropriate modifier. Refer to Section 4 of this manual, "Procedure Codes," for a detailed listing of procedure codes. If the beneficiary is enrolled with an MCO plan, the LIP must request reimbursement from the prospective MCO.</p>
<p>Service Location</p>	<p>Excluded settings for assessment services are Psychiatric Residential Treatment Facilities (unless prior approved for retro-eligibility) and freestanding Inpatient Psychiatric Facilities.</p>

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

**Service Location (Cont'd.)** Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

#### PSYCHOLOGICAL TESTING AND EVALUATION

Psychological Testing and Evaluation services include psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (*e.g.*, MMPI, Rorschach, WAIS) and are only to be rendered by a Licensed Psychologist or Licensed Psycho-Educational Specialist (LPES).

Testing and evaluation must involve face-to-face interaction between a Licensed Psychologist/LPES and the beneficiary for the purpose of evaluating the beneficiary's intellectual, psychiatric and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, and personality characteristics, as well as use of other non-experimental methods of evaluation. Testing includes face-to-face time administering the tests to the beneficiary and time interpreting these test results and preparing the report.

Psychological testing/assessment may be used for the purpose of psychodiagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning. Psychological testing/assessment can be used to confirm or rule out a diagnosis of Autism Spectrum Disorder.

All psychological assessment/testing by the assessor must include a specific referral question(s) that can be reasonably answered by the proposed psychological assessment/testing tools to be administered. All requests for psychological assessment/testing must clearly establish the benefits of the psychological assessment/testing, including but not limited to, how the psychological evaluation/testing will inform treatment.

When necessary/appropriate, consultation shall only include telephone or face-to-face contact by a Psychologist/LPES to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary. The Psychologist/LPES must document the recommended course of action.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

**Staff-to-Beneficiary Ratio** The ratio for Psychological Testing and Evaluation requires one Psychologist/LPES for each beneficiary.

**Service Documentation** Minimum standards require service note documentation in the beneficiary's record that includes the purpose of the session, the results of the Psychological testing and evaluation and/or make reference to the completed test. When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and level of impairment, a Psychologist/LPES must carry out the diagnostic assessment.

A documentation format example can be found in the Forms section. Assessments performed by unlicensed supervisees are not separately reimbursable.

Psychological Testing and evaluation is billed as a 60-minute unit with a limit of 10 units within a week and limit of 20 units billed annually.

**Service Location** The only excluded settings for Psychological Testing and Evaluation services are Psychiatric Residential Treatment Facilities and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

**SERVICE PLAN DEVELOPMENT (SPD)** SPD is a face-to-face or telephonic interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop the IPOC based on the assessed needs, strengths, weaknesses, social history, and support systems of the beneficiary and to establish treatment goals and treatment services to reach those goals.

The planning process should focus on the identification of the beneficiary's/family's needs and desired life outcomes. The beneficiary, multiple agency staff or interdisciplinary team members (if applicable) should identify the skills and abilities of the beneficiary that can help them achieve their goals (*e.g.*, competitive employment, independent living, etc.), identify areas in which the beneficiary needs assistance and support and decide how the team can meet those needs.

For multiple agency staff or interdisciplinary team members, a minimum of three human service agency staff or interdisciplinary team members constitute a team.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### SERVICE PLAN DEVELOPMENT (SPD) (CONT'D.)

Multi-agency meetings may be face-to-face or telephonic and only allowable when the discussion focuses on planning and coordinating service provision for the identified beneficiary.

While attendance of multiple provider representatives may be necessary, only one staff person that is actively involved in the planning process from each provider office may receive reimbursement.

#### Service Documentation

Documentation should include the involvement of the clinical professional and/or team of professionals in the following:

- The development, staffing, review and monitoring of the IPOC
- Discharge criteria/achievement of goals
- Confirmation of medical necessity
- Establishment of one or more diagnoses
- Recommended treatment

#### Service Location

SPD may be offered in all settings in the community that allow for privacy and confidentiality.

#### PSYCHOTHERAPY SERVICES OVERVIEW

**Psychotherapy** is the treatment of mental illness and behavioral disturbances in which the LIP, through definitive therapeutic communication, addresses the emotional disturbance, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. Psychotherapy times are for face-to-face services with the beneficiary and/or family member.

Psychotherapy services are provided within the context of the goals identified in the beneficiary's ITP or Individualized Plan of Care (IPOC). Assessments, plans of care and progress notes in the beneficiary's records must justify, specify and document the initiation, frequency, duration and progress of the therapeutic modality. The nature of the beneficiary's needs and diagnosis including substance abuse, strengths, and resources, determine the extent of the issues addressed in treatment, the psychotherapeutic modalities used by the clinical professional and its duration.

Psychotherapy Services may be provided in an individual, group or family setting. All CSN's must document how the individual, group, or family psychotherapy session applied to the identified beneficiary's treatment goals.

**SECTION 2 POLICIES AND PROCEDURES****PROGRAM SERVICES**

<b>INDIVIDUAL PSYCHOTHERAPY</b>	Individual psychotherapy is a face-to-face intervention with the beneficiary and/or family member with the purpose of restoring the beneficiary to his/her best possible functional level. Procedure codes for psychotherapy with patient and/or family member are used when individual psychotherapy is being provided. The beneficiary must be present for all or some of the service.
<b>Staff-to-Beneficiary Ratio</b>	The ratio for individual psychotherapy is one LIP to one beneficiary and/or family member.
<b>GROUP PSYCHOTHERAPY</b>	Group psychotherapy is a face-to-face intervention with a group of beneficiaries, who are addressing similar issues, with the purpose of restoring the beneficiary to his/her best possible functional level.  Group psychotherapy is conducted in small groups. The group must be a part of an active treatment plan and the goals of the group therapy must match the overall treatment plan for the individual beneficiary. The focus of the therapy sessions must not be exclusively educational or supportive in nature.
<b>Staff-to-Beneficiary Ratio</b>	The ratio for group psychotherapy requires one LIP for up to eight beneficiaries.
<b>FAMILY PSYCHOTHERAPY</b>	Family psychotherapy a face-to-face intervention with family members of the beneficiary with the purpose of treating the beneficiary's condition and improving the interaction between the beneficiary and family member(s) so that the beneficiary may be restored to their best possible functional level.  Family psychotherapy may be rendered with or without the beneficiary to family members of the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.
<b>Staff-to-Beneficiary Ratio</b>	The ratio for family psychotherapy requires one LIP for each family unit. Only <u>one</u> individual beneficiary can be billed for any one session of family psychotherapy.
<b>Service Documentation</b>	The documentation for individual, family, and group psychotherapy shall address the following items:

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#### Service Documentation (Cont'd.)

- The specific objective(s) from the IPOC toward which the session is focused
- The structured activities of the beneficiary/family in the session
- The beneficiary's/family's response to the intervention/treatment
- The specific intervention(s) used
- The beneficiary's progress or lack of progress made in treatment
- Recommendation and future plans for working with the beneficiary
- Service duration – start and end time

Psychotherapy is billed as an encounter code based on the length of the session time. Only one individual beneficiary can be billed for any one session of family psychotherapy. Please refer to Section 4 of the manual for appropriate coding.

#### Service Location

The only excluded settings for psychotherapy services are hospitals, Psychiatric Residential Treatment Facilities and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

#### CRISIS MANAGEMENT (CM)

Crisis Management (CM) is a face-to-face, or telephonic, short-term service is to assist a beneficiary, who is experiencing a marked deterioration of functioning related to a specific precipitant, in restoring his/her level of functioning and/or to stabilize the beneficiary. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care.

The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he/she can rely on to cope with this crisis, and in developing specific strategies to be used to mitigate this crisis and prevent similar incidents.

CM should therefore be immediate methods of intervention that include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### CRISIS MANAGEMENT (CM) (CONT'D.)

CM is for beneficiaries who are experiencing seriously acute psychiatric symptoms or psychological/emotional changes that result in increased personal distress and who would without intervention, be at risk for a higher level of care, such as hospitalization or other out of home placement.

Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning. The beneficiary must be present for all or some of the service.

Face-to-face interventions require immediate response by a clinical professional and include:

- A preliminary evaluation of the beneficiary's specific crisis
- Intervention and stabilization of the beneficiary
- Reduction of the immediate personal distress experienced by the beneficiary
- Development of an action plan that reduces the chance of future crises through the implementation of preventative strategies
- Referrals to appropriate resources
- Follow up with each beneficiary within 24-hours, when appropriate
- Telephonic interventions are provided either to the beneficiary or on behalf of the beneficiary to collect an adequate amount of information to provide appropriate and safe services, stabilize the beneficiary, and prevent a negative outcome.

**Staff-to-Beneficiary Ratio** The ratio for CM requires at least one LIP for each beneficiary.

**Service Documentation** A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and duration
- All participants during the service
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis
- Content of the session
- Active participation and intervention of the staff

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### Service Documentation (Cont'd.)

- The response of the beneficiary to the treatment
- Beneficiary's status at the end of the session
- A plan for what will be worked on with the beneficiary

#### Service Location

Crisis Management services may be provided in a beneficiary's home, nursing facility, emergency room, outpatient hospital, clinic setting, or other community locations in the beneficiary's natural environment. Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Services may not be provided to beneficiaries residing in a Psychiatric Residential Treatment Facility or freestanding Inpatient Psychiatric Facility.

Services provided to younger beneficiaries (children) must include coordination with family or guardians and other systems of care as appropriate.

#### SERVICE LIMIT EXCEPTION FOR FEE FOR SERVICE BENEFICIARIES

Maximum billable units for all services are outlined in Section 4. There may be clinical exceptions to the service limits when the number of units or encounters allowed may not be sufficient to meet the complex and intensive needs of a beneficiary. On these occasions, requests for frequencies beyond the service limits may be submitted directly to the South Carolina Department of Health and Human Services (SCDHHS) for approval. See below for required documentation for these requests.

- Most recent Diagnostic Assessment
- Most Recent IPOC
- All CSNs for all services rendered to beneficiary during the previous 90-days of request
- QIO approval letter
- Fax Cover Sheet for Service Limit Exceptions (if applicable)
- LIP Exception Request Form

Requests must be complete and submitted in accordance with the defined sets of documentation requirements noted above. Requests that do not meet all of the requirements will not be processed.

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### PROGRAM SERVICES

#### SERVICE LIMIT EXCEPTION FOR FEE FOR SERVICE BENEFICIARIES (CONT'D.)

Requests can be submitted to SCDHHS via the following methods:

- Fax: "Attn: LIPs Exceptions" to 803-255-8204
  - A fax cover sheet must be included with the fax
- **Encrypted** email to [behavioralhealth002@scdhhs.gov](mailto:behavioralhealth002@scdhhs.gov)

SCDHHS will either approve or deny, or request additional information within 10 business days of receipt of the request. The provider will be notified in writing if additional information is required. Additionally, should the request be denied, the provider will be notified in writing. The denial letter will explain how the provider may appeal the decision.

#### SERVICES RENDERED UNDER THE SUPERVISION OF A LICENSED PSYCHOLOGIST

Medicaid reimbursement may be sought for services rendered by an unlicensed person providing psychological services under the direct supervision of a psychologist licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the supervising psychologist must provide services at the same location as the supervisee and be immediately accessible by phone or other electronic device when the services being billed are provided. In addition, there must be a written protocol in place for addressing crisis situations when they arise. The supervising psychologist is responsible for all services rendered, fees charged, and reimbursement received.

For Medicaid billing purposes, the supervising psychologist must cosign all session notes to indicate that he or she accepts responsibility for the service rendered. No more than three full-time supervisees may be in the employ of any one supervising licensed psychologist.

In addition to the above requirements for Medicaid billing purposes, the South Carolina Board of Examiners in Psychology (SCBEP) maintains a set of Guidelines for Employment or Supervision of Unlicensed Persons Providing Psychological Services. The supervising licensed psychologist must register all information deemed necessary by SCBEP with SCBEP at the time of initiation of supervision, prior to service delivery, and at the time of annual license review. There must be evidence that supervision guidelines have been adhered to as set forth by this Board.

To obtain copies of the SCBEP requirements or to ask questions regarding supervision, call the South Carolina Board of Examiners in Psychology at (803) 896-4664 or visit <http://www.llr.state.sc.us/POL/Psychology/>.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### SERVICES RENDERED UNDER LICENSED PROFESSIONAL COUNSELOR SUPERVISORS AND MARRIAGE AND FAMILY THERAPIST SUPERVISORS

Medicaid reimbursement may be sought for services rendered by a Licensed Professional Counselor Intern (LPC/I) or Licensed Marriage and Family Therapist Intern (LMFT/I) under the direct supervision of a Licensed Professional Counselor Supervisor (LPC/S) or a Licensed Marriage and Family Therapist Supervisor (LMFT/S) licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the LPC/S or LMFT/S must provide services at the same location as the supervisee and be immediately accessible by phone or other electronic device when the services being billed are provided. In addition, there must be a written protocol in place for addressing crisis situations when they arise. The LPC/S or LMFT/S is responsible for all services rendered, fees charged, and reimbursement received.

For Medicaid billing purposes, the LPC/S or LMFT/S must co-sign all session notes to indicate that he or she accepts responsibility for the service rendered and there must be no more than six full-time supervisees in the employ of any one LPC/S or LMFT/S.

In addition to the above requirements for Medicaid billing purposes, the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists maintains policy and guidelines for Intern supervision.

All of the required supervision documents must be submitted to the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists at the time of initiation of supervision and prior to service delivery. There must be evidence that supervision guidelines have been adhered to as set forth by this Board.

To obtain copies of the Board requirements or to ask questions regarding supervision, please call The South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists at (803) 896-4658 or visit <http://www.llr.state.sc.us/POL/Counselors/>.

#### SERVICES RENDERED UNDER LICENSED INDEPENDENT SOCIAL WORKER-CLINICAL PRACTICE

Medicaid reimbursement may be sought for services rendered by applicants for LISW licensure under the direct supervision of a Licensed Independent Social Worker–Clinical Practice (LISW-CP) licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the LISW-CP must provide services at the same location as the supervisee and be immediately accessible by phone or other electronic device

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### SERVICES RENDERED UNDER LICENSED INDEPENDENT SOCIAL WORKER-CLINICAL PRACTICE (CONT'D.)

when the services being billed are provided. In addition, there must be a written protocol in place for addressing crisis situations when they arise.

The LISW-CP is responsible for all services rendered, fees charged, and reimbursement received. For Medicaid billing purposes, the supervising LISW-CP must co-sign all session notes to indicate that he or she accepts responsibility for the service rendered. There must be no more than six full-time supervisees in the employ of any one supervising LISW-CP.

In addition to the above requirements for Medicaid billing purposes, the South Carolina Board of Social Work Examiners maintains policy and guidelines for LISW Supervision. All of the required documents must be submitted to the South Carolina Board of Social Work Examiners at the time of initiation of supervision and prior to service delivery. There must be evidence that supervision guidelines have been adhered to as set forth by this Board

To obtain copies of the Board requirements or to ask questions regarding supervision, please call the South Carolina Board of Social Work Examiners at (803) 896-4664 or visit <http://www.llr.state.sc.us/POL/SocialWorkers/>.

#### Non-Covered Services

The following services are **not** reimbursable by Medicaid:

- Court appearances
- Supervision/staffing
- Mileage/driving time
- Completing/amending a Medicaid billing form
- Any contact on behalf of a non-referred Medicaid beneficiary
- Telephone contact related to office procedures or appointment time
- Consultation for beneficiaries who are not involved in an ongoing assessment or treatment
- Consultation performed by persons supervised by the psychologist
- Report preparation and completion
- Services provided to Medicaid-eligible beneficiaries who do not fall within the population served by Rehabilitative Services, with the exception of services provided to Medicaid

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### Non-Covered Services (Cont'd.)

eligibles who are also Qualified Medicare Beneficiaries (QMBs)

**Note:** For this population, Medicaid will reimburse the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by South Carolina Medicaid. Reimbursement for these services will be consistent with State Plan. Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries. Please refer to the Medicaid Web-Based Claims Submission Tool, in Section 1 of this manual for instructions on how to access beneficiary information, including QMB status

- Services of an experimental, research, or unproven nature, or services in excess of those deemed medically necessary
- Biofeedback
- Hypnotherapy
- Sensitivity Training
- Encounter groups or workshops
- Parenting classes
- Cancelled appointments or appointments not kept
- Court testimony

This list may not include all non-covered services. If you have questions regarding the types of services covered under this service array or otherwise covered by Medicaid, please contact the SCDHHS Medicaid Provider Service Center at 1-888-289-0709. You may also submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

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## **SECTION 2 POLICIES AND PROCEDURES**

### **PROGRAM SERVICES**

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