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**POLICIES AND PROCEDURES**

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## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

The statutory requirements that Federally Qualified Health Centers (FQHCs) must meet to qualify for Medicare and/or Medicaid benefits are found in federal regulations §1861 (aa)(4) of the Social Security Act.

The purpose of this manual is to provide pertinent information for successful participation in the South Carolina Medicaid Program. This manual provides a comprehensive overview of the behavioral health policies and procedures for FQHCs rendering behavioral health services.

### PROVIDER QUALIFICATIONS

In addition to conditions for participation in the Medicaid Program and by their scope of practice according to South Carolina law, licensed physicians and two other types of licensed practitioners may provide behavioral health services: non-physician practitioners and allied professionals. Non-physician practitioners include: advanced practice registered nurse (APRN), physician assistant, licensed independent social worker - clinical practice (LISW-CP), PhD. psychologist, and certified nurse midwife. Allied professionals are defined as licensed master's social worker (LMSW), licensed professional counselor (LPC), and licensed marriage and family therapist (LMFT). In order to claim Medicaid reimbursement for behavioral health services, these practitioners and physician(s) are required to be employed and/or contracted and receive payment from an FQHC.

### SUPERVISION

Medicaid reimburses for services rendered under general supervision of the FQHC physician or APRN. General supervision means that the supervisor does not have to be located on the premises, but must be accessible by phone or other electronic device. All individual rendering practitioners are responsible for providing services within their scope of practice as prescribed by South Carolina state law and under the FQHC's policy for supervision.

Medicaid limits the number of allied professionals rendering services under general supervision. The physician or APRN may supervise no more than three full-time allied professionals. The LISW-CP may supervise no more than three full-time LMSW professionals. The FQHC

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### SUPERVISION (CONT'D.)

agrees to provide the Division of Behavioral Health a list of all the practitioners providing behavioral health services at the center.

#### Physician or APRN

The supervising physician or APRN must ensure appropriate supervision of the allied professionals to ensure that beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervising physician or APRN must meet with the allied professional and document the monitoring of performance, consultation, guidance and education at a minimum of every three months to ensure the delivery of medically necessary services.

#### Licensed Independent Social Worker-Clinical Practice (LISW-CP)

A licensed independent social worker – clinical practice (LISW-CP) may provide supervision of an LMSW. The supervising LISW-CP must spend as much time as necessary supervising the services to ensure that beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. The supervising LISW-CP must meet with the LMSW and document the monitoring of performance, consultation, guidance and education at a minimum every three months to ensure the delivery of medically necessary services.

#### Physician or APRN Supervision of Allied Professionals

All clinical staff rendering services to SC Medicaid beneficiaries must be enrolled with the SC Medicaid Program. Once enrolled individually with Medicaid, the clinical staff must be linked to each individual FQHC group number to meet claims submission criteria and be reimbursed by SC Medicaid. Please refer to Provider Enrollment manual for specific enrollment requirements.

Services provided under general supervision of a physician and APRN are covered only if the following conditions are met:

- The physician or APRN cannot be employed by the allied professional.
- The allied professional must be a part-time, full-time, or contracted employee of the supervising physician, group practice or of the legal entity that employs the clinician, or the allied professional must be an independent contractor engaged by the physician through a written agreement.

**SECTION 2 POLICIES AND PROCEDURES**

**PROGRAM REQUIREMENTS**

Physician or APRN  
Supervision of Allied  
Professionals (Cont'd.)

- The behavioral health service must be furnished in connection with a covered physician service that was billed to Medicaid. Therefore, the beneficiary must have been seen by the physician.

SOUTH CAROLINA  
LICENSURE,  
CERTIFICATION AND  
APPROPRIATE  
STANDARDS OF CONDUCT

Providers of behavioral health services must fulfill the requirements for South Carolina licensure and/or certification and meet 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, who have received appropriate education, experience and 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 South Carolina Department of Health and Human Services (SCDHHS), may qualify to provide behavioral health services. 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.

INITIAL INTERNAL OR  
EXTERNAL REFERRAL  
CRITERIA

In order to be reimbursed by Medicaid, all eligible beneficiaries must have a referral for behavioral health services from a Medicaid enrolled physician or APRN using a physician’s order. The referring physician or APRN may either be an employee of the FQHC or an external practitioner.

The physician’s order must include the following information to establish a referral:

- Identification of the beneficiary’s current problem area(s)
- Signature, title and date of a physician or APRN

The physician’s/APRN order must be maintained in the beneficiary’s clinical record.

If SCDHHS or its designee determines that services were reimbursed when there was no valid physician’s order in

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### INITIAL INTERNAL OR EXTERNAL REFERRAL CRITERIA (CONT'D.)

the beneficiary's file, the provider payment will be subject to recoupment. If services are to be continued, a new referral must be confirmed and documented annually.

#### PROVIDER PARTICIPATION CREDENTIALS AND CRITERIA

This section lists Medicaid-enrolled providers including physicians, non-physician practitioners and allied professionals who can render behavioral health services and make referrals for additional visits.

#### Physicians

Medicaid-enrolled physicians can make referrals and render professional services to include diagnosis, treatment and therapy. An external physician that is not employed by the FQHC can only make initial referrals. Physician requirements include:

##### **Physician**

- A Doctor of Medicine or Doctor of Osteopathy
- A current license by the South Carolina Board of Medical Examiners
- If rendering services, is employed by or receives compensation from an FQHC
- The ability to perform professional services to a beneficiary to include diagnosis, therapy, surgery and consultation

##### **Psychiatrist**

- A Doctor of Medicine or Doctor of Osteopathy and has completed a residency in psychiatry
- A current license by the South Carolina Board of Medical Examiners
- If rendering services, is employed by or receives compensation from an FQHC
- The ability to perform professional services to a beneficiary to include diagnosis, therapy, surgery and consultation

#### Non-Physician Practitioners

The following Medicaid enrolled non-physician practitioners can render behavioral health services. These practitioners must also meet the following qualifications:

**SECTION 2 POLICIES AND PROCEDURES****PROGRAM REQUIREMENTS****Non-Physician  
Practitioners (Cont'd.)****Advanced Practice Registered Nurse (APRN)**

- Has completed an doctoral, post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing
- Must have general supervision by a physician who is readily available for consultation and shall operate within written protocols if performing delegated medical acts
- Is currently licensed by the South Carolina Board of Nursing and nationally certified as recognized by the board
- Provides services that a APRN is legally permitted to provide by state law
- If rendering services, is employed by or receives compensation from a FQHC
- FQHC has written policy that specifies what services a APRN may render to FQHC beneficiaries
- An external APRN that is not employed by the FQHC can only make initial referrals for behavioral health services

**Physician Assistant**

- Completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs
- Is currently licensed by the South Carolina Board of Medical Examiners
- Is under a physician's general (or direct, if required by state law) medical supervision
- Provides services that a physician assistant is legally permitted to provide by state law
- FQHC has written policy that specifies what services a physician assistant may render to FQHC beneficiaries
- Is employed by or receives compensation from a FQHC

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Non-Physician Practitioners (Cont'd.)

#### Certified Nurse Midwife

- A master's degree in specialty area and provides nurse-midwifery management of women's health care, focusing particularly on pregnancy, childbirth, postpartum, care of the newborn, family planning and gynecological needs of women
- FQHC has written policy that specifies what services a certified nurse midwife may render to FQHC beneficiaries
- Is under a physician's general (or direct, if required by state law) medical supervision
- Provides services that a certified nurse midwife is legally permitted to provide by state law
- If rendering services, is employed by or receives compensation from a FQHC
- If rendering services, has sufficient mental/behavioral health experience documented in the staff member's record

#### Psychologist

- A Ph.D. or PsyD. from an accredited college or university
- A valid and current license with a specialty in clinical, counseling, or school psychology as approved by the South Carolina Board of Examiners in Psychology

#### Licensed Independent Social Worker-Clinical Practice (LISW-CP)

- A master's or doctorate degree from a social work program accredited by the Council on Social Work Education
- A valid and current license as approved by the South Carolina Board of Social Work Examiners

#### *Physician Assistant Service Exclusions*

The physician assistant is qualified to render services under the direct supervision of a physician. They are not authorized to do the following functions:

- Referrals for additional visits or prior authorizations



## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### *Physician Assistant Service Exclusions (Cont'd.)*

- Determine medical necessity, diagnosis, or treatment
- Sign a Medical Necessity Statement
- Review or sign a progress summary

#### Allied Professionals

The allied professionals listed below may render services to Medicaid beneficiaries under the general supervision of a physician or APRN. An LISW-CP may supervise the LMSW. These practitioners must also meet the following qualifications:

##### **Licensed Master Social Workers (LMSW)**

- A master's or doctoral degree from a social work program accredited by the Council on Social Work Education and one year of experience working with the population to be served

##### **Licensed Marriage and Family Therapist (LMFT)**

- A master's, specialist, or doctorate degree from a 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. Each course must be a minimum of at least a 3 semester hour graduate level course with a minimum of 45 classroom hours or 4.5 quarter hours. One course cannot be used to satisfy two different categories.
- A valid and current license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists

##### **Licensed Professional Counselor (LPC)**

- All coursework, including any additional core coursework, must be taken at a college or university accredited by the commission on the 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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Allied Professionals (Cont'd.)

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.

- A minimum of 48 graduate semester hours during a master's degree or higher degree program and have been awarded a graduate degree as provided in the regulation
- A valid and current license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists

#### Maintenance of Staff Credentials

All FQHCs shall ensure that all staff, contractors, volunteers, and other individuals under the authority of the FQHC who have direct contact with beneficiaries are properly qualified, trained, and supervised. FQHCs must comply with all applicable state and federal requirements. FQHCs must maintain and make available upon request appropriate records and documentation of such qualifications, trainings and investigations.

If these records are kept in a central location, the FQHC will be given five business days to retrieve the records for the agency that is requesting them. The FQHC shall maintain a file substantiating that each staff member meets staff qualifications. This shall include employer verification of the staffs' certification, licensure, and work experience. The FQHC providing the treatment must maintain a signature sheet that identifies all professionals providing services by name, signature, and initials.

#### Training Requirements for Treatment Staff

The following general training requirements apply:

- All FQHCs must ensure treatment staff receives adequate orientation on the behavioral health services in this policy manual.
- The content of the training must be directly related to the duties of the staff.
- Individuals who are qualified to conduct such training shall carry out instruction.
- Documentation of training received and successfully completed, including all required

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Training Requirements for Treatment Staff (Cont'd.)

certification documentation, shall be kept in the staff's training record.

- Documentation of the training shall consist of an outline of the training provided and the trainer's credentials.

In addition to documentation of training received by staff and documentation of staff credentials, the FQHC must keep the following specific documents on file:

- A completed employment application form
- Copies of official college diploma, high school diploma or GED, or transcripts with the official raised seal
- A copy of all applicable licensure
- Letters or other documentation of verification of previous employment and/or volunteer work to document experience with the population to be served. (A resume will not serve as the only resource to document experience.)

#### ELIGIBILITY FOR SERVICES

Medicaid-eligible beneficiaries, regardless of age, may receive behavioral health services. Determination of eligibility for behavioral health services is based on the use of a system-wide assessment process utilizing recognized assessment tools. Medicaid-eligible beneficiaries may receive behavioral health services when one of the following have been documented in his or her clinical record:

- A psychiatric diagnosis from the current edition of the *Diagnostic and Statistical Manual* (DSM) and/or *the International Classification of Diseases* (ICD), Clinical Modification (ICD-CM) (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)

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

- Is in imminent danger of being removed from the home due to substantiated developmental or behavioral problems; a V-code may be used to substantiate this problem

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

##### **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 services must be maintained in the child's clinical record.

The date the beneficiary has been determined to meet the eligibility requirements for behavioral health services must be clearly documented in the record.

#### MENTAL HEALTH VISITS/ ENCOUNTERS

A mental health visit is defined as a face-to-face encounter between the FQHC beneficiary and the physician, clinical psychologist, clinical social worker, advance practice registered nurse, physician assistant, and certified nurse midwife or an allied professional under the direct supervision of a physician or APRN for mental health services. With the exception of the diagnostic evaluations (codes 90791 and 90792), psychotherapy services are not included in the 12 ambulatory visit limit for beneficiaries age 21 and older. Eligible Medicaid beneficiaries ages 21 and older will be allowed 12 mental health visits per fiscal year (beginning July 1st through June 30th of each year) without prior authorization. Beneficiaries under age 21 are exempt from this limitation.

Only one behavioral health encounter code is allowed per day and 12 mental health visits per fiscal year (beginning July 1st through June 30th of each year). FQHC services are covered when furnished to beneficiaries at the center that renders behavioral health services, in a skilled nursing facility, or at the beneficiary's place of residence. Services provided to hospital beneficiary, including emergency room services, are not considered to be FQHC services.

All behavioral health encounters must be billed using procedure code T1015 with the HE modifier, mental health

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MENTAL HEALTH VISITS/ ENCOUNTERS (CONT'D.)

program. This code is not intended for billing case management services.

#### ADDITIONAL VISITS/ PRIOR AUTHORIZATIONS

Additional behavioral health services over the 12 allowed visits require prior authorization from the SCDHHS designated Quality Improvement Organization (QIO). Requests for additional visits must be submitted by the beneficiary's physician, APRN, PA, or non-physician practitioner using the DHHS Mental Health Form. The request must include clinical documentation such as a screening tool, assessment and/or individual care plans that validate the need for extended coverage.

Supporting documentation may include specific therapeutic goals and techniques that were utilized (*e.g.*, cognitive behavioral therapy, dialectic behavioral therapy, or parent child interaction therapy). The clinical documentation should be appropriate for the developmental level of the beneficiary, and the results should support the need for mental health treatment. In order to be approved, requests must substantiate medical necessity and be received by the QIO 10 days in advance. The signature of the physician or non-physician practitioner is required on the DHHS Mental Health Form.

All requests for authorization of additional visits must be submitted to the QIO using one of the following methods:

Fax: 1-855-300-0082

Telephone: 1-855-326-5219

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

The DHHS Mental Form should be submitted with a cover letter identifying the FQHC making the request along with appropriate contact information. The DHHS Mental Health Form can be found the Forms section of this manual.

#### UTILIZATION MANAGEMENT

SCDHHS or its designee will conduct periodic utilization reviews. However, this is not intended to replace the FQHCs review of services or quality assurance activities. Reimbursement received for unauthorized services/visits is subject to recoupment.

#### COORDINATION OF CARE

It is the responsibility of the referring physician or non-physician practitioner to coordinate care among FQHC service providers.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### CLINICAL RECORDS

The FQHC must maintain a clinical record for each Medicaid-eligible beneficiary receiving behavioral health services that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid reimbursement, and clearly specify the course of treatment. The absence of appropriate and complete records may result in recoupment of previous payments by SCDHHS. An index as to how the clinical record is organized must be maintained and made available to Medicaid reviewers and/or auditors at the time of request.

Each FQHC provider has 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:

- Identification and social data, consent forms, pertinent medical history, assessment of the health status and health disposition, and instructions to the beneficiary
- Completed MNS(s) and/or all physician's order(s), reports of treatments and medications, and other pertinent information necessary to monitor the beneficiary's progress
- Signed, titled and dated Individual Plan of Care (IPOC) initial, reviews, and reformulations
- Signed, titled and dated clinical service notes
- Reports of physical examinations, diagnostic and laboratory test results, and consultative findings
- Signatures of the physician or other health professional

#### Release of Information and Consent for Treatment

The FQHC will maintain the confidentiality of record information and provide safeguards against loss, destruction, or unauthorized use; written policies and procedures that govern the use and removal of records from the FQHC; and conditions for release of information. The beneficiary's written consent is required for treatment, as well as for release of information. A consent form and a

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Release of Information and Consent for Treatment (Cont'd.)

release of information form dated and signed by the beneficiary, parent and/or guardian, or primary caregiver in cases of a minor, or legal representative must be obtained at the onset of treatment from all beneficiaries.

A new consent form should be signed and dated each time a beneficiary is readmitted to the FQHC system after discharge or when a beneficiary has not received behavioral health services within a 90 calendar day period.

#### Clinical Service Notes

All behavioral health services must be documented in clinical service notes (CSNs) upon the delivery of services. 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.

The CSN must:

- Be completed each time a behavioral health service is provided and whenever information is obtained that has bearing on the identified beneficiary's treatment
- Be individualized
- Document that behavioral health services correspond to billing by type of service and dates of service (with month, day and year)
- Be typed or handwritten using only black or blue ink. Refer to Section 1 of this policy and procedure manual for electronic record guidelines.
- Be legible and kept in chronological order
- List the specific service that was rendered or its approved abbreviation
- Document the start and end time(s) for each behavioral service delivered
- Reference individuals by full name, title and agency/provider affiliation at least once in each note
- Specify the place of service, as appropriate for the particular service provided
- Be signed, titled and signature dated (month/date/year) by the person responsible for the provision of services. The signature verifies that the

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Clinical Service Notes (Cont'd.)

services are provided in accordance with these standards. Refer to Section 1 for electronic records guidelines.

- Be completed and placed in the clinical record within ten business days from the date of rendering the service

The CSN must also address the following items in order to provide a pertinent clinical description and to ensure that the service conforms to the service description and authenticates the charges:

- The focus and/or reason for the session and/or interventions which should be related to a treatment objective or goal listed in the IPOC, unless there is an unexpected event that needs to be addressed
- The interventions and involvement of treatment staff in service provision to the beneficiary to include coordination of care
- The response of the beneficiary and family (as applicable) to the interventions/treatment
- The general progress of the beneficiary to include observations of their conditions and/or mental status
- The future plan for working with the beneficiary

#### Error Correction

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

- Draw one line through the error, and write “error,” “ER,” “mistaken entry,” or “ME” to the side of the error in parenthesis. Enter the correction, sign or initial, and date it
- Errors cannot be totally marked through; the information in error must remain legible
- No correction fluid may be used

#### Late Entries

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in the documentation.



## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Late Entries (Cont'd.)

Late entries should be rarely 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:

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

#### Transition/Discharge

The referring physician or non-physician practitioner is responsible for determining the duration of treatment based on the individual needs of the beneficiary. The physician assistant or a directly supervised allied professional(s) involved in the delivery of services to the beneficiary may gather and/or give information to assist with this process. Beneficiaries should be discharged from treatment when they meet one of the following criteria:

- Level of functioning has significantly improved with respect to the goals outlined in the (IPOC)
- Achieved goals as outlined in the IPOC
- Developed skills and resources needed to transition to a lower level of care
- 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)

#### Record Retention

The records are retained for at least six years from the date of last entry and longer if required by state statute. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the six year period, whichever is later. In the

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Record Retention (Cont'd.)

event of an entity's closure, FQHC providers must notify SCDHHS regarding clinical 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 CFR Title 42 and Section 1 of this manual.

#### MEDICAL NECESSITY

In order to be covered under the Medicaid program, a service must be medically necessary. Medical necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is expected to relieve pain, improve and preserve health, or be essential to life. Medicaid-eligible beneficiaries may receive psychotherapy services when there is a confirmed psychiatric diagnosis from the current edition of the DSM or the ICD.

A physician or a non-physician practitioner must certify that the beneficiary meets the medical necessity criteria for services. Medical necessity for behavioral health services must be substantiated with a diagnosis using the most current edition of the DSM and/or ICD.

The determination of medically necessary treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or guardians who are familiar with the beneficiary
- Based on current clinical information (if diagnosis has not been reviewed in a 12 or more months the diagnosis should be confirmed immediately)
- Based on individualized treatment planning that actively involves the beneficiary in the process
- Made by the physician and/or non-physician practitioner as specified
- Made within SCDHHS standards for timeliness.

Medical necessity must be documented on a Medical Necessity Statement (MNS) or confirmed through a psychiatric diagnostic evaluation. The documentation must

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MEDICAL NECESSITY (CONT'D.)

be completed and signed by the physician or non-physician practitioner prior to the initiation of the service. The MNS or evaluation must be maintained in the beneficiary's clinical record and be available to confirm that services have met medical necessity requirements prior to billing Medicaid.

The MNS must contain the following information to substantiate medical necessity:

- Identification of the beneficiary's current problem area(s)
- Specification of treatment goals that need to be addressed by the service provider
- Include a current diagnosis
- The signature of the physician or non-physician practitioner(excluding the physician assistant), professional title and date

The physician or non-physician practitioner shall:

- Establish one or more diagnoses, including co-occurring substance abuse or dependence if present in accordance with the current edition of the DSM and/or 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

If the beneficiary needs continuing behavioral health services, a medical necessity must be confirmed and documented annually (within 365 calendar days) by the physician or non-physician practitioner. The initial signature date from the documentation that was used to confirm medical necessity stands as the date to be used for all subsequent renewals and/or annual confirmations.

If the beneficiary has not received a behavioral health service for 90 consecutive calendar days, medical necessity must be re-established by completing a new MNS or evaluation confirming the need for services. If SCDHHS or its designee determines that services were reimbursed

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MEDICAL NECESSITY (CONT'D.)

when there was no valid MNS or evaluation substantiating medical necessity in the beneficiary's file, the provider payment will be subject to recoupment.

The medical necessity documentation used by the FQHC must include the following information on the statement to establish medical necessity:

- The beneficiary's name, date of birth and Medicaid number,
- A psychiatric diagnosis from the current edition of the DSM and/or ICD manuals (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)
- The specific behavioral health service(s) recommended
- Identification of the beneficiary's problem areas
- Justification of the recommended behavioral health services
- The signature of the physician or non-physician practitioner professional title and date

#### INDIVIDUAL PLAN OF CARE (IPOC)

The IPOC is an individualized, comprehensive treatment plan with the goal of improving the beneficiary's condition. The IPOC should be developed prior to the delivery of a behavioral health service with the full participation of the beneficiary and his or her family, if appropriate, unless in the case of an emergency. The IPOC shall be based upon an assessment of the beneficiary's current problems and needs in the areas of emotional, behavioral, and functional development.

The IPOC should encompass all treatment goals and objectives and outlines each team member's responsibilities within the treatment process.

The IPOC must be based on the individual needs of the beneficiary and confirms the appropriateness of services, and outlines the service delivery needed to meet the identified needs and improve overall functioning.

The physician or non-physician practitioners are

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

responsible for the development of the IPOC. The physician assistant or a directly supervised allied professional(s) involved in the delivery of services to the beneficiary may gather and/provide information to assist with this process.

The IPOC must be finalized within 90 calendar days of the signature date of the physician or the non-physician practitioner on the medical necessity documentation or physician's order to confirm the appropriateness of care the client. If the IPOC is not developed within 90calendar days, services rendered from the 91<sup>st</sup> day until the date of completion of the IPOC are not Medicaid reimbursable.

The IPOC provides the overall direction for the treatment of the beneficiary and must include the following elements, at a minimum:

- Personal goals developed with input from the beneficiary that guides the treatment process
- Major behavioral health service goals that serve as intermediate steps toward the achievement of the beneficiary's personal goals
- Objectives describing the concrete skills and behaviors that will be achieved by the beneficiary
- Interventions planned to help the beneficiary reach the objectives

All IPOCs must include the following information :

- **Beneficiary Identification:** Name and Medicaid ID number
- **Presenting Problem(s):** Statements that outline the specific needs that require treatment. (Providers must validate the need for and appropriateness of treatment.)
- **Justification for Treatment:** Statement based on the diagnosis and needs of the beneficiary.
- **Diagnosis:** The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the DSM and/or ICD. For individuals who have more than one diagnosis regarding mental health, substance use, and/or medical conditions, all diagnoses must be recorded.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

- **Goals and Objectives:** A list of specific short and long term goals and objectives addressing the expected outcome of treatment. Goals (should include input from the beneficiary) and objectives should be written so that they are observable, measurable, individualized (specific to the beneficiary's problems or needs), and realistic
- **Treatment Methods:** Specific interventions and/or methods the treatment team will use to meet the stated goals/objectives
- **Frequency of Services:** The frequency must be listed on the IPOC for each service. Each service should be listed by its name or approved abbreviation with a planned frequency.
- **Criteria for Achievement:** Outline how success for each goal and/or objective will be measured. Criteria must be reasonable, attainable, and measurable, must include target dates, and must indicate a desired outcome to the treatment process
- **Target Dates:** Timeline that is individualized to the beneficiary and the goal and/or objective.
- **Beneficiary Signature:** The beneficiary must sign the IPOC indicating they were involved in the planning process and were offered a copy of the IPOC. If the beneficiary does not sign the plan of care 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 clinical record.
- **Authorized Signature(s):** The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and renewals. The dated signature of the physician or non-physician practitioner is required to confirm the appropriateness of care. Each page of the IPOC must be signed, titled and signature dated by the physician or non-physician practitioner. Other forms that reference signature sheets do not meet the IPOC signature requirements. The IPOC must be filed in the beneficiary's clinical record with any supporting documentation.

**SECTION 2 POLICIES AND PROCEDURES****PROGRAM REQUIREMENTS****IPOC Additions and/or Changes**

If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary within 10 calendar days. A faxed copy is acceptable or by “certified mail/return receipt requested” provided the beneficiary grants permission for either of these alternative delivery means.

Services added or frequencies of services changed in an existing IPOC must be signed or initialed and dated by the supervising physician or non-physician practitioner. All additions to the IPOC should be listed in chronological order.

**IPOC Addendum**

An addendum IPOC, used in conjunction with an existing IPOC if the space is insufficient on the current IPOC, must be labeled “Addendum IPOC” and must accompany the existing IPOC. The addendum must include the signature and title of the physician or non-physician practitioner who formulated the addendum(s), and the date it was formulated. The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and renewals.

**IPOC Reformation**

The maximum duration of an IPOC is 12 months (365 days) from the date of the signature of the physician or non-physician practitioner that are responsible for service delivery. Annually and/or prior to termination or expiration of the treatment period, the physician or non-physician practitioner that made the referral for treatment must review the IPOC, preferably with the beneficiary, and evaluate the beneficiary’s progress in reference to each of the treatment objectives. The physician assistant or directly supervised allied professional may gather and/or provide information to assist in this process.

The signature of the physician or non-physician practitioner responsible for the reformulation is required. The physician or non-physician practitioner should also assess the need for continued services and the specific services needed based on the progress of the beneficiary.

The IPOC must include the signature date when the reformulation was completed, the signature and title of the physician or non-physician practitioner authorizing the services. When the IPOC is developed prior to the expiration date, the new plan is effective with the anniversary date.

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTIONS

Behavioral health services are reimbursable when delivered in an office or outpatient setting **only**. Behavioral Health Services are non-covered in an inpatient setting when reimbursement of their service is included in the hospital reimbursement.

#### DIAGNOSTIC ASSESSMENT (DA) SERVICES

##### Purpose

**Psychiatric Diagnostic Evaluation 90791/90792** – The purpose of this face-to-face assessment is to determine the need for behavioral health services, to establish or confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and needs, and/or to assess progress in treatment and confirm the need for continued treatment. This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records.

Assessments must be completed face-to-face with the beneficiary and include an evaluation of the beneficiary for the presence of a mental illness and/or substance use disorder.

If information obtained during the assessment results in a diagnosis, the assessment must identify the beneficiary's current symptoms or disorder via the current edition of the DSM or the ICD.

As a best practice, diagnoses should be updated as the condition of the beneficiary changes.

The assessment is used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

Assessments include clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational records and history, including past psychological assessment report and records. Initial assessments must include a clinical summary that identifies recommendations



## SECTION 2 POLICIES AND PROCEDURES

### SERVICE GUIDELINES

#### Purpose (Cont'd.)

for and the prioritization of mental health and/or other needed services.

Once the initial assessment has been completed and services are deemed to be medically necessary, the development of the individual plan of care should be next.

#### SERVICE DESCRIPTION

Psychiatric Diagnostic Assessment identify the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. The assessment must include a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records to obtain information necessary to establish or support a diagnosis. It also serves to drive the development or revision of the treatment plan and development of discharge criteria.

The following components must be included in the Psychiatric Diagnostic Assessment without Medical Services (Comprehensive Diagnostic Assessment) include:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Beneficiary's demographic information
  - Age
  - Date of birth (DOB)
  - Phone Number
  - Address
  - Relationship/Marital Status
  - Preferred Language
- Beneficiary's cultural identification, including gender expression, sexual orientation, culture and practices, spiritual beliefs, etc.
- Presenting complaint, source of distress, areas of need, including urgent needs (*e.g.*, suicide risk, personal safety, and/or risk to others)
- Risk factors and protective factors, including steps taken to address identified current risks (*e.g.*, detailed safety plan)
- Mental/Behavioral health history of beneficiary,

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE GUIDELINES

#### SERVICE DESCRIPTION (CONT'D.)

including previous diagnoses, treatment (including medication), hospitalizations

- Psychological history including previous psychological assessment/testing measures, reports, etc.
- Substance use history including previous diagnoses, treatment (including medication), hospitalizations
- Exposure to physical abuse, sexual assault, antisocial behavior or other traumatic events
- Physical health history, including current health needs and potential high-risk conditions
- Medical history and medications, including history of past and current medications
- Family history, including relationships with family members, and involvement of individuals in treatment and services, family psychiatric and substance use history
- Mental status
- Functional assessment(s) (with age-appropriate expectations)
- Education and employment history
- Housing/living situation
- Diagnosis(es) of a serious behavioral health disorder (description and code must be identified for each) from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria
- Initial start date of behavioral health Services
- Planned service type and frequency of each recommended behavioral health service
- Referrals for external services, support, or treatment

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE GUIDELINES

#### PSYCHOLOGICAL TESTING WITH INTERPRETATION AND REPORT

**Psychological Testing with Interpretation and Report – 96101:** This is a face-to-face encounter between a psychologist and a beneficiary. The use of this code is confined to the administering and interpretation of psychological testing with a written report of these findings by a clinician. The time must be documented in the medical records.

#### INDIVIDUAL PSYCHOTHERAPY

**Individual Psychotherapy** – This is a face-to-face encounter between a physician, non-physician practitioner, an allied professional (LMSW, LMFT and LPC) under direct supervision of the physician or an APRN and the beneficiary. This service must be therapeutic, supportive, or palliative. It must be a one-on-one systematic intervention focused on prevention of deterioration, remediation, development, enhancement, or the rehabilitation of the beneficiary. For individual psychotherapy encounters, the following procedure codes must be used:

**Unit:**

**90832** – Psychotherapy, 30 minutes

**90834** – Psychotherapy, 45 minutes

**90837** – Psychotherapy, 60 minutes

**Individual Psychotherapy with medical evaluation and management** - This is a face-to-face encounter between a physician or a non-physician practitioner and the beneficiary.

**Unit:**

**90833** – Psychotherapy, 30 minutes

**90836** – Psychotherapy, 45 minutes

**90838** – Psychotherapy, 60 minutes

#### FAMILY PSYCHOTHERAPY

**Family Psychotherapy including patient, 50 minutes – 90847:** This is a face-to-face encounter between a physician, non-physician practitioner, an allied professional (LMSW, LMFT, and LPC) under supervision of a physician or an APRN and the beneficiary, the family unit and/or significant others. Billing for telephone calls is not allowed. Additionally, family therapy should not be billed along with pharmacological management.

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE GUIDELINES

#### FAMILY PSYCHOTHERAPY (CONT'D.)

Documentation of family therapy should address the beneficiary's problems or issues and the reduction or resolution of those identified problems and/or issues. Reimbursement is limited to one session per day and is not based on time increments. If several family members are present during the family psychotherapy, reimbursement is only approved for the individual identified as the recipient of the service. A separate and distinct service must be provided for each beneficiary with the appropriate time and progress note generated to support payment.

#### PSYCHOTHERAPY FOR CRISIS

Psychotherapy for Crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a beneficiary in high distress.

**90839 – Psychotherapy for Crisis** – This code is used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician or other qualified health care professional is not continuous on that date. The beneficiary must be present for all or some of the service.

#### PROGRESS SUMMARY

The 90-day progress summary is a periodic evaluation and review 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 physician assistant or a generally supervised allied professional(s) involved in the delivery of services to the beneficiary may gather and/or provide information to assist with this process.

A review of the beneficiary's participation in all services will be conducted at least every 90 calendar days from the date of the IPOC signature date and must be summarized by the physician or non-physician practitioner and documented in the IPOC clearly identified as the progress summary.

At the third 90-day review, if a FQHC anticipates that treatment services will be needed at the anniversary date, the physician or non-physician practitioner must re-

## SECTION 2 POLICIES AND PROCEDURES

### SERVICE GUIDELINES

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

establish medical necessity.

The physician or non-physician practitioner that made the referral for treatment 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