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GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) provides Medicaid reimbursement for medically necessary services provided to Medicaid-eligible individuals in the Local Education Agency (LEA). This includes, but is not limited to, children under the age of 21 who have or are at risk of developing sensory, emotional, behavioral, or social impairments, physical disabilities, medical conditions, intellectual disabilities or related disabilities, or developmental disabilities or delays.

Each Local Education Agency (LEA) recognized as such by the South Carolina Department of Education has contracted with SCDHHS to provide Medicaid-reimbursable School-Based Services to Medicaid-eligible children with special needs. Individual service providers employed or contracted by an LEA must meet the specified Medicaid provider qualifications.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) AND MEDICAID

The development of an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP) is a requirement of the Individuals with Disabilities Education Act (IDEA). Medicaid requires School-Based Services to be indicated on the IEP, IFSP, or the Individualized Treatment Plan (ITP). However, Medicaid will not reimburse for any administrative or direct services performed for pre-IEP/IFSP activities. Medicaid will not reimburse for the IEP team member meetings or the cost related to attendance at those meetings by medical professionals.

The following policies apply when an LEA relies upon Social Security Act §1903(c) (42 U.S.C. 1396b(c)) as its basis for billing Medicaid:

- Medicaid-reimbursed School-Based Rehabilitative Therapy Services must be included in the Individual Education Program (IEP) or Individual Family Service Plan (IFSP).
- Medicaid-reimbursed School-Based Rehabilitative Behavioral Health Services **are required** to be included in the IEP, IFSP Individual Treatment Plan (ITP), or Individual Plan of Care (IPOC).

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) AND MEDICAID (CONT'D.)

- Medicaid-reimbursed Medicaid Adolescent Pregnancy Prevention Services (MAPPS) are not required to be included in the IEP, IFSP, or ITP.

LEAs must adhere to the applicable IDEA requirements when Medicaid-reimbursed School-Based Services are included in the IEP or IFSP. However, Rehabilitative Behavioral Health Services must be indicated on an ITP. The IEP or IFSP may be used as the ITP if all of the minimum components are indicated. If IDEA permits the Medicaid-reimbursed School-Based Service to be documented in attachments to the IEP file, then such documentation meets these requirements.

PROVIDER QUALIFICATIONS

LEAs and/or subcontractors must meet all applicable Medicaid provider qualifications as well as the applicable state licensure regulations in addition to any specified requirements by the State Department of Education for the provision of Medicaid School-Based Services. The contracted LEA is responsible for ensuring the individuals rendering Medicaid School-Based Services are approved, credentialed, or licensed.

LEAs may contract with any qualified provider for School-Based Services. The LEA must utilize the subcontract format approved and provided by SCDHHS. This can be found in the applicable appendix of the LEA contract. This format includes the federal and state contractual components that are required to ensure that Medicaid reimbursement is available. There may be additional state and/or federal requirements for approval by SCDHHS. LEAs may include other terms and conditions necessary to define the responsibilities of both parties.

All subcontracts (*i.e.*, billing contracts, contracted providers, etc.) are subject to the terms of the LEA's contract with SCDHHS and the LEA provider is held solely responsible for the performance of the subcontractor. Additionally, a copy of the LEA's contract with SCDHHS, if applicable, must be provided to the subcontractor by attachment to the subcontract. Please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> if a copy of the current SCDHHS subcontract format is needed.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

PROVIDER QUALIFICATIONS (CONT'D.)

Medicaid reimbursement is available for School-Based Rehabilitative Services (*i.e.*, Speech-Language Pathology, Audiology, Physical Therapy, Occupational Therapy, and Orientation & Mobility Services) when provided by or under the direction of the qualified rehabilitative therapy provider for which the beneficiary has been referred. Referrals must be made by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law.

Supervision

In accordance with Centers for Medicare and Medicaid Services (CMS) directives, CMS has interpreted the term “under the direction of” to mean that the provider is individually involved with the patient and accepts ultimate legal responsibility for the services rendered by the individuals that he or she agrees to direct. The supervisor is responsible for all the services provided or omitted by the individual that he or she agrees to directly supervise.

At no time may the individual being supervised perform tasks when the supervisor cannot be reached by personal contact, phone, pager, or other immediate means. The supervisor must make provisions, in writing, for emergency situations including designation of another qualified provider who has agreed to be available on an as-needed basis to provide supervision and consultation to the individual when the supervisor is not available. **All Clinical Service Note entries made by a staff who requires supervision must be cosigned by the supervisor (unless otherwise indicated for a specific Medicaid reimbursement service).**

The supervisor must be readily available to offer continuing supervision. “Readily available” means that the supervisor must be physically accessible to the individual being supervised within a certain response time based upon the medical history and condition of the beneficiary and competency of personnel. Supervision should involve specific instructions from the supervisor to the individual regarding the treatment regimen, responses to indications of adverse beneficiary reactions, and any other issues necessary to ensure the appropriate provision of the Medicaid-reimbursable services.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Supervision (Cont'd.)

All supervisory staff licensed by Labor, Licensing and Regulation (LLR) must adhere to any provisions as required by LLR.

In addition to the above requirements, SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25-mile radius of the SC border.

COVERED SERVICES

Reimbursement is available for services that conform to accepted methods of diagnosis and treatment. Reimbursement is not available for services determined to be unproven, experimental or research-oriented, in excess of those deemed medically necessary to treat the beneficiary's condition, or not directly related to the beneficiary's diagnosis, symptoms, or medical history. Reimbursement is not available for time spent documenting services or traveling to or from services, or for canceled visits and missed appointments.

Medicaid reimbursement is available for the following School-Based Services:

- Audiological
- Physical Therapy
- Occupational Therapy
- Speech and Language Pathology
- Orientation & Mobility
- Rehabilitative Behavioral Health Services
 - Behavioral Health Screening
 - Diagnostic Assessment(s)
 - Psychological Testing and Evaluation
 - Individual Psychotherapy
 - Group Psychotherapy
 - Family Psychotherapy
 - Multiple Family Group Psychotherapy
 - Service Plan Development
 - Crisis Management

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

COVERED SERVICES (CONT'D.)

- Psychosocial Rehabilitation Services
- Behavior Modification
- Behavioral Health Screening
- Family Support
- Nursing Services for Children Under 21
- Administrative Claiming
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Non-Emergency Transportation

Reimbursement is not available for services provided in an inpatient hospital or other institutional care facility.

MEDICAL NECESSITY

Medicaid will pay for service when the service is covered under the South Carolina State Plan and is medically necessary. “Medically necessary” means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider’s medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.

PROCEDURAL AND DIAGNOSTIC CODING

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

Medicaid recognizes the medical terminology as defined in the Current Procedural Terminology (CPT), Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Ninth Edition (ICD-9), provided by the U.S. National Center for Health Statistics.

ICD-9 codes are used to describe a patient’s diagnosis including symptoms, diseases, or disorders. The ICD-9 code is used to help establish medical necessity for service delivery. Providers must submit a valid ICD-9 diagnosis code on claims that is of the highest level of specificity that describes the service delivered. Patient records should support the codes assigned to all claims. Without the correct diagnosis code appended to a service code, payment can be denied as not meeting medical necessity and are subject to Program Integrity recoupment.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

PROCEDURAL AND DIAGNOSTIC CODING (CONT'D.)

For Dates of Service on or after October 1, 2015:

Medicaid recognizes the medical terminology as defined in the Current Procedural Terminology (CPT), Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Tenth Revision (ICD-10), provided by the U.S. National Center for Health Statistics.

ICD-10 codes are used to describe a patient's diagnosis including symptoms, diseases, or disorders. The ICD-10 code is used to help establish medical necessity for service delivery. Providers must submit a valid ICD-10 diagnosis code on claims that is of the highest level of specificity that describes the service delivered. Patient records should support the codes assigned to all claims. Without the correct diagnosis code appended to a service code, payment can be denied as not meeting medical necessity and are subject to Program Integrity recoupment.

In 1996, the Centers for Medicare & Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The S.C. Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in postpayment review of providers' records. For assistance in billing, providers may access the CCI Edit Information online at the CMS Web site, <http://www.cms.hhs.gov/>.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

DOCUMENTATION REQUIREMENTS

Clinical Records

As a condition of participation in the Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid beneficiary. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care. Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is essential that an internal records review be conducted by each LEA to ensure that the services are medically necessary and appropriate both in quality and quantity, and that service delivery, documentation, and billing comply with Medicaid policy and procedure.

Records Maintenance

There must be a record for each beneficiary that includes sufficient documentation of services rendered to justify Medicaid participation. The record should be arranged in a logical manner so that the clinical description, course of treatment, and services can be easily and clearly reviewed and audited. All clinical records must be kept in a confidential and safeguarded manner as outlined in Section 1.

Medical Services Documentation

Documentation of services should comply with guidelines set forth under each service in this section. Adequate documentation must reflect the following:

- A description of the service
- The need for the service
- The provider who delivered the service
- The length of time of the service delivered
- Future plans for continued care, if applicable

A reviewer should be able to discern from the information that adequate and appropriate observations were used in assessing needs and planning care.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

<i>Medical Services Documentation (Cont'd.)</i>	Notations should be concise, but descriptive and pertinent. Although minimum parameters must be addressed, documentation should reflect individualization of care.
<i>Abbreviations and Symbols</i>	Each provider must maintain a list of approved abbreviations and symbols used in the beneficiary's clinical record.
<i>Legibility</i>	All entries must be in ink or typed, legible, and in chronological order. These entries must be dated (month, day, and year) and legibly signed with the appropriate signatory authority. Providers must maintain a signature sheet that identifies all staff names, signatures, and initials.
<i>Error Correction Procedures</i>	The child's clinical record is a legal document. Therefore, extreme caution should be used when altering any part of the record. Appropriate procedures for the correction of errors in legal documents must be followed when correcting an error in a clinical record. Errors in documentation should never be totally marked out and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature/initials and date next to the correction. If warranted, an explanation of the correction may be appropriate.
Telemedicine	<p>Telemedicine is the use of medical information about a patient that is exchanged from one site to another via electronic communications to provide medical care to a patient in circumstances in which face-to-face contact is not necessary. In this instance, a physician or other qualified medical professional has determined that medical care can be provided via electronic communication with no loss in the quality or efficacy of the care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the patient and the physician or practitioner at the referring site.</p> <p>Telemedicine includes consultation, diagnostic, and treatment services. Telemedicine as a service delivery option, in some cases, can provide beneficiaries with increased access to specialists, better continuity of care, and eliminate the hardship of traveling extended distances.</p>

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Telemedicine (Cont'd.)

Telemedicine services are not an expansion of Medicaid-covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective through medical assessment or problems in beneficiaries' understanding of telemedicine, hands-on or direct face-to-face care must be provided to the beneficiary instead. Quality of health care must be maintained regardless of the mode of delivery.

Consultant Sites

A consultant site means the site at which the specialty physician or practitioner providing the medical care is located at the time the service is provided via telemedicine. The health professional providing the medical care must be currently and appropriately licensed in South Carolina and located within the South Carolina Medical Service Area (SCMSA), which is defined as the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border.

Referring Sites

A referring site is the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunication system occurs. Medicaid beneficiaries are eligible for telemedicine services only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters should be a provider knowledgeable in how the equipment works and can provide the clinical support if needed during a session.

Covered referring sites are:

- The office of a physician or practitioner
- Hospital (Inpatient and Outpatient)
- Rural Health Clinics
- Federally Qualified Health Centers
- Community Mental Health Centers
- Public Schools

Telemedicine Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for telemedicine and telepsychiatry when the service is within the scope of their practice.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Telemedicine Providers (Cont'd.)

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis, and/or treatment.

The consulting provider is the provider who evaluates the beneficiary via telemedicine mode of delivery upon the recommendation of the referring provider. Practitioners at the distant site who may furnish and receive payment of covered telemedicine services are:

- Physicians
- Nurse practitioners

Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician and/or nurse practitioner are the only providers of telepsychiatry services. As a condition of reimbursement, an audio and video telecommunication system that is HIPAA compliant must be used that permits interactive communication between the physician or practitioner at the consultant site and the beneficiary at the referring site.

Office and outpatient visits that are conducted via telemedicine are counted towards the applicable benefit limits for these services.

Medicaid covers telemedicine when the service is medically necessary and under the following circumstance:

- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need; and
- The medical care can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

The list of Medicaid telemedicine services includes:

- Office or other outpatient visits (CPT codes 99201 – 99215)

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Covered Services (Cont'd.)

- Inpatient consultation (CPT codes 99251-99255)
- Individual psychotherapy (CPT codes 90832 – 90838)
- Pharmacologic management (CPT code 90863)
- Psychiatric diagnostic interview examination (CPT code 90791 and 90792)
- Neurobehavioral status examination (CPT code 96116)
- Electrocardiogram interpretation and report only (CPT code 93010)
- Echocardiography (CPT code 93307, 93308, 93320, 93321, and 93325)

Non-Covered Services

The following interactions do not constitute reimbursable telemedicine or telepsychiatry services and will not be reimbursed:

- Telephone conversations
- E-mail messages
- Video cell phone interactions
- Facsimile transmissions
- Services provided by allied health professionals

Coverage Guidelines

The following conditions apply to all services rendered via telemedicine.

1. The beneficiary must be present and participating in the telemedicine visit.
2. The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
3. Interactive audio and video telecommunication must be used; permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the Telemedicine information transmitted.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Coverage Guidelines (Cont'd.)

4. The telemedicine equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Staff involved in the telemedicine visit must be trained in the use of the telemedicine equipment and competent in its operation.
5. An appropriate certified or licensed health care professional at the referring site is required to present (patient site presenter) the beneficiary to the physician or practitioner at the consulting site and remain available as clinically appropriate.
6. If the beneficiary is a minor child, a parent and/or guardian must present the minor child for telemedicine service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.
7. The beneficiary retains the right to withdraw at any time.
8. All telemedicine activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996: Standards for Privacy of individually identifiable Health Information and all other applicable state and federal laws and regulations.
9. The beneficiary has access to all transmitted medical information, with the exception of live interactive video, as there is often no stored data in such encounters.
10. There will be no dissemination of any beneficiary's images or information to other entities without written consent from the beneficiary.
11. The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

Reimbursement for Professional Services

Reimbursement to the health professional delivering the medical service is the same as the current fee schedule amount for the service provided. Consulting site physicians and practitioners submit claims for telemedicine or telepsychiatry services using the appropriate CPT code for

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

*Reimbursement for
Professional Services
(Cont'd.)*

the professional service along with the telemedicine modifier GT, “via interactive audio and video telecommunications system” (e.g., 99243 GT). By coding and billing the “GT” modifier with a covered telemedicine procedure code, the consulting site physician and/or practitioner certifies that the beneficiary was present at originating site when the telemedicine service was furnished. Telemedicine services are subject to copayment requirements. Fee schedule are located on the SCDHHS Web site at <http://www.scdhhs.gov>.

*Reimbursement for the
Originating Site Facility Fee*

The **referring site** is only eligible to receive a facility fee for telemedicine services. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). The reimbursement is \$14.96 per encounter. If a provider from the referring site performs a separately identifiable service for the beneficiary on the same day as telemedicine, documentation for both services must be clearly and separately identified in the beneficiary’s medical record, and both services are eligible for full reimbursement.

*Reimbursement for FQHCs
and RHCs*

Referring Site

RHCs and FQHCs are eligible to receive reimbursement for a facility fee for the telemedicine services when operating as the referring site. Claims must be submitted with HCPCS code Q3014 (Telemedicine originating site facility fee). The reimbursement is \$14.96 per encounter. When serving as the referring site, the RHCs and FQHCs cannot bill the encounter T1015 code if these are the only services being rendered.

Consulting Site

The FQHCs would bill a T1015 encounter code when operating as the consulting site. Only one encounter code can be billed for a date of service. FQHCs will use the appropriate encounter code for the service along with the "GT" modifier (via interactive audio and video telecommunications system) indicating interactive communication was used.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Hospital Providers

Hospital providers are eligible to receive reimbursement for a facility fee for telemedicine when operating as the referring site. Claims must be submitted with revenue code 780 (Telemedicine). There is no separate reimbursement for telemedicine services when performed during an inpatient stay, outpatient clinic or emergency room visit, or outpatient surgery, as these are all-inclusive payments.

Documentation

Documentation in the medical records must be maintained at the referring and consulting locations to substantiate the service provided. A request for a telemedicine service from a referring provider and the medical necessity for the telemedicine service must be documented in the beneficiary's medical record. Documentation must indicate the services were rendered via telemedicine. All other Medicaid documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

- The diagnosis and treatment plan resulting from the telemedicine service and progress note by the health care provider
- The location of the referring site and consulting site
- Documentation supporting the medical necessity of the telemedicine service
- Start and stop times

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

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.

BENEFICIARY REQUIREMENTS

In order to be eligible for School-Based Rehabilitative Therapy Services, a Medicaid-eligible individual must:

- Be under the age of 21 and
- Have a current and valid Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or an Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) examination that identifies the need for rehabilitative therapy services

DOCUMENTATION

Clinical Records

LEAs are required to maintain a clinical record on each Medicaid-eligible child that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid payment. Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of the services provided and progress toward treatment goals. The information in the clinical services notes must be clearly linked to the goals listed on the IEP/IFSP. For example, descriptions should be used to clearly link information from goals to the interventions performed and progress obtained in the clinical service notes. Clinical records should be arranged logically so that information may be easily reviewed, copied, and audited.

The provider of services is required to maintain clinical records on each Medicaid-eligible child. Each clinical record must include the following:

- A referral for services by a physician or other Licensed Practitioner of the Healing Arts (LPHA)

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Clinical Records (Cont'd.)

- A Release of Information form signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the child (this may be incorporated into a Consent for Treatment form)
- Test results and evaluation reports
- A current and valid Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), or valid ITP indicating the child's need for services
- Clinical Service Notes
- Progress Summary Notes

Referrals

Referral by Other Licensed Practitioners of the Healing Arts for Rehabilitative Therapy Services Only (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Orientation & Mobility Services, and Audiology)

Referral means that the physician or other LPHA has asked another qualified health provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies and equipment.

When the IEP/IFSP multidisciplinary team is used as the referral source for Rehabilitative Therapy Services, the team must include an individual who meets the other LPHA as defined by Medicaid. The other LPHA initial referral must be obtained from a Licensed Practitioner of the Healing Arts other than the individual direct provider of the Rehabilitative Service.

The referral documentation must occur prior to the provision of the Medicaid evaluation and Rehabilitative Therapy Service. The referral must meet the following requirements:

- Be updated before the annual renewal of re-evaluation and the IEP
- Be obtained from an LPHA other than the direct provider of services (*e.g.*, the referring LPHA)

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Referrals (Cont'd.)

cannot supervise the service or cosign the documentation)

- Be clearly documented in the clinical record with the name, date, and title of the provider
- Explain reason for referral

The following list indicates the professional designations of those considered as Licensed Practitioners of the Healing Arts for the purpose of Medicaid reimbursement of School-Based Rehabilitative Therapy Services (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Orientation & Mobility Services, and Audiology):

- Licensed Physician Assistant
- Licensed Advanced Practice Registered Nurse (APRN)
- Registered Nurse (RN)
- Licensed Audiologist
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Speech-Language Pathologist
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Psychologist
- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Baccalaureate Social Worker

A beneficiary is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Prior Authorization

School districts that refer children to private therapists/audiologists must provide their seven-digit prior authorization number (beginning with “ED”) to the private therapist/audiologist. The private therapist/audiologist then must enter this number in field 23 on the CMS-1500 claim form.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Release of Information

A Release of Information form must be signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims. This is required for requesting payment of government benefits on behalf of the child. This may be incorporated into a Consent for Treatment form.

Evaluations

Evaluations must occur prior to the provision of the Medicaid Rehabilitative Therapy Service. Evaluations must be completed by the enrolled Medicaid provider of services after receiving the referral from another LPHA.

Re-evaluations

A re-evaluation is performed subsequently to the initial evaluation and relates to the disorder. A re-evaluation must be completed after receiving an updated referral from another LPHA. A re-evaluation must be conducted annually (every 12 months) for each beneficiary; however, a re-evaluation can be within a six-month time frame. A re-evaluation must be completed when enough time has passed to accurately assess the beneficiary's progress. This service may be performed twice a year.

The results of the evaluation must include a narrative summary. The documentation must justify the number of units billed.

Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP)/ Individual Treatment Plan (ITP)

If the evaluation findings indicate a Medicaid Rehabilitative Therapy Service is determined to be medically necessary, the evaluation must result in the development of an IEP or IFSP and the service must be indicated on the IEP or IFSP.

If the evaluation findings do not indicate the need for provision of a Medicaid Rehabilitative Therapy Service, then the results of the evaluation must be indicated on the IEP, IFSP, ITP, or the evaluation instrument in order to be reimbursed by Medicaid. The ITP may be developed as a separate document or may appear as a Clinical Service Note.

Medicaid will not reimburse for providers attending an IEP or an IFSP meeting.

Individual Treatment Plan

If an evaluation indicates that therapy is warranted, the therapist must develop and maintain a treatment plan that

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP)/ Individual Treatment Plan (ITP)
(Cont'd.)

outlines long-term goals, short-term objectives, as well as the recommended scope, frequency, and duration of treatment. The IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the beneficiary. The treatment plan must be individualized and should specify problems to be addressed, goals of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each ITP should specify the exact service the beneficiary should be receiving (*i.e.*, individual or group therapy). If it is found medically necessary for a beneficiary to receive both individual and group therapy services, the ITP must reflect the frequency and duration of treatment for each service (*e.g.*, 30 minutes group therapy per week and 15 minutes individual therapy two (2) times per week). Indicating the beneficiary's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the therapist and the date signed.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new referral must be obtained annually and a new treatment plan must be developed after reevaluation.

Clinical Service Notes

Services should be documented in Clinical Service Notes. A Clinical Service Note is a written summary of each treatment session. The purpose of these notes is to record the nature of the child's treatment by capturing the services provided and summarizing the child's participation in treatment. In the event that services are discontinued, the provider must indicate the reason for discontinuing treatment on the Clinical Service Notes.

Clinical Service Notes must:

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Clinical Service Notes (Cont'd.)

1. Provide a pertinent clinical description of the activities that took place during the session, including an indication of the child's response to treatment as related to stated goals listed in the IEP, IFSP, or ITP
2. Reflect delivery of a specific billable service as identified in the physician's or other LPHA's referral and the child's IEP, IFSP, or ITP
3. Document that the services rendered correspond to billing as to date of service, type of service rendered (i.e. minutes or hours), and length of time of service delivery
4. Be individualized with patient's level of participation and response to intervention when documenting group services

When completing Clinical Service Notes:

1. Each entry must be individualized and patient-specific. Each entry must stand on its own and may not include arrows, ditto marks, "same as above," etc.
2. All entries must be made by the provider delivering the service and should be accurate, complete, and recorded immediately.
3. All entries must be typed or legibly handwritten in dark ink. Copies are acceptable, but must be completely legible. Originals must be available if needed.
4. All entries must be dated and legibly signed with the provider's name or initials and professional title.
5. All entries must be filed in the child's clinical record in chronological order by discipline.

All Clinical Service Notes used must include a narrative summary. The documentation must justify the number of units billed.

Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the provider every three months from the start date of treatment or when

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Progress Summary Notes (Cont'd.)

medically necessary. The purpose of the Progress Summary is to record the longitudinal nature of the child's treatment, describe the child's attendance at therapy sessions, document progress toward treatment goals and objectives, and establish the need for continued participation in treatment.

The Progress Summary must be written by the provider, contain the provider's signature and title as well as the date written, and must be filed in the child's clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled "Progress Summary."

AUDIOLOGICAL SERVICES

Program Descriptions

In accordance with 42 CFR 440.110(c)(1), Audiological Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. It includes any necessary supplies, equipment, and services related to hearing aid use. Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment.

Audiological Services include diagnostic, screening, preventive, and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts, within the scope of his or her practice under state law, must refer individuals to receive these services. A referral occurs when the physician or other LPHA has asked another qualified health care provider (Licensed Audiologist) to recommend, evaluate, or perform therapies, treatment, or other clinical activities for the beneficiary.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff

The following requirements are cited from Section 440.110(c)(3) of the Code of Federal Regulations:

(c) [**Audiological Services** are] services for individuals with speech, hearing, and language disorders.

(1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

A “qualified audiologist” means an individual with a master’s or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets **one** of the following conditions:

(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, **and** the individual is licensed by the State as an audiologist to furnish audiology services.

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet **one** of the following conditions:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master’s or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Supervision See “Supervision” under “Provider Qualifications” earlier in this section.

Hearing Aids Hearing aids may be provided for individuals under the age of 21 when the medical need is established through an audiological evaluation. The attending Audiologist may send a request for a hearing aid or aids, along with a physician’s statement completed within the last six months indicating that there is no medical contraindication to the use of a hearing aid, to the South Carolina Department of Health and Environmental Control’s (DHEC) local Children’s Rehabilitative Services (CRS) office. DHEC will arrange for the requested hearing aids. Children birth to 21 years of age should be enrolled in the CRS program. Requests for hearing aids for children birth to 21 years of age should be sent to:

CRS Central Office
Robert Mills Complex
PO Box 101106
Columbia, SC 29211

For more information, call CRS at (803) 898-0784.

Service Description

Pure Tone Audiometry **92552: Pure tone audiometry (threshold), air only**

In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies in each ear. **This service may be performed six times every 12 months.**

Audiological Evaluation **92557: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**

In comprehensive audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies on each ear. Bone thresholds are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sounds. The patient is also asked to repeat bisyllabic (spondee) words. The threshold is recorded for each ear. The word discrimination score is the percentage of spondee words

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Audiological Evaluation (Cont'd.)

that a patient can repeat correctly at a given intensity level above speech reception threshold in each ear. **This service may be performed once every 12 months.**

92557-52: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

An audiological evaluation is when appropriate components of the initial evaluation are re-evaluated and provided as a separate procedure. The necessity of an audiological evaluation must be appropriately documented. **This service may be performed six times every 12 months.**

Tympanometry (Impedance Testing)

92567: Tympanometry (impedance testing)

Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. **This service may be performed six times every 12 months.**

Acoustic Reflex Testing; Threshold

92568: Acoustic reflex testing; threshold

Acoustic reflex testing, threshold is used in determining the differential diagnosis between, sensory, conductive or central hearing loss. Acoustic reflex test results give the clinician valuable information regarding the severity of a hearing loss and the possible cause of a hearing loss. It is also a valuable test in detecting problems in the auditory pathway. This service may be performed two times every 12 months.

Electrocochleography

92584: Electrocochleography

An electrocochleography tests the internal components of the implanted receiver and connected electrode array. This procedure verifies the integrity of the implanted electrode array and is completed immediately after the operation. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team. **This service may be performed once per implantation.**

Hearing Aid Examination and Selection

92590: Hearing aid examination and selection; monaural

History of hearing loss and ears are examined, medical or surgical treatment is considered if possible, and the

SECTION 2 POLICIES AND PROCEDURES**SCHOOL-BASED REHABILITATIVE THERAPY SERVICES**

Hearing Aid Examination and Selection (Cont'd.)	appropriate type of hearing aid is selected to fit the pattern of hearing loss. This service may be performed six times every 12 months.
Hearing Aid Check	92592: Hearing aid check; monaural The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. This service may be performed six times every 12 months. 92592-52: Hearing aid recheck; monaural The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. This service may be performed six times every 12 months.
Evaluation of Auditory Rehabilitation Status	92626: Evaluation of auditory rehabilitation status; first hour This service involves the measurement of patient responses to electrical stimulation used to program the speech processor and functional gain measurements to assess a patient's responses to his or her cochlear implant. Instructions should be provided to the parent/guardian, teacher, and/or patient on the use of a cochlear implant device to include care, safety, and warranty procedures. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed 10 times a year.
Fitting/Orientation/Checking of Hearing Aid	V5011: Fitting/orientation/checking of hearing aid Includes hearing aid orientation, hearing aid checks, and electroacoustic analysis. The service may be provided six times every 12 months.
Dispensing Fee	V5090: Dispensing fee, unspecified hearing aid The dispensing fee is time spent handling hearing aid repairs. This service may be performed six times every 12 months.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Ear Impression

V5275: Ear impression, each

Taking of an ear impression; please specify one or two units for one or two ears. **This service may be performed six times every 12 months.**

Modifiers LT and RT have been removed from V5275. If you are billing this procedure code, instead of using the modifiers to identify the right and left ear impression, SCDHHS asks that you put one unit with no modifier if you are billing only one ear impression. If you are billing both ear impressions, SCDHHS asks that you put two units with no modifier.

Documentation

See “Documentation” under “School-Based Rehabilitative Therapy Services” and “Documentation Requirements” under “General Information” earlier in this section.

PHYSICAL THERAPY SERVICES

Program Description

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Physical Therapist. It includes any necessary supplies and equipment. Physical Therapy Services involve evaluation and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Specific services rendered: Physical Therapy Evaluation, Individual and Group Therapy (a group may consist of no more than six children).

Physical Therapy Services involve evaluation and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems. Physical Therapy involves the use of physical agents, mechanical means, and other remedial treatment to restore normal physical functioning following illness or injury.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff	Physical Therapy Services are provided by or under the direction of a Physical Therapist.
<i>Physical Therapist</i>	A Physical Therapist (PT) is a person licensed to practice physical therapy by the South Carolina Board of Physical Therapy Examiners. In accordance with 42 CFR 440.110(a)(2)(i)(ii), a qualified physical therapist is an individual who is (i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and (ii) where applicable, licensed by the State.
<i>Physical Therapist Assistant</i>	A Physical Therapist Assistant (PTA) is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. A physical therapy assistant provides services under the direction of a qualified physical therapist.
<i>Supervision of Physical Therapy Assistants</i>	Physical Therapist Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Physical Therapist. Additionally, the supervising therapist must review and initial each Summary of Progress completed by the assistant. These licensed individuals must adhere to any provisions as required by the South Carolina Department of Labor Licensing and Regulations (LLR).
<i>Supervision Requirements</i>	See “Supervision/Under the Direction of under Provider Qualifications.”
Service Description	
<i>Physical Therapy Evaluation</i>	<p>97161-GP: Evaluation of physical therapy, typically 20 minutes</p> <p>97162-GP: Evaluation of physical therapy, typically 30 minutes</p> <p>97163-GP: Evaluation of physical therapy, typically 45 minutes</p> <p>A Physical Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the</p>

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Physical Therapy Evaluation Cont'd.)

American Physical Therapy Association and South Carolina Board of Physical Therapy Examiners guidelines, the physician or other LPHA, the Physical Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records, an observation of the patient, and an interview, when possible. The evaluation must include diagnostic testing and assessment, and a written report with recommendations.

Individual and Group Physical Therapy

Individual 97110-GP: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility

Group 97150-GP: Therapeutic procedure(s), group (two or more individuals)

Individual or Group Physical Therapy is the development and implementation of specialized Physical Therapy programs that incorporate the use of appropriate modalities; performance of written and/or oral training of teachers and/or family regarding appropriate Physical Therapy activities/therapeutic positioning in the school or home environment; recommendations on equipment needs; and safety inspections and adjustments of adaptive and positional equipment. Physical Therapy performed on behalf of one child should be documented and billed as Individual Physical Therapy. Physical Therapy performed on behalf of two or more clients should be documented and billed as Group Physical Therapy. A group may consist of no more than six children.

Documentation

See "Documentation" under "School-Based Rehabilitative Therapy Services" and "Documentation Requirements" under "General Information" earlier in this section.

Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the physical therapy practitioner every three months from the start date of treatment. The purpose of the Progress Summary is to record the longitudinal nature of the child's treatment, describe the child's attendance at therapy sessions, document progress toward treatment goals, and establish the need for continued participation in therapy.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Progress Summary Notes (Cont'd.)

The Progress Summary must be written by the physical therapy practitioner, contain the therapist's signature and title as well as the date written, and must be filed in the child's clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled "Progress Summary."

OCCUPATIONAL THERAPY SERVICES

Program Description

In accordance with 42 CFR 440.110(b)(1), Occupational Therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Occupational Therapist. It includes any necessary supplies and equipment. Occupational therapy services are channels to improve or restore functional abilities for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Occupational Therapy Services are related to Self-Help Skills, Adaptive Behavior, Fine/Gross Motor, Visual, Sensory Motor, Postural, and Emotional Development that have been limited by a physical injury, illness, or other dysfunctional condition. Occupational Therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance. Specific services rendered: Occupational Therapy Evaluation, Individual and Group Occupational Therapy (a group may consist of no more than six children), Fabrication of Orthotic, Fabrication of Thumb and Finger Splints.

Program Staff

Occupational Therapy Services are provided by Occupational Therapists or Occupational Therapy Assistants.

Occupational Therapist

An **Occupational Therapist (OT)** is a person licensed to practice occupational therapy by the South Carolina Board of Occupational Therapy. In accordance with 42 CFR 440.110(b)(2)(i)(ii) a qualified occupational therapist is – (i) certified by the National Board of Certification for Occupational Therapy; or (ii) a graduate of a program in

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Occupational Therapist (Cont'd.)

occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before certification by the National Board of Certification for Occupational Therapy.

Occupational Therapy Assistant

An **Occupational Therapy Assistant (OTA)** is an individual who is currently licensed as a Certified Occupational Therapy Assistant (COTA/L or OTA) by the South Carolina Board of Occupational Therapy who works under the direction of a qualified occupational therapist pursuant to 42 CFR 440.110(b)(2)(i) or (ii).

Supervision of Occupational Therapy Assistants

Occupational Therapy Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Occupational Therapist. Additionally, the supervising therapist must review and initial each Progress Summary completed by the assistant. These licensed individuals must adhere to any provisions as required by South Carolina Department of Labor, Licensing, and Regulation (LLR).

Supervision Requirements

See Supervision/Under the Direction of under Provider Qualifications.

Service Description

Occupational Therapy Evaluation

97165-GO: Evaluation of occupational therapy, typically 30 minutes

97166-GO: Evaluation of occupational therapy, typically 45 minutes

97167-GO: Evaluation of occupational therapy, typically 60 minutes

An Occupational Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Occupational Therapy Association and South Carolina Board of Occupational Therapy guidelines, the physician or other LPHA referral, the Occupational Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records and an observation of the patient and interview, when possible. The evaluation must

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Occupational Therapy Evaluation (Cont'd.)

include diagnostic testing and assessment and a written report with recommendations.

Individual and Group Occupational Therapy

Individual 97530-GO: Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Group 97150-GO: Therapeutic procedure(s), group (two or more individuals)

Individual or Group Occupational Therapy involves the development and implementation of specialized Occupational Therapy programs that incorporate the use of appropriate interventions, occupational therapy activities in the school or home environment, and recommendations on equipment needs and adaptations of physical environments.

Occupational Therapy performed directly with one child should be documented and billed as Individual Occupational Therapy. Occupational Therapy performed for two or more individuals should be documented and billed as Group Occupational Therapy. A group may consist of no more than six children.

Fabrication of Orthotic

Fabrication of Orthotics for upper and lower extremities and Thumb and Finger Splints: Fabrication of Orthotic is the fabrication of orthotics for lower and upper extremities, and the Fabrication of Thumb Splint and Finger Splint is the fabrication of orthotic for the thumb and likewise, the fabrication of Finger Splint is the fabrication of orthotic for the finger.

L2999: Fabrication of Orthotic

Lower extremity orthoses, not otherwise specified (NOS)

L3999: Fabrication of Orthotic

Upper limb orthosis, not otherwise specified (NOS)

Wrist Hand Finger Orthosis (WHFO)

L3808: Wrist hand finger orthosis

Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Documentation See “Documentation” under “School-Based Rehabilitative Therapy Services” and “Documentation Requirements” under “General Information” earlier in this section.

Progress Summary Notes The Progress Summary is a written note outlining the child’s progress that must be completed by the occupational therapy practitioner every three months from the start date of treatment. The purpose of the Progress Summary is to record the longitudinal nature of the child’s treatment, describe the child’s attendance at therapy sessions, document progress toward treatment goals, and establish the need for continued participation in therapy.

The Progress Summary must be written by the occupational therapy practitioner, contain the therapist’s signature and title as well as the date written, and must be filed in the child’s clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled “Progress Summary.”

SPEECH-LANGUAGE PATHOLOGY SERVICES

Program Description

In accordance with 42 CFR 440.110(c)(1), Speech-Language Pathology Services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a Speech-Language Pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment. Speech-Language Pathology Services means evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (*i.e.*, Curriculum-Based Assessments, Portfolio Assessments, Criterion Referenced Assessments, Developmental Scales, and Language Sampling Procedures) may be used. Tests or measures described as “teacher-made” or “informal” are not acceptable for purposes of Medicaid reimbursement. Specific services rendered: Speech Evaluation, Individual Speech Therapy, and Group Speech Therapy (and group may consist of no more than six children).

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Description (Cont'd.)

Speech-Language Pathology Services involve the evaluation and treatment of speech and language disorders for which medication or surgical treatments are not indicated. Services include preventing, evaluating, and treating disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition/communication, auditory and/or visual processing and memory, and interactive communication; as well as the use of augmentative and alternative communication systems (sign language, gesture systems, communication boards, electronic automated devices, mechanical devices) when appropriate.

Program Staff

Speech Language Pathology Services are provided by or under the direction of a Speech-Language Pathologist. We recognize that some individuals in the school setting will be licensed through LLR as Speech-Language Pathologists, Speech-Language Pathology Assistants, Speech-Language Pathology Interns, or Speech-Language Pathology Therapists. These licensed individuals will need to adhere to any provisions as required by LLR. The licensed Speech-Language Pathologist can supervise the licensed Speech-Language Pathology Intern and Speech-Language Pathology Assistant or Speech-Language Pathology Therapist.

A **Speech-Language Pathologist** in accordance with 42 CFR 440.110(c)(2)(i)(ii)(iii) is an individual who meets one of the following conditions: (i) Has a certificate of Clinical Competence from the American Speech and Hearing Association. (ii) Has completed the necessary equivalent educational requirements and work experience to qualify for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

A **Speech-Language Pathology Assistant** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology. The Speech-Language Pathology Assistant works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

A **Speech-Language Pathology Intern** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology and is seeking

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff (Cont'd.)	<p>the academic and work experience requirements established by the American Speech and Hearing Association (ASHA) for the Certification of Clinical Competence in Speech-Language Pathology. The Speech-Language Pathology Intern works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).</p> <p>A Speech-Language Pathology Therapist is an individual who does not meet the credentials outline in the 42 CFR 440.110(c)(2)(i)(ii) and (iii) that must work under the direction of a qualified Speech-Language Pathologist.</p>
Supervision Requirements	See “Supervision” under “Provider Qualifications” earlier in this section.
Service Description	
<i>Speech-Language Pathology Services</i>	<p>Reimbursable Speech-Language Pathology Services are evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (<i>i.e.</i>, curriculum-based assessments, portfolio assessments, criterion referenced assessments, developmental scales, and language sampling procedures) may be used. Tests or measures described as “teacher-made” or “informal” are not acceptable for purposes of Medicaid reimbursement. The following services are components of Speech-Language Pathology Services.</p>
<i>Speech Evaluation</i>	<p>92521: Evaluation of speech fluency (<i>e.g.</i>, stuttering, cluttering)</p> <p>92522: Evaluation of speech sound production (<i>e.g.</i>, articulation, phonological process, apraxia, dysarthria)</p> <p>92523: Evaluation of speech sound production (<i>e.g.</i>, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (<i>e.g.</i>, receptive and expressive language)</p> <p>92524: Behavioral and qualitative analysis of voice and resonance</p> <p>92610: Evaluation of oral and pharyngeal swallowing function</p>

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Speech Evaluation (Cont'd.)

The appropriate procedure code may be billed for an initial speech evaluation performed on or after January 1, 2014.

Upon receipt of the physician or other LPHA referral, a Speech Evaluation is conducted. A Speech Evaluation is a face-to-face interaction between the Speech-Language Pathologist and the child for the purpose of evaluating the child's dysfunction and determining the existence of a speech disorder. The evaluation should include review of available medical history records and must include diagnostic testing and assessment, and a written report with recommendations. **This service may be performed once per lifetime.**

Note: Reimbursement is available for a subsequent initial evaluation if, and only if, it is conducted as the result of a separate and distinct speech disorder. Presentation of medical justification is required. Contact the PSC or submit an online inquiry for more information.

S9152: Re-evaluation of speech, language, voice, communication, and/or auditory processing

Speech Re-evaluation includes a face-to-face interaction between the Speech-Language Pathologist/Therapist and the child for the purpose of evaluating the child's progress and determining if there is a need to continue therapy. Re-evaluation may consist of a review of available medical records and diagnostic testing and/or assessment, but must include a written report with recommendations.

Any evaluation performed subsequently to the initial evaluation and related speech disorder is considered a re-evaluation and should be billed under this code.

Individual Speech Therapy

92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

Individual Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps to a child whose speech and/or language patterns deviate from standard, based on evaluation and testing, to include training of teacher or parent with child present. Individual Speech Therapy Services may be provided in a regular education classroom.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Group Speech Therapy

92508: Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals

Group Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps in a group setting to children whose speech and/or language patterns deviate from standard, based on evaluation and testing, to include training of teacher or parent with child present. A group may consist of no more than six children. Group Speech Therapy services may be provided in a regular education classroom.

Speech Language Disorders

Reimbursement may be available for assessment and treatment of the following categories of speech-language disorders.

1. A developmental language disorder is the impairment or deviant development of comprehension and/or use of a spoken, written, and/or other symbol system (*e.g.*, sign/gesture). A developmental language disorder ranges from mild delays to severe impairment. The disorder may evidence itself in the form of language (phonologic, morphologic, and syntactic systems), content of language (semantic system), and/or function of language in communication (pragmatic system) in any combination.
2. An acquired language disorder (non-developmental) occurs after gestation and birth with no common set of symptoms. Acquired language disorders may differ in the areas of language affected and in severity, and may occur at any age. Causes may include focal and diffuse lesions such as those associated with traumatic brain injury and other kinds of brain injury or encephalopathy.
3. An articulation disorder is incorrect production of speech sounds due to faulty placement, timing, direction, pressure, speech, or integration of the movement of the lips, tongue, velum, or pharynx.
4. A phonological disorder is a disorder relating to the component of grammar that determines the meaningful combination of sounds.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Speech Language Disorders (Cont'd.)

5. A fluency disorder is an interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. This may be accompanied by excessive tension, struggle behavior, and secondary mannerisms.
6. A voice disorder is any deviation in pitch, intensity, quality, or other basic vocal attribute, which consistently interferes with communication, or adversely affects the speaker or listener, or is inappropriate to the age, sex, or culture of the individual.
7. A resonance disorder is an acoustical effect of the voice, usually the result of a dysfunction in the coupling or uncoupling of the nasopharyngeal cavities.
8. Dysphagia is difficulty in swallowing due to inflammation, compression, paralysis, weakness, or hypertonicity in the oral, pharyngeal, or esophageal phases.

Documentation

Medical necessity criteria must be met for all services billed to Medicaid.

See “Documentation” under “School-Based Rehabilitative Therapy Services” and “Documentation Requirements” under “General Information” earlier in this section.

ORIENTATION AND MOBILITY (O&M) SERVICES

PROGRAM DESCRIPTION

Orientation and Mobility (O&M) Services are provided to assist individuals who are blind and visually impaired to achieve independent movement within the home, school, and community settings. O&M Services utilize concepts, skills, and techniques necessary for a person with visual impairment to travel safely, efficiently, and independently through any environment and under all conditions and situations. The goal of these services is to allow the individual to enhance existing skills and develop new skills necessary to restore, maximize, and maintain physiological independence.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff	<p>O&M Services are performed by an Orientation and Mobility Specialist.</p> <p>An Orientation and Mobility (O&M) Specialist is an individual who holds a current and valid certification in Orientation and Mobility from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or an individual who holds a current and valid certification in Orientation and Mobility from the National Blindness Professional Certification Board (NBPCB).</p>
Beneficiary Requirements	<p>To be eligible to receive Medicaid-reimbursable O&M Services, an individual must meet all of the following requirements:</p> <ul style="list-style-type: none">• Be a Medicaid beneficiary under the age of 21 whose need for services is identified through a current and valid Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)• Have a vision report completed by an Optometrist or Ophthalmologist that verifies visual impairment or blindness
Provider Qualifications	<p>Providers who render O&M services must meet the following requirements:</p> <ul style="list-style-type: none">• The service must be recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.• The service must be provided for a defined period of time, for the maximum reduction of physical or mental disability and restoration of the individual to his or her best possible functional level.• The service must be furnished by individuals working under a recognized scope of practice established by the state or profession.
<i>Assessment</i>	<p>T1024</p> <p>An Orientation & Mobility Assessment is a comprehensive evaluation of the child's level of adjustment to visual impairment and current degree of independence with or without assistive/adaptive devices, including functional use</p>

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

<i>Assessment (Cont'd.)</i>	of senses, use of remaining vision, tactile/Braille skills, and ability to move safely, purposefully, and efficiently through familiar and unfamiliar environments. Assessment must include a review of available medical history records, diagnostic testing and assessment, and written report with recommendations.
<i>Reassessment</i>	T1024-TS An Orientation & Mobility Reassessment is an evaluation of the child's progress toward treatment goals and determination of the need for continued services. Reassessment may consist of a review of available medical history records and diagnostic testing and assessment, but must include a written report with recommendations. Reassessment must be completed at least annually but more often when appropriate.
<i>Services</i>	T1024-TM Orientation & Mobility Services is the use of systematic techniques designed to maximize development of a visually impaired child's remaining sensory systems to enhance the child's ability to function safely, efficiently, and purposefully in a variety of environments. O&M Services enable the child to improve the use of technology designed to enhance personal communication and functional skills such as the long cane, pre-mobility and adapted mobility devices, and low vision and electronic travel aids. O&M Services may include training in environmental awareness, sensory awareness, information processing, organization, route planning and reversals, and training in balance, posture, gait, and efficiency of movement. O&M Services may also involve the child in-group activities to increase their capacity for social participation, or provide adaptive techniques and materials to improve functional activities such as eating, food preparation, grooming, dressing, and other living skills.
<i>Documentation</i>	See "Documentation" under "School-Based Rehabilitative Therapy Services" and "Documentation Requirements" under "General Information" earlier in this section.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

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SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID- COVERED SCHOOL-BASED SERVICES

NURSING SERVICES FOR CHILDREN UNDER 21

Program Description

Nursing Services for Children Under 21 are those specialized health care services including nursing assessment and nursing diagnosis; direct care and treatment; administration of medication and treatment as authorized and prescribed by a physician or dentist and/or other licensed/authorized healthcare personnel; nurse management; health counseling; and emergency care. A Registered Nurse as allowed under state licensure and regulation must perform acts of nursing diagnosis or prescription of therapeutic or corrective measures.

The need for services must be appropriately documented in an Individualized Education Program (IEP), Individualized Family Services Plan (IFSP), Treatment Plan, or Clinical Service Notes, when appropriate.

Program Staff

A **nurse** is defined as an individual who is currently licensed as a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) by the State Board of Nursing for South Carolina.

Services performed by health room aides, nurses' aides or any other unlicensed medical personnel are not Medicaid reimbursable.

Licensed Practical Nurse

An LPN must adhere to the following when providing Nursing Services:

1. An LPN must be supervised at all times by a RN. The RN may either be physically present or accessible by phone or pager (Exceptions to on-site supervision are allowable in accordance with SC Code of Law, Title 40-33-770).
2. The LPN can provide any service allowable under state licensure and regulations.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Licensed Practical Nurse (Cont'd.)

3. The LPN must follow the policies, procedures, and guidelines for the employing entity.
4. The RN supervisor will provide the initial assessment of the child's condition as appropriate and establish a plan of care based on the child's medical condition in accordance with state licensure and regulation. If the LPN receives additional information regarding the child's health condition after the initial assessment, the LPN will consult with the RN in accordance with Advisory Opinion #23 of the South Carolina Board of Nursing.
5. Supervision by the RN of the LPN must be performed at a minimum of every 60 days. This can be done through direct observation or a review of clinical service notes.

Physician Oversight

Medicaid recognizes Nursing Services as those that fall within the scope of practice of an RN or LPN as authorized by the South Carolina State Board of Nursing. Nursing Services may be billed to Medicaid provided all services rendered are allowed under state law. Administering prescription medications and conducting medical acts must be under the direction of a physician, dentist, or other authorized personnel or included in a written protocol. If a nurse is practicing in an "Extended Role" according to the Nurse Practice Act (§ 40-33-270 of the 1976 code), a written physician preceptor agreement and a written protocol must be agreed upon by the physician and nurse, signed and dated by both parties, and reviewed annually. The preceptor agreement and written protocols must be readily available for review by SCDHHS upon request.

All requirements stated in the Nurse Practice Act (§40-33-270 of the 1976 code) and the Medical Practice Act (§40-47-10) must be met and followed. Additionally, specific requirements for written protocols may be found in these statutes. If a physician preceptor agreement and written protocols are in place, the physician must be readily available and be able to be contacted in person or by telecommunications or other electronic means to provide consultation and advice when needed.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Service Description

Services that are part of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination are not reimbursable under this program. However, services rendered subsequent to and as a result of an anomaly discovered during an EPSDT exam are reimbursable. EPSDT provides a comprehensive and preventive, well child screening program in South Carolina. EPSDT provides comprehensive and preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. If you would like additional information about the EPSDT program, contact the PSC at 1-888-289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>. Mass screenings are not reimbursable under this program; however, vision and hearing assessments are reimbursable if they are performed in conjunction with a nursing assessment for IEP services.

Reimbursement is available for services that conform to accepted methods of diagnosis and treatment for appropriate personnel. Reimbursement is not available for time spent documenting services, time spent traveling to or from services, or for cancelled visits and missed appointments. Medicaid will only pay for nursing direct service provision. Observation is included in the direct services payment as long as the nurse (RN or LPN) is attending to one individual during a face-to-face encounter. If the child needs monitoring after a specific service provision, then his or her Plan of Care documentation must reflect the ongoing need for monitoring. Although the nurse may be accountable for the time the child is in the Health Room, it may not be Medicaid-billable time.

Reimbursable nursing services under this program will include any service that an RN or LPN is allowed to provide under state licensure and regulation. Nursing Services can include, but are not limited to, the following: nursing care assessments, nursing procedures, emergency care, or individual/group health counseling.

Nursing Assessment

- Nursing assessment of applicants registering for early child development programs
- Nursing assessment of children referred for special education eligibility evaluation
- Nursing assessment related to the IEP, IFSP, or ITP

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Nursing Assessment (Cont'd.)

- Nursing assessment of new or previously identified medical/health problems based on child initiated or teacher/staff referral to nurse, including substance use assessment, child abuse assessment, pregnancy confirmation, etc.
- Home visits for comprehensive health, developmental, and/or environmental assessment

Nursing referrals for any reasons are Medicaid reimbursable only when they occur as a part of a Nursing Assessment.

Nursing Care Procedures

- Administration of immunizations to children in accordance with state immunization law
- Medication assessment, monitoring, and/or administration
- Interventions related to the IEP, IFSP, or ITP
- Nursing procedures required for specialized health care including, but not limited to, feeding, catheterization, respiratory care, ostomies, medical support systems, collecting and/or performance of test, other nursing procedures, and development of health care and emergency protocols (See chart on following page.)

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

NURSING PROCEDURES REIMBURSED BY MEDICAID	
Feeding	<ul style="list-style-type: none"> • Nutritional assessment • Naso-gastric feeding • Gastrostomy feeding • Jejunostomy tube feeding • Parenteral feeding (IV) • Naso-gastric tube insertion or removal • Gastrostomy tube reinsertion
Catheterization	<ul style="list-style-type: none"> • Clean intermittent catheterization • Sterile catheterization
Respiratory Care	<ul style="list-style-type: none"> • Postural drainage • Percussion • Pharyngeal suctioning • Tracheostomy tube replacement • Tracheostomy care
Ostomies	<ul style="list-style-type: none"> • Ostomy care • Ostomy irrigation
Medical Support Systems	<ul style="list-style-type: none"> • Ventricular peritoneal shunt monitoring • Mechanical ventilator monitoring and emergency care • Oxygen administration • Nursing care associated with Hickman/Broviac/IVAC/IMED • Nursing care associated with peritoneal dialysis • Apnea monitoring • Medications: Administration of medications-oral, injection, inhalation, rectal, bladder, instillation, eye/ear drops, topical, intravenous
Collecting and/or Performance of Test	<ul style="list-style-type: none"> • Blood glucose • Urine glucose • Pregnancy testing
Other Nursing Procedures	<ul style="list-style-type: none"> • Sterile dressing • Soaks
Development of Health Care and Emergency Protocols	<ul style="list-style-type: none"> • Health care procedures • Emergency Protocols • Health for Individual Education Plan (IEP), Individual Family Services Plan (IFSP), or Individualized Treatment Plan

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Emergency Care

Emergency Care is the assessment, planning, and intervention for emergency management of a child with a chronic or debilitating health impairment.

The provision of emergency care may include the following:

- Nursing assessment and emergency response treatment (*e.g.*, CPR, oxygen administration, seizure care, administration of emergency medication, and triage).
- Post-emergency assessment and development of preventive action plan

Individual/Group Health Counseling

Individual/Group Health Counseling is the nursing assessment, health counseling, and anticipatory guidance for a child's identified health problem or developmental concern. There is no reimbursement for Health Education.

Documentation

See "Documentation Requirements" under "General Information" earlier in this section.

SECTION 2 POLICIES AND PROCEDURES

SOUTH CAROLINA MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING

Some of the activities routinely performed by school districts are activities that could be eligible for Medicaid reimbursement under the School District Administrative Claiming (SDAC) Program. The South Carolina Medicaid School-Based Administrative Claiming Guide is intended to provide information for schools, State Medicaid Agencies, Centers for Medicare and Medicaid Services staff, and other interested parties on the existing requirements for claiming Federal Financial Participation (FFP). To obtain a copy of the guide, contact the PSC or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED PSYCHOLOGICAL TESTING AND EVALUATION

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SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

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. Local Education Agency (LEA) providers must administer a Diagnostic Assessment to determine if services are medically necessary for Rehabilitative Behavioral Health Services (RBHS). If deemed medically necessary for further clinical understanding or treatment planning, Psychological Testing and Evaluation may be used for the purpose of psycho-diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis before RBHS are rendered. Refer to Assessment services for further guidelines.

As of July 1, 2016, all RBHS services are covered under the managed care benefit package. If a beneficiary is enrolled with one of Medicaid's contracted MCOs, all RBHS providers, including SC Local Education Agencies (LEAs) must receive prior approval and claim reimbursement directly from the member's MCO for services covered under the managed care service package. Please refer to the managed care policy and procedure manual at https://msp.scdhhs.gov/managed_care/site-page/mco-contract-pp for additional information regarding behavioral health and substance abuse services.

The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at <https://msp.scdhhs.gov/managedcare/> for additional information regarding MCO coverage. This policy covers Fee-For-Service only.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

REQUIREMENTS FOR PARTICIPATION IN REHABILITATIVE BEHAVIORAL HEALTH SERVICES

As outlined in 42 CFR 440.130.d, Rehabilitative Behavioral Health Services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice, under South Carolina State Law and as further determined by the South Carolina Department of Health and Human Services (SCDHHS) for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. This section describes these services, legal authorities, and the characteristics of the providers of services.

Potential Local Education Agency (LEA) providers must complete the following in order to become an approved RBHS provider.

The following information should be submitted to the Division of Behavioral Health Services:

- List of Professional Staff
- List of the Professional License
- List of RBHS Services that the district will render

Once the potential provider has completed the applicable RBHS information, please forward to:

SC Department of Health and Human Services
Division of Behavioral Health
PO Box 8206
Columbia, SC 29202-8206

Or

Behavioralhealth002@scdhhs.gov

Upon receipt of the information, the Division of Behavioral Health will review the items listed on the statements. If additional information or clarification is needed, potential providers will be contacted.

Upon approval, the LEA will be notified of the application status by the Division of Behavioral Health.

As a condition of participation in the Medicaid program, the provider must ensure that adequate and correct fiscal and medical records shall be kept. Such disclosures will

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

REQUIREMENTS FOR PARTICIPATION IN REHABILITATIVE BEHAVIORAL HEALTH SERVICES (CONT'D.)

indicate the extent of services rendered and ensure that claims for funds are in accordance with all applicable laws, regulations, and policies.

Providers are encouraged to subscribe to SCDHHS Medicaid Bulletins located on our Web site under Providers, to receive bulletins and newsletters via email. You may review the manual for policy and procedures at the SCDHHS Web site. Updates and changes will continue to be posted on the SCDHHS Web site at <http://www.scdhhs.gov/>.

SC MOTOR VEHICLE DRIVING RECORD

If an employee's position description requires that he or she transport beneficiaries, a copy of their motor vehicle record (MVR) shall be kept in the employee's personnel record. Individuals whose MVR shows involvement in more than two accidents in the last three years in which said individual was at fault, or against whom more than eight current violation points have been assessed, shall be unqualified to transport beneficiaries.

Providers must also adhere to any other state or federal regulations regarding transportation of beneficiaries as applicable, *e.g.*, "Jacob's Law."

BUSINESS REQUIREMENTS

Once enrolled, these requirements must be met:

- SCDHHS and USDHHS assume no responsibility with respect to accidents, illness, or claims arising out of any activity performed by any State or private organization. The organization shall take necessary steps to insure or protect its recipient, itself and its personnel. The provider agrees to comply with all applicable local, staff, and federal occupational and safety acts, rules and regulations.
- Providers must have cost information available for review by SCDHHS upon request.
- Providers must have a policy on file for the 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.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

MAINTENANCE OF STAFF CREDENTIALS

Providers shall ensure that all staff, subcontractors, volunteers, interns, and other individuals under the authority of the provider who come into contact with beneficiaries are properly qualified, trained, and supervised. Providers must comply with all other applicable state and federal requirements.

The provider must also identify a clinical director responsible for supervision of the Rehabilitative program. The clinical director must be a licensed and/or master's level clinical professional. The clinical director must be available to staff by phone during all hours the provider is in operation for clinical consultation and emergency support. During times of absence (e.g., medical leave, vacation, etc.), the provider must appoint, in writing, a qualified designee.

All providers shall maintain a file substantiating that each treatment staff member meets staff qualifications. This shall include employer verification of staff certification, licensure, diploma, or degree or school transcripts and work experience. The treatment provider must maintain a signature sheet that identifies all professionals providing services by name, signature, and initial.

All providers 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 "corporate office," the provider will be given five business days to retrieve the records for the agency that is requesting them.

All providers who enroll with South Carolina Medicaid to provide services in a category that require a professional license must be licensed to practice in the State of South Carolina and operate within their scope of practice as required by South Carolina State Law. Providers rendering services outside of the South Carolina border must not exceed the licensed scope of practice granted under that state's laws. Providers who enroll as a physician or LPHA must be able to document experience working with the population to be served. Any services that are provided by staff who do not meet SCDHHS staff qualification requirements are subject to recoupment.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

REPORTING PROGRAM CHANGES

Certain changes may impact your status as a South Carolina Medicaid provider. Changes affecting business operations must be reported to the Division of Behavioral Health within ten days of the change, using the Program Changes for Rehabilitative Behavioral Health Services Form (located in the 'Forms' section of the manual). The form can be submitted via the following options:

E-mail: behavioralhealth002@scdhhs.gov

Fax: (803) 255-8204

The following changes must be reported by the director of the RBHS program or by management:

- Email addresses or telephone numbers of the primary business location or mailing address
- Clinical Director or Director of the Program
- Adverse events concerning staff licensure
- Other changes which affect compliance with Medicaid requirements

Providers wishing to expand their services must obtain approval from the Division of Behavioral Health prior to the expansion. An expansion is defined as adding a new population to be served, and adding an additional service.

BUSINESS TERMINATION GUIDELINES

In the event the LEA is no longer operational and closes for business, the LEA will adhere to all applicable state laws, rules, and regulations, including but not limited to, the following requirements:

- Upon voluntary termination or closure, the LEA shall provide written notification 30 days prior to closure to SCDHHS and other appropriate agencies.
- The notification shall include the location where beneficiary and administrative records will be stored.
- The LEA is responsible for retaining administrative and beneficiary records for five years.
- Prior to the LEA closure, the district provider shall notify all beneficiaries and assist them with

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

BUSINESS TERMINATION GUIDELINES (CONT'D.)

discharge planning, ensuring continuity of care; evidence of these efforts shall be retained by the provider.

- When a LEA closes, the clinical director is responsible for releasing records to any beneficiary who requests a copy of his or her records. The clinical director must also be responsible for the transfer of records to the appropriate state agencies, if applicable.
- The LEA will be responsible for any outstanding Program Integrity Issues, including any refunds of overpayments that occurred during the time it was active in the Medicaid program.
- 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.
- This information must be submitted in writing via the following options:
 - Behavioralhealth002@scdhhs.gov
 - Fax: (803) 255-8204

REHABILITATIVE SERVICES

The following rehabilitative behavioral health services can be rendered in accordance with this policy:

- Behavioral Health Screening
- Diagnostic Assessment
- Psychological and Evaluation and Testing
- Individual Psychotherapy
- Group Psychotherapy
- Multiple Family Group Psychotherapy
- Family Psychotherapy
- Service Plan Development
- Crisis Management
- Psychosocial Rehabilitation Services
- Behavior Modification
- Family Support

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

UNIT OF SERVICE

Rehabilitative Behavioral Health Services must be billed in units or encounters as defined in the service standard. Providers must maintain adequate documentation to support the number of units or encounters billed.

ELIGIBILITY FOR REHABILITATIVE SERVICES

The determination of eligibility for RBHS should include a system-wide assessment and/or an intake process. This requires that specific information be gathered consistently regardless of the assessment tool being used. **Medicaid-eligible beneficiaries may receive RBHS when there is a confirmed psychiatric diagnosis 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 behavioral health that meets current edition DSM criteria).**

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

The use of V-codes is allowed under certain circumstances, but in general is considered temporary. Please see additional guidance regarding V-Codes and Medical Necessity for Child and Adolescent Community Support Services later in the manual.

For dates of service on or after October 1, 2015:

The use of Z-codes is allowed under certain circumstances, but in general is considered temporary. Please see additional guidance regarding Z-Codes and Medical Necessity for Child and Adolescent Community Support Services later in the 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 reasonably expected to relieve pain, improve and preserve health, or be essential to life.

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for RBHS. A LPHA hired by the school district must certify that the beneficiary meets the medical necessity criteria for services. LPHAs authorized to confirm medical necessity can be found under “Licensed Practitioners of the Healing Arts (LPHAs).”

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

MEDICAL NECESSITY (CONT'D.)

If the Medicaid recipient is in Fee for Service Medicaid, the following guidelines must be used to confirm medical necessity. If the Medicaid recipient is in one of the managed-care plans, SCDHHS allows for Managed Care Organizations (MCO's) to set prior authorization rules and guidance.

Services are not primarily for the benefit of the provider and/or for the convenience of the beneficiary/family, caretaker, or provider. Services and treatment shall be consistent with generally accepted professional standards of practice as determined by the Medicaid program, shall not be experimental, or investigational in nature, and shall be substantiated by records including evidence of such medical necessity and quality.

The determination of medically necessary treatment must be:

- Based on information provided by the beneficiary, the beneficiary's family, and/or collaterals 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.)
- Made by a RBHS - LPHA enrolled in SC Medicaid

Documenting Medical Necessity

As of July 1, 2016, medical necessity must be documented on a diagnostic assessment. For beneficiaries receiving services prior to July 1, 2016 whose medical necessity was documented via the IPOC, a diagnostic assessment must be completed to document medical necessity before the expiration of the IPOC.

The DA must be completed prior to any RBHS services being rendered.

The diagnostic assessment must document the presence of a serious behavioral health disorder 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. The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Documenting Medical Necessity (Cont'd.)

Required elements of the diagnostic assessment can be referenced in the Diagnostic Assessment Service description located later in this manual.

The LPHA's name, professional title, signature and date must be listed on the document to confirm medical necessity.

The diagnostic assessment must be maintained in the Medicaid beneficiary's clinical record and available during post-payment review.

Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative service(s).

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

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.

REFERRAL PROCESS TO PRIVATE RBHS PROVIDERS

Referrals may be made to private providers enrolled in the SC Medicaid Program.

Referrals from an LEA must be done via encrypted email, fax and hard copy mail.

The Rehabilitative Behavioral Health Services Referral Form must be completed and signed by an LPHA. This form may be found in Section 4.

The form must document presence of serious mental health and/or substance use disorder(s) or serious emotional disturbance (SED) 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 health disorder that meets the current edition DSM criteria.

- Upon receipt of the Rehabilitative Behavioral Health Services Referral Form from an LEA, the private provider will submit the form to the Quality Improvement Organization (QIO) for prior authorization.

Note: Providers must comply with the provisions of the

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

REFERRAL PROCESS TO PRIVATE RBHS PROVIDERS (CONT'D.)

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

When referrals are made between providers, the referring provider should furnish the receiving provider the assessment, IPOC, list of services to render and any other clinical documentation.

Who Can Confirm Medical Necessity for LEAs - RBHS Licensed Practitioners of the Healing Arts (LPHAs)

The following professionals are considered Licensed Practitioners of the Healing Arts and must confirm medical necessity:

- Licensed Psychiatrist
- Licensed Physician
- Licensed PhD and PsyD Psychologists
- Licensed Advanced Practice Registered Nurse
- Licensed Independent Social Worker-Clinical Practice
- Licensed Master Social Worker
- Licensed Physician's Assistant
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Psycho-Educational Specialist

Retroactive Coverage

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

UTILIZATION REVIEW

All providers will ensure that only authorized amounts of services are provided and submitted to SCDHHS for reimbursement. The provider will ensure that all services are provided in accordance with all SCDHHS policy requirements.

SCDHHS or its designee will conduct periodic utilization reviews. This does not replace state agency or LEA reviews of services. Reimbursement received in excess of authorized amount/duration is subject to recoupment.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

RBHS STAFF QUALIFICATIONS

All providers of Rehabilitative Behavioral Health Services must fulfill the requirements for South Carolina licensure/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, who have received appropriate education, experience and have passed prerequisite examinations as required by the applicable state laws and licensing/certification board and additional requirements as may be further established by SCDHHS, may qualify to provide Rehabilitative Behavioral Health Services. **The presence of licensure/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.**

To render RBHS, certain professionals and paraprofessionals are required to submit certification or training information to SCDHHS for prior approval. Please refer to each service for more information.

Medicaid RBHS Staff Qualifications

Title of Professional	Qualifications	Services Able to Provide
PROFESSIONALS		
Licensed Psychologist	Must hold a doctoral degree in psychology from an accredited university or college and is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling areas.	BHS, DA, SPD, IP, FP, GP, MFGP, CM, PRS, FS, PT

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Medicaid RBHS Staff Qualifications (Cont'd.)

Title of Professional	Qualifications	Services Able to Provide
PROFESSIONALS		
Advanced Practice Registered Nurse (APRN)	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	BHS, DA, SPD, IP, FP, GP, MFGP, CM, PRS, FS,
Certified School Psychologist I, II, III)	Must hold a master's or doctoral degree from a program that is primarily psychological in nature (e.g., counseling, guidance, or social science equivalent) from an accredited university or college, and one year of experience working with the population to be served. Training and/or certification information must be sent to SCDHHS for approval.	DA, IP, FP, GP MFGP SPD, BHS, CM, B-Mod, FS, PRS, PT only when provided by the school
Licensed Psycho-Educational Specialist	Must hold a current license from the appropriate State Board of Examiners, or a regionally accredited institution of higher education, whose program is 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 SC Board in regulation. In addition, a Psycho-Educational Specialist is certified by the South Carolina Department of Education as a school psychologist level II or III, must have two years of experience as a certified school psychologist (at least one year of which is under the supervision of a licensed Psycho-Educational Specialist), and a satisfactory score on the PRAXIS Series II exam.	DA, IP, FP, GP MFGP, SPD, BHS, CM, B-Mod, FS, PRS, PT
Licensed Independent Social Worker-Clinical Practice (LISW-CP)	Must hold a master's degree or doctorate degree from an accredited college or university and is licensed by the appropriate State Board of Examiners, and has one year of experience working with the population to be served.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS
Licensed Master's Social Worker - (LMSW)	Must hold a master's degree from an accredited college or university and is licensed by the appropriate State Board of Social Work Examiners, and has one year of experience working with the population to be served.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS
Licensed Marriage and Family Therapist	Must be licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist and must hold 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 and have 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 three-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.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Medicaid RBHS Staff Qualifications (Cont'd.)

Title of Professional	Qualifications	Services Able to Provide
PROFESSIONALS		
Licensed Professional Counselor (LPC)	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 regulations. 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. 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.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS
Mental Health Professional	Must hold a master's or doctoral degree from a program that is primarily psychological in nature (<i>e.g.</i> , counseling, guidance, or social science equivalent) from an accredited university or college, and one year of experience working with the population to be served.	DA, IT, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS
Clinical Chaplain	Must hold a Master of Divinity degree from an accredited theological seminary, and has two years of pastoral experience and one year of Clinical Pastoral Education that includes provision of supervised clinical services, and has a minimum of one year of experience working with the population to be served.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS
Behavior Analyst	Must hold a master's degree and has 225 classroom hours of specific graduate level coursework, meets experience requirements and passed the Behavior Analysis Certification Examination.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS
Licensed Baccalaureate Social Worker	Must hold a bachelor's degree or a doctorate degree from an accredited college or university and is licensed by the appropriate State Board of Examiners, and has one year of experience working with the population to be served	BHS, B-Mod, CM, FS, PRS, SPD
Baccalaureate Behavior Analyst	Must hold a bachelor's degree and has 135 classroom hours of specific graduate level coursework, meets experience requirements, and passed the Behavior Analysis Certification Examination.	BHS, CM, B-Mod, FS, PRS and assist with developing the SPD
Child Service Professional	Must hold a bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development or a related field or bachelor's degree in another field and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment	BHS, B-Mod, CM, FS, PRS and assist with developing the SPD

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Key

Service	Abbr.	Service	Abbr.
Behavior Modification	B-Mod	Group Psychotherapy	GP
Behavioral Health Screening	BHS	Individual Psychotherapy	IP
Crisis Management	CM	Multiple Family Group Psychotherapy	MFGP
Diagnostic Assessment	DA	Psychosocial Rehabilitation Services (Formally – Rehabilitation Psychosocial Services)	PRS (formally – RPS)
Family Support	FS	Service Plan Development	SPD
Family Psychotherapy	FP	Psychological Testing and Evaluation	PT

Please refer to the specific service section for a description of RBHS requirements. Providers are subject to termination or denial of services if they do not comply with current policies and procedures.

Maintenance of Staff Credentials

All RBHS providers shall ensure that all staff, subcontractors, volunteers, interns, and other individuals under the authority of the provider who render services to beneficiaries are properly qualified, trained, and supervised. Providers must comply with all other applicable state and federal requirements. All staff rendering services must be employed by the agency providing the service.

All providers shall maintain a file substantiating that each treatment staff member meets staff qualifications. This shall include employer verification of staff certification; licensure; diploma, degree, or school transcripts; and work experience. The treatment provider must maintain a signature sheet that identifies all professionals providing services by name, signature, and initial.

All RBHS providers 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 “corporate office,” the provider will be given five business days to retrieve the records for the agency that is requesting them.

Training

Providers are expected to operate within current best practices to ensure competence and quality performance of staff. Training is essential to the development of a competent workforce capable of providing quality Rehabilitative Behavioral Health Services. Training provides the opportunity to respond to and strengthen the individual needs and skills of employees, subsequently strengthening and supporting the individual needs and

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Training (Cont'd.)

skills of beneficiaries served. The following table outlines the training requirements for staff of RBHS:

Rehabilitative Behavioral Health Service Trainings			
Training:	Orientation	Core Services	Community Support Services
Timeframe to Complete:	Prior to rendering any services	Within first 60 days of hire	Within first 60 days of hire
Minimum # of Hours Required	20 total hours	8 total hours	8 hours minimum <i>plus</i> an additional 3 hours of "Service Specific Training" for each specific service to be rendered by individual staff (PRS, B-MOD, and FS)
Required Material to be Covered	<ul style="list-style-type: none"> • Confidentiality/Protected Health Information* • Beneficiary Rights* • Prohibition of Abuse, Neglect, & Exploitation* • Overview of provider's Policy and Procedures • Ethics & Professional Conduct • Overview of Behavioral Health • Health & Safety/ Emergency Preparedness* • Workplace Violence • Cultural Competency/Diversity • Fraud, Waste, & Abuse • Overview of Service Documentation Expectations & Completion • Medicaid Billing <p>*Additional information provided below</p>	<ul style="list-style-type: none"> • Crisis Response and Intervention • IPOC Development • Person Centered Values, Principles, and Approaches • Assessments 	<ul style="list-style-type: none"> o 8 hours minimum, covering the following topics: o Crisis Response and Intervention o IPOC Development o Person Centered Values, Principles, and Approaches o Childhood/Adolescent Development (if serving) o 3 hours minimum for each CSS Service Specific Training, covering the following topics: <ul style="list-style-type: none"> o Purpose and Service Description o Medical Necessity criteria for all populations served o Staff Qualifications o Staff-to-Beneficiary Ratio o Billing Frequency o Billable Place of Service o Non-Billable Medicaid Activities o Documentation Requirements o Modalities o Interventions o Example: Staff A renders both FS and B-Mod to beneficiaries. Staff A must have 3 hours of FS training <u>and</u> 3 hours of B-Mod training Interventions

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Rehabilitative Behavioral Health Service Trainings

Resources:

Confidentiality/Protected Health Information

Overview of Code of Federal Regulation, Title 45 CFR, Section 164.502 (45 CFR 164.502 - Uses and disclosures of protected health information: General rules) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Beneficiary Rights

Overview of the following (but not limited to):

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)
- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)
- Appeal
- Freedom of Choice

Prohibition of Abuse, Neglect, & Exploitation

Focuses on mandated reporting, the provider's reporting policy, requirements for reporting abuse, neglect, exploitation, and disciplinary actions (internally and lawfully) which may be taken as a result of failure to report or follow policy and procedures.

Health & Safety/ Emergency Preparedness

Focuses on procedures detailing actions to be taken in the event or occurrence of a natural disaster (*e.g.*, tornado, hurricane, flood, earthquake, ice storm, snow storm, and etc.) and/or violent or other threatening situation (*e.g.*, explosion, gas leak, biochemical threats, acts of terrorism, and use of weapons, and etc.).

Staff Qualifications

All RBHS providers who enroll with South Carolina Medicaid to provide services in a category that require a professional license must be licensed to practice in the State of South Carolina and must not exceed their licensed scope of practice under state law. Providers who enroll as a physician or other LPHA must be able to document experience working with the population to be served. Any services that are provided by staff who do not meet SCDHHS staff qualification requirements are subject to recoupment. It is the provider's responsibility to ensure staff operates within the scope of practice as required by South Carolina State law.

The following general training requirements apply:

- All providers must ensure treatment staff receives adequate orientation to RBHS.
- The content of the training must be directly related to the duties of the individual receiving the training.
- Individuals who are qualified to conduct such training shall carry out the instruction.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Staff Qualifications (Cont'd.)

- Documentation of the training received and successfully completed shall be kept in the individual's training record.
- Documentation of the training shall consist of an outline of the training provided and the trainer's credentials.
- When required, document the completion of certification criteria

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

- A completed employment application form
- Copies of the official college diploma or high school diploma or GED, or transcripts with the official raised seal
- A copy of all applicable licenses
- Letters or other documentation to verify previous employment or volunteer work that documents work experience with the population to be served
- A copy of the individual's criminal record check form from an appropriate law enforcement agency. Verification from the child abuse registry that there are no findings of abuse or neglect against the individual
- Verification from the state and national sex offender registries that there are no findings of criminal charges against the individual. Sex offender and child abuse registries should be checked annually.

It is the responsibility of the referring state agency or LEA to coordinate care among all service providers.

Staff Monitoring/ Supervision

Rehabilitative Behavioral Health Services provided by any unlicensed or uncertified professional must be supervised by a qualified licensed or master's level clinical professional. Supervision requirements must be documented in the clinical record appropriately, as indicated in the service sections. Licensed or master's level clinical professionals have the responsibility of planning and guiding the delivery of services provided by

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Staff Monitoring/ Supervision (Cont'd.)

unlicensed or uncertified professionals. These clinical professionals will evaluate and assess the beneficiary as needed.

When services are provided by an unlicensed or uncertified professional, the state agency or LEA must ensure the following:

- The qualified licensed or master's level clinical professional who monitors the performance of the unlicensed professional must provide documented consultation, guidance, and education with respect to the clinical skills, competencies and treatment provided at least every 30 days.
- The supervising licensed or master's level clinical professional must maintain a log documenting supervision of the services provided by the unlicensed or uncertified professional to each beneficiary.
- Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care(s) and the individual beneficiary's progress. Issues relevant to an individual beneficiary will be documented in a service note in the clinical record.
- Case supervision and consultation does not supplant training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

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. Ratios must be maintained in accordance with the requirements of each individual service standard. Staff involved in the treatment delivery must have direct contact with beneficiaries. Staff present, but not involved in the treatment delivery, cannot be included in the ratio. Staff shall be in direct contact and involved with the beneficiary's activities during service delivery.

If at any time during the delivery of a service, the staff-to-beneficiary ratio is not in accordance with the service standard, billing for beneficiaries in excess of the required ratio should be discontinued and subject to recoupment. The ratio count applies to all beneficiaries receiving

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

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

services from the provider regardless of whether or not the beneficiary is Medicaid eligible.

Appropriately credentialed staff must be substituted or group sizes must be adjusted to meet the service standard requirements before billing may resume.

When services are provided in a group setting, the provider must maintain a list of beneficiaries and individuals present in the group and the staff person(s) responsible for service delivery. This documentation must be available upon request.

EMERGENCY SAFETY INTERVENTION (ESI)

The Emergency Safety Intervention (ESI) policy applies to any community-based provider that has policies prohibiting the use of seclusion and restraint, but who may have an emergency situation requiring staff intervention. The LEA must have a written policy and procedure for emergency situations and must ensure that direct care staff are properly trained and prepared to implement in the event of an emergency.

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

- The LEA 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 the beneficiary's safety. For more information on selecting training models, go to the Project Rest Manual of Recommended Practice, available at <http://www.frcdsn.org/rest.html>.
- The LEA 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.

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

COORDINATION OF CARE

It is the responsibility of the referring state agency or LEA to coordinate care among all service providers.

If a beneficiary is receiving treatment from multiple service providers, there must be evidence of care coordination in the beneficiary's clinical record.

If the LEA refers the child or adolescent to a private RBHS provider for services, the private RBHS provider must not exceed the recommendations from the LEA. The LEA should provide the specific recommendations for services in writing to the private RBHS provider.

OUT-OF-HOME PLACEMENT

In accordance with the Code of Federal Regulations, 42 CFR § 435.1009-1011, Rehabilitative Services are not available for beneficiaries residing in an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution may be deemed as an Institution for Mental Diseases based on its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive an all-inclusive, per diem rate for services. Rehabilitative Behavioral Health Services provided to beneficiaries in these settings are not Medicaid reimbursable.

DOCUMENTATION REQUIREMENTS

Clinical Records

All Rehabilitative Behavioral Health Services providers shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid participation, and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. The absence of appropriate and complete records, as described below, 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 or auditors upon request.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Clinical Records (Cont'd.)

Each provider shall have the responsibility of maintaining accurate, complete, and timely records and ensure the confidentiality of the beneficiary's clinical record.

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

- A comprehensive diagnostic assessment
- Signed, titled and dated individual plan of care (IPOC) — initial, reviews, and reformulations
- Signed, titled and dated Clinical Service Notes (CSNs)
- Behavior Modification Plan (BMP), if applicable
- Court orders, if applicable
- Copies of any evaluations and or tests, if applicable
- Signed releases, consents, and confidentiality assurances for treatment
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered)
- Copies of written reports (relevant to the beneficiary's treatment)
- Medicaid eligibility information, if applicable
- Other documents relevant to the care and treatment of the beneficiary

Consent For Treatment

A consent form for each treatment provider must be signed and dated by the beneficiary, parent, legal guardian, primary caregiver (in cases of a minor), or legal representative at the onset of the treatment and placed in the beneficiary's file. If the beneficiary, parent, legal guardian, or legal representative cannot sign the consent form due to a crisis, and the beneficiary is accompanied by a family member 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" must be noted on the consent form and must be signed by the physician or other LPHA and one other staff member. The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit. A new

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Consent For Treatment (Cont'd.)

consent form should be signed and dated each time a beneficiary is readmitted to the system after discharge. Consent forms are not necessary to conduct court ordered examinations; however a copy of the court order must be kept in the clinical record.

Clinical Service Notes

All Rehabilitative Behavioral Health Services must be documented in the clinical service note (CSN) upon the delivery of services. 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.

The CSN must include the following information:

- The beneficiary's name and Medicaid ID number
- Date of Service
- The individualized treatment for the beneficiary
- The rehabilitative service provided and/or additional information that has an effect on the identified beneficiary's treatment
- The name of the specific services or its approved abbreviations which corresponds to the procedure code from the manual, units of service, and dates of service (with month, day and year)
- Be typed or legibly handwritten using only black or blue ink
- Be kept in chronological order
- 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
- Document the start and end time(s) for each rehabilitative service delivered. Please refer to each individual service description in this section for specific documentation requirements.
- Reference individuals by full name, title, and agency or provider affiliation at least once in each

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Clinical Service Notes (Cont'd.)

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 services are provided in accordance with these standards.
- Be placed in the beneficiary's record as soon as possible but no later than five business days from the date of rendering the service

Providers must maintain adequate documentation to support the number of units or encounters billed.

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

- The focus and/or reason for the session 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 clinician and/or treatment staff in service provision
- The response of the beneficiary and his or her family (as applicable) to the interventions and/or treatment
- The general progress of the beneficiary to include observations of their conditions/mental status
- The future plan for working with the beneficiary

Availability of Clinical Documentation

A CSN or other service documentation should be completed and placed in the clinical record immediately following the delivery of a service. If this is impossible due to the nature of the service, the documentation must be placed in the clinical record no later than five business days from the date of service.

Services must be documented in the clinical record and the documentation must justify the amount of reimbursement claimed to Medicaid.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Billable Code/Location of Service

See the “Billable Place of Service” heading for each service under “Core Rehabilitative Behavioral Health Standards” in this section. The following list provides the codes most commonly used:

- 03 — School
- 11 — Doctor’s Office
- 12 — Beneficiary’s Home
- 99 — Other Unlisted Facility

Billing Requirements

RBHS must not be rendered concurrently with academic instruction/classroom time.

The following is a list of activities that are not Medicaid-reimbursable under the Rehabilitative Behavioral Health Services policy. Professional judgment should be exercised in distinguishing between billable and non-billable activities. The following list is not an exhaustive list, but serves as a guide to identify activities that may not be billed as RBHS include:

- Transportation and/or travel time
- Transportation of beneficiaries
- Any activities to attempt contact with beneficiaries (*e.g.*, attempted phone calls, home visits, and face-to-face contacts, etc.)
- “Outreach” activities in which an agency or a provider attempts to contact potential Medicaid recipient
- Record audits or chart reviews
- Review of clinical record to become familiar with a beneficiary’s case
- Staff meetings, trainings and supervision
- Activities provided by anyone other than a person who meets the qualifications to render a service
- Completion of any specially requested information regarding beneficiaries from the state office or from other agencies for administrative purposes
- Any social or recreational activities, or the supervision of such activities (*e.g.*, playing basketball, watching movies, etc.)

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Billing Requirements (Cont'd.)

- Life Coaching
- Mentoring beneficiaries
- Documentation of service notes
- Unstructured client time (Periods of inactivity, free, and unstructured time may be necessary for a client, but is not part of a billable service.)
- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (*e.g.*, GED, Adult Development), or tutorial services in relation to a defined education course
- Education interventions that do not include individual process interactions
- Services provided to teach academic subjects or as a substitute for educational personnel (*e.g.*, a teacher, teacher's aide, an academic tutor, etc.)
- Shadowing beneficiary in the classroom
- Assisting beneficiary with homework or other educational assignments
- Any child care services or other services provided as a substitute for the parent or other primary care taker responsible for the beneficiary
- When prior authorization is required, dates of services not covered in the range of the QIO approval letter
- Services not identified on the IPOC (excluding those not required to be listed on the IPOC per policy)
- Services provided to children, spouse, parents or siblings of the beneficiary under treatment, or others in the beneficiary's life, to address problems not directly related to the beneficiary's issues and not listed on the beneficiary's IPOC
- Any art, movement, dance or drama therapies
- Filing, mailing, and faxing of any reports to other entities or individuals on behalf of the beneficiary
- Medicaid eligibility determinations and re-determinations

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Billing Requirements (Cont'd.)

- Medicaid intake processing
- Completion of and monitoring of prior authorization requests for Medicaid services
- Required Medicaid utilization review
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) administration
- Participation in job interviews
- The on-site instruction of specific employment tasks
- Staff supervision of actual employment services
- Assisting beneficiary in obtaining job placements
- Assisting clients in filling out applications (*i.e.*, job, disability, etc.)
- Assisting clients in performing the job or performing jobs for clients
- Drawing client's blood and/or urine specimen, and/or taking the specimen(s) to the lab
- Visiting beneficiaries while in another mental health service program, unless for a special treatment activity
- Retrieving medications for a beneficiary served by an RBHS provider and/or handing out prescriptions or medications
- Scheduling appointments with the physician or any other clinicians within same provider
- Staffing between clinicians in the same clinical unit within the RBHS provider for the purpose of supervision
- Waiting for and/or with a beneficiary in waiting rooms
- Respite care

Abbreviations and Symbols

Abbreviations may be used in the IPOC or the CSN. Service providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation. An abbreviation key must be maintained to support the use of

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Abbreviations and Symbols (Cont'd.)

abbreviations and symbols in entries. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

Legibility

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

Original legible signature and credentials (*e.g.*, registered nurse) or functional title (*e.g.*, SAP, MHP) of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service or co-signature, when required, are not acceptable. (See Section 1 of this manual for the use of electronic signatures and/or exceptions).

Error Correction Procedures

Clinical records are legal documents. Staff should be extremely cautious in altering 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. If an explanation is necessary to explain the corrections, they must be entered in a separate CSN.

Late Entries

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

- Identify the new entry as a “late entry.”
- Enter the current date and time.

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Late Entries (Cont'd.)

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

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, 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 five-year period, whichever is later. In the event of an entity's closure, providers must notify SCDHHS regarding medical records.

Clinical records 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 the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1 of this manual.

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.

Components of The Individual Plan of Care (IPOC)

The individual plan of care (IPOC) is an individualized comprehensive plan of care to improve the beneficiary's condition. The IPOC is developed in collaboration with the beneficiary, which may include an interdisciplinary team of the following: significant other(s), parent, guardian,

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Components of The Individual Plan of Care (IPOC) (Cont'd.)

primary caregiver, other state agencies and staff, or service providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. While there may be certain treatment methodologies commonly utilized within a particular service, providers must ensure that services are tailored to the beneficiary's individual needs and the service delivery reflects knowledge of the particular treatment issues involved.

The assessment is used to identify problems and needs, develop goals and objectives, and determine appropriate Rehabilitative Services and methods of intervention for the beneficiary. The IPOC outlines the service delivery needed to meet the identified needs of the beneficiary and improve overall functioning.

The IPOC utilizes information gathered during the evaluation, screening and assessment process. The IPOC must be written to provide a beneficiary centered and/or family-centered plan. The beneficiary must be given the opportunity to determine the direction of his or her IPOC. If family reunification or avoiding removal of the child from the home is a goal for the beneficiary, the family, legal guardian, legal representative, or 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, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the beneficiary's clinical record. For adults, the family or a legal representative should be included as appropriate.

For beneficiaries receiving retroactive coverage, all other Medicaid service and documentation requirements must be met to receive Medicaid reimbursement for retroactively covered periods.

IPOC Documentation

Each provider is responsible for developing the IPOC. When the state agency refers for services and does not provide the IPOC, the private organization must develop the IPOC. However, the LEA shall provide the private provider with specific service recommendations in writing. The private provider shall not exceed the recommendations from the LEA.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

IPOC Documentation (Cont'd.)

IPOC documentation must meet all SCDHHS requirements and the following components listed below. If these components are also listed on the assessment, the assessment must be attached to the IPOC. It is important for overall health care and wellness issues to be addressed.

Individual Plan of Care Components

The IPOC must include the following components:

- **Beneficiary Identification:** Name and Medicaid ID number
- **Presenting Problem(s):** Statements that outline the specific needs that require treatment (validate the need for and appropriateness of treatment).
- **Justification for Treatment:** 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 or the ICD. For individuals who have more than one diagnosis regarding mental health, substance use, and/or medical conditions, all diagnoses should be recorded.
- **Goals and Objectives:** The IPOC should include 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 and/or needs), and realistic.
- **Specific interventions:** A list of specific approaches used to meet the stated goals and objectives must be included.
- **Specific services:** All services to be rendered to beneficiaries and/or families must be identified on the IPOC (e.g., Individual Therapy, Group Therapy, Family Therapy, Family Support, etc.).
- **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 objective will be demonstrated.

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Individual Plan of Care Components (Cont'd.)

Criteria must be reasonable, attainable, and measurable, must include target dates, and must indicate a desired outcome to the treatment process.

- **Target Dates:** The dates should be a timeline that is individualized to the beneficiary's goals and objectives.
- **Medical or Health History:** A brief summary of medical history must include present medications, medical issues, and any safety services and supports systems (a safety net).
- **Family or Social Support:** A brief family or psycho-social summary of the beneficiary to identify support systems available to aid the beneficiary in achieving goals.
- **Contact Information:** A list of all emergency contacts.
- **Discharge Plan:** The IPOC must include a plan of action for discharge. This plan must include the anticipated date of discharge from services, beneficiary's and/or family's expected gains to be achieved through participation in treatment and services, and anticipated aftercare needed (if applicable).
- **Beneficiary Signature:** The beneficiary or their guardian 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 plan of care or if it is not considered appropriate for the beneficiary to sign the plan of care, the reason must be documented in the clinical record.
- **Authorized Signature(s):** An LPHA, master's level or LBSW staff, the beneficiary, the clinician and/or interdisciplinary team which may include: significant other(s); parent, guardian, or primary caregiver; other state agencies, staff, or service providers must sign and date a signature sheet or the IPOC which identifies who was present during the IPOC meeting. If a separate signature sheet is completed, it must be kept with the IPOC.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Individual Plan of Care Components (Cont'd.)

The IPOC must be signed, titled and signature dated by the physician, LPHA, master's level qualified clinical professional or LBSW. The IPOC must be filed in the beneficiary's clinical record with any supporting documentation such as the diagnostic assessment.

Services Not Required on the Individual Plan of Care

The following services are billable prior to development of the IPOC and are not required to be listed on the IPOC:

- Crisis Management
- Service Plan Development
- Behavioral Health Screening
- Diagnostic Assessment

The provider may render these services prior to the completion of the IPOC provided they are medically necessary.

Duration of the IPOC

The initial IPOC must be finalized, signed, titled and signature dated by the physician, LPHA, master's level qualified clinical professional or LBSW within 30 calendar days from the Diagnostic Assessment. 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 30 days, services rendered are not Medicaid reimbursable.

Addendum to the IPOC

When services are added or frequencies of services changed in an existing IPOC, the addendum must include the signature and titles of the clinician, who formulated the addendum and the date it was formulated. All service changes must be medically necessary. The original IPOC signature date stands as the date to use for all subsequent progress summaries and review. If the medical necessity was document using only the IPOC addendums must include an LPHA signature.

Beneficiaries do not have to be present when changes are made to the IPOC. All additions to the IPOC should be listed in chronological order. The IPOC must be signed or initialed and dated by the reviewing physician, LPHA, master's level qualified clinical professional or LBSW to confirm changes. The addendum is added to the existing IPOC, when space is unavailable on the current IPOC. A

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Addendum to the IPOC (Cont'd.)

separate sheet must be added and labeled as “Addendum IPOC” and the addendum must accompany the existing IPOC.

If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary and other involved parties within 10 business days.

IPOC Reformulation

The maximum duration of the IPOC is 365 calendar days from the date of the signature of the physician, LPHA, master’s level qualified clinical professional or LBSW on the IPOC. Prior to termination or expiration of the treatment period, the physician, LPHA, master’s level qualified clinical professional or LBSW must review the IPOC, preferably with the beneficiary and evaluate the beneficiary’s progress in reference to each of the treatment objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The signature of the physician, LPHA, master’s level qualified clinical professional or LBSW responsible for the treatment is required. The professional should also assess the need for continued services and specify services needed based on the progress of the beneficiary.

The IPOC must include the date when the reformulation was completed, the signature and title of the physician, LPHA, master’s level qualified clinical professional or LBSW authorizing services and the signature date. There should be evidence in the clinical record regarding the involvement of the beneficiary in the reformulation of the IPOC. Copies of the reformulated IPOC must be distributed to all involved participants within 10 business days.

Service Plan Development (SPD) of the IPOC

Purpose

The purpose of this service is to allow the interdisciplinary team the opportunity to discuss and or review the beneficiary’s needs in collaboration and develop a plan of care. The interdisciplinary team will establish the beneficiary’s goals, objectives and identify appropriate treatment or services needed by the beneficiary to meet those goals. Service Plan Development (SPD) assists beneficiaries and their families in planning, developing and

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Purpose (Cont'd.)

choosing needed services.

SPD is interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop a plan of care based on the assessed needs, physical health, personal strengths, weaknesses, social history, 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 and his/or her family's needs, desired goals and objectives. The beneficiary and clinical professional(s) or interdisciplinary team should identify the skills and abilities of the beneficiary that can help achieve their goals, identify areas in which the beneficiary needs assistance, support, and decide how the team of professionals can help meet those needs.

An interdisciplinary team is typically composed of the beneficiary, his or her family and/or other individuals significant to the beneficiary, treatment providers and care coordinators.

An interdisciplinary team may be responsible for periodically reviewing progress made toward goals and modifying the IPOC as needed.

When there are multiple agencies or providers involved in serving the beneficiary, SPD should be conducted as a team process with the beneficiary. This treatment planning process requires meeting with at least two other health and human service agencies or providers to develop an individualized, multi-agency service plan that describes corresponding needs of the beneficiary and identifies the primary or lead provider for accessing and/or coordinating needed service provision.

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

SPD Interdisciplinary Team — Conference with Client/ Family

The purpose of this service is to allow the physician, LPHA, master's level staff or LBSW to review the treatment goals with other entities or support teams. In addition, this service will provide the interdisciplinary team with the opportunity to discuss issues that are relevant to the needs of the beneficiary with the beneficiary

SECTION 2 POLICIES AND PROCEDURES**REHABILITATIVE BEHAVIORAL HEALTH SERVICES*****SPD Interdisciplinary Team
— Conference with Client/
Family (Cont'd.)***

or a family member being present. Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or a family member or their legal representative. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented.

The Physician, LPHA, Master's level or LBSW must sign the final document.

***SPD Interdisciplinary Team
— Conference without
Client/ Family***

The purpose of this service is to allow the physician, LPHA, master's level staff or LBSW to review the treatment goals with other entities or support teams. In addition, this service will provide the interdisciplinary team with the opportunity to discuss issues that are relevant to the needs of the beneficiary without the beneficiary or a family member being present. The components of the interdisciplinary team conference must be followed for this service.

Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or their legal representative. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented.

The LPHA, Master's level or LBSW must sign the final document.

***Service Plan Development
by Non-Physicians***

The purpose of this service is to allow a LPHA, master's level or LBSW to review, with other entities or support teams, the issues that are relevant to the needs of the beneficiary with the beneficiary and/or a family member or a legal representative.

Effective service planning should include representation from all systems of support in which the beneficiary is engaged

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Plan Development by Non-Physicians (Cont'd.)

and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary cannot sign the IPOC, the reason must be documented.

The Physician, LPHA, Master's level or LBSW must sign the final document.

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 plan of care
- Discharge criteria and/or achievement of goals
- Confirmation of medical necessity
- Establishment of one or more diagnoses, including co-occurring substance use or dependence, if present ("N/A" for private organizations when documented on MNS)
- Recommended treatment
- Copy of the Assessment summary

The IPOC must include the date it was completed, the signature and title of the physician, LPHA, or master's level qualified clinical professional or LBSW signing the IPOC to authorize services. Refer back to the IPOC section to ensure all components are listed on the IPOC.

While attendance of multiple provider representatives may be necessary, only one professional that is actively involved in the planning process from each provider office may receive reimbursement. The provider representative must have documentation of the invitation to the IPOC meeting in the clinical record.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder. The results of the assessment and/or screening tool must support the need for services.

Staff Qualifications

SPD is provided by, or under the supervision of, qualified professionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law.

SECTION 2 POLICIES AND PROCEDURES**REHABILITATIVE BEHAVIORAL HEALTH SERVICES**

<i>Staff-to-Beneficiary Ratio</i>	<p>SPD requires at least one professional for each beneficiary. An interdisciplinary team requires participation from at least two qualified health professionals from any agency that have involvement with the beneficiary.</p>
<i>Billing Frequency</i>	<p>An SPD Interdisciplinary Team Conference with and without the beneficiary and/or a family member, or their legal representative present is billed as an encounter.</p> <p>SPD by a non-physician is billed in a 15-minute unit.</p>
<i>Special Restrictions Related to Other Services</i>	<p>State agencies that refer SPD to qualified providers may designate and authorize the provider to develop the plan of care. Providers must ensure state agencies receive a copy of the IPOC within 30 days of the authorization date. The state agency must approve the IPOC and ensure all of the components of the IPOC are completed.</p> <p>SPD codes 99366, 99367, and H0032 cannot be billed on the same date of service. Assessment codes cannot be billed on the same date of service as 99366 and 99367. The assessment must be completed prior to the development of the IPOC.</p> <p>If the state agency provides the IPOC to an enrolled private provider to establish medical necessity, the IPOC must be signed titled and dated by an LPHA from the referring state agency.</p>
<i>90-Day Progress Summary</i>	<p>The 90-day progress summary is a periodic evaluation and review of a beneficiary's progress toward the treatment objectives, the appropriateness of services rendered, and the need for the beneficiary's continued participation in the treatment.</p> <p>The progress summary of the beneficiary's participation in treatment will be conducted at least every 90-calendar days from the signature date on the initial IPOC and every 90 days thereafter.</p> <p>The progress summary must be completed by the physician, LPHA, or other qualified clinical professional. The progress summary review must be clearly identified in the IPOC.</p> <p>The physician, LPHA, or other qualified clinical</p>

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

90-Day Progress Summary (Cont'd.)

professional must review the following areas:

- The beneficiary's name and Medicaid ID number
- The beneficiary's progress toward treatment goals and objectives
- The appropriateness and frequency of the services provided
- The need for continued treatment
- Recommendations for continued services or discharge of services as outline in the success criteria for each objective

Discharge/Transition Criteria

Beneficiaries should be considered for discharge from treatment or transferred to another level of care when they meet any of the following criteria:

- Level of functioning has significantly improved
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC
- Achieved the goals as outlined in the IPOC or reached maximum benefit
- Developed the skills and resources needed to transition to a lower level of care
- The beneficiary requires a higher level of care (e.g. more intensive outpatient treatment, PRTF, or inpatient treatment)
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals

The beneficiary should be re-evaluated for services before discharge from that particular service or level of care.

Discharge summary must include:

- Each RBHS service(s) the beneficiary received
- Dates of duration each service(s)
- Presenting concerns/condition and diagnosis(es) at time of admission

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Discharge/Transition Criteria (Cont'd.)

- Description of the progress, or lack of progress, in achieving planned goals and objectives in the IPOC
- Rationale for discharge from service(s)
- Summary of the beneficiary's status/presentation at last contact
- Recommendations for possible services and supports needed after discharge for continuity of care (*e.g.*, medical care, personal care, self-help groups, peer connections, etc.)
- Date of discharge from service(s)
- Medications prescribed or administered, if applicable
- Attempts to contact beneficiary/family, if discharge is unplanned

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

CORE REHABILITATIVE BEHAVIORAL HEALTH STANDARDS

Behavioral Health Screening (BHS)

Purpose

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

Service Description

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 of the common tools used for screenings are:

- GAIN — Global Appraisal of Individual Needs - Short Screener
- DAST — Drug Abuse Screening Test
- ECBI — Eyberg Child Behavior Inventory
- SESBI—Sutter Eyberg Student Behavior Inventory
- CIDI—Composite International Diagnostic Interview

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

Screenings should focus on patterns of behavior and associated factors such as legal problems, mental health status, educational functioning, and living situation. The beneficiary's awareness of the problem, feelings about his or her behavior, mental health or substance use and motivation for changing behaviors may also be integral parts of the screen.

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 90 days. If a recent screening has

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<i>Service Description (Cont'd.)</i>	<p>been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.</p> <p>Reimbursement for this service is only available for the interpretation and/or scoring of the screening tool and does not include time spent administering the tool.</p>
<i>Medical Necessity Criteria</i>	<p>All Medicaid-eligible beneficiaries who have been identified as having or at risk of behavioral health and/or substance use disorder are eligible for this service.</p>
<i>Staff Qualifications</i>	<p>BHS may be provided by qualified clinical professionals as defined in the “RBHS Staff Qualifications” section of this manual, who have been specifically trained to review the screening tool and make a clinically appropriate referral.</p>
<i>Service Documentation</i>	<p>The BHS should be documented during the screening session with the beneficiary. The completed screening tool and its interpretation results must be filed in the beneficiary’s record within 10 working days from the date of the service. The documentation must:</p> <ul style="list-style-type: none">• Include the outcome of the screening• Identify any referrals resulting from the screening,• Support the number of units billed
<i>Staff-to-Beneficiary Ratio</i>	<p>BHS requires one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.</p>
<i>Billing Frequency</i>	<p>BHS is billed in 15-minute units for a maximum of two units per day. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>
<i>Billable Place of Service</i>	<p>The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional</p>

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*Billable Place of Service
(Cont'd.)*

that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

*Special Restrictions Related
to Other Services*

BHS shall not be billed on the same date of service as 90791 and/or H2000.

**Diagnostic Assessment
Services (DA)**

Purpose

The purpose of an Initial Diagnostic 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 diagnoses or to determine differential diagnoses.

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.

Information obtained during the assessment must lead to a diagnosis that identifies the beneficiary's current symptoms or disorder by using the current edition of the DSM or the ICD.

Diagnoses should be updated as the condition of the beneficiary changes. Information relating to a diagnosis that has not been reviewed in a 12-month or more periods should be confirmed immediately.

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 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.

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.

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Service Description

Psychiatric Diagnostic Assessment without medical and/or Comprehensive Diagnostic Assessment services 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 includes a bio-psychosocial assessment to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of a Diagnostic Assessment Service 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, 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

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Service Description (Cont'd.)

- 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 Rehabilitative Behavioral Health Services
- Planned frequency of each recommended rehabilitative service
- Referrals for external services, support, or treatment

Psychiatric Diagnostic Assessment with medical services includes those same components listed above in the assessment, and will include the medical components. As of February 1, 2015, this assessment is billed as the initial comprehensive assessment.

Components of a psychiatric diagnostic assessment Service include:

Components of a Diagnostic Assessment Service include:

- Medical history and medications
- Assess the appropriateness of initiating or

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Service Description (Cont'd.)

continuing the use of medications, including medications treating concurrent substance use disorders

- Diagnose, treat, and monitor chronic and acute health problems
- This may include completing annual physicals and other health care maintenance activities such as ordering, performing, and interpreting diagnostic studies (lab work, x-rays, etc.).

Mental Health Comprehensive Diagnostic Assessment - Follow-up

A mental health follow-up assessment occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any significant 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.

When significant changes occur in behaviors and/or conditions, changes must be documented separately on the CSN and comply with the service documentation requirements. The course of treatment and documentation in the IPOC must reflect these changes.

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

Staff Qualifications

The assessment must be provided by a qualified clinical professional operating within their scope of practice. The professional must be specifically trained to render and review the assessment tool to make a clinically appropriate referral.

Service Documentation

The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within five working days from the date of service.

Documentation must include components of the assessment and the following:

- Beneficiary's name and Medicaid ID number
- Include the outcome of the assessment
- Identify any referrals resulting from the assessment

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*Service Documentation
(Cont'd.)*

- The diagnostic code and diagnoses

Staff-to-Beneficiary Ratio

The initial and follow-up assessments require one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

The initial and follow-up assessments are billed as an encounter. The initial session should last at least an hour. One encounter is allowed every six months and coordination care should occur between providers. The follow-up assessment may be rendered twelve times in a year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions Related to Other Services

The assessment with medical cannot be rendered or billed on the same day as the assessment without medical.

The Mental Health Comprehensive follow-up assessment should only be utilized when documented behavioral changes have occurred and when the beneficiary needs to be reassessed

Efforts should be made to determine whether another diagnostic assessment has been conducted in the last 90 days and information should be updated as needed. If a diagnostic assessment has been conducted within the last 90 days, efforts should be made to access those records.

**Psychological Testing/
Evaluation**

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REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Purpose

Psychological Testing and Evaluation services include psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g. MMPI, Rorschach, and WAIS).

Testing and evaluation must involve face-to-face interaction between licensed psychologists or when provided by the school district must be administered by the staff listed below and the beneficiary for evaluating the beneficiary's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics, as well as use of other non-experimental methods of evaluation.

Psychological testing/assessment may be used for the purpose of psycho-diagnostic 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.

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 assessment/testing will inform treatment.

When necessary or appropriate, consultation shall only include telephone or face-to-face contact by a psychologist 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 is expected to render an opinion and/or advice. The psychologist must document the recommended course of action.

Referral Process

Psychological Testing and Evaluation, in accordance with 42 CFR 440.130,d, must be recommended by a physician or other licensed practitioner of the healing arts, within his or her scope of practice under State law. The referral must be documented on the CSN and placed in the clinical record. The referring LPHA staff include the following:

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Referral Process (Cont'd.)

- Licensed Psychiatrist
- Licensed Physician
- Licensed Psychologist
- Licensed Advanced Practice Registered Nurse
- Licensed Independent Social Worker-Clinical Practice
- Licensed Master Social Worker
- Licensed Physician's Assistant
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Psycho-educational Specialist

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.

Staff Qualifications

Psychological Testing and Evaluation must be provided by a qualified Psychologist operating within their scope of practice, as allowed by state law and who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

Psychological Testing and Evaluation and Testing services are provided by a certified school psychologist with one of the following qualifications:

School Psychologist I is an individual that is currently certified by the South Carolina Department of Education and holds a master's degree from a regionally or nationally accredited college or university with an advanced program for the preparation of school psychologists and qualifying score on the South Carolina Board of Education required examination.

School Psychologist II is an individual that is currently certified by the South Carolina Department of Education and holds a specialist degree from a regionally or nationally accredited college or university with an advanced program for the preparation of school psychologists, and qualifying score on the South Carolina Board of Education required examination.

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Staff Qualifications (Cont'd.)

School Psychologist III is an individual that is currently certified by the South Carolina Department of Education and holds a doctoral degree from a regionally or nationally accredited college or university with an advanced program for the preparation of school psychologists, qualifying score on the South Carolina Board of Education required examination, and completion of an advanced program approved for the training of school psychologists.

Psycho-Educational Specialist is an individual that holds a 60-hour master's degree, plus 30 hours, or a doctoral degree in school psychology from a regionally accredited institution approved by NASP or APA, or its equivalent, certification by the South Carolina Department of Education as a school psychologist level II or III, two years of experience as a certified school psychologist (at least one year of which is under the supervision of a licensed psycho-educational specialist) and satisfactory score on the PRAXIS Series II exam. The psycho-educational specialist must be licensed by the South Carolina Board of Examiners of Professional Counselors, Marriage and Family Therapists.

Note: A school psychologist I must be supervised by a school psychologist II, III or a licensed psycho-educational specialist and each evaluation must be signed by the supervising school psychologist.

Service Documentation

A clinical service note must document the services to include a start time and end time. The CSN must include the purpose of the test, the results of the Psychological testing and evaluation, recommendations, name and title of administering staff and refer to the completed test.

The completed test and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date the service was completed.

Documentation of the test must include the following:

- Beneficiary's name and Medicaid ID number
- Include the outcome of the test
- Identify any referrals resulting from the test
- The diagnoses code and the diagnose
- Documentation must support the number of units

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*Service Documentation
(Cont'd.)*

billed

- The name and title of the referring LPHA
- Name and title of the administering Staff

Staff-to-Beneficiary Ratio

Psychological Testing and Evaluation requires one staff member for each beneficiary.

Billing Frequency

Psychological Testing and Evaluation is billed as a 60 minute unit with a limit of ten units billed within a week and a limit of 20 units billed per year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions Related to Other Services

Efforts should be made to determine whether another psychological testing has been conducted in the last 90 days and the information should be updated as needed. If an assessment has been conducted within the last 90 days, 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. A repeated assessment must be added to the clinical records.

Delivery of this service should include contacts with family and/or guardians of children for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

The Diagnostic Assessment must be completed before the Psychological Testing and Evaluation has been conducted.

Psychological Testing and Evaluation and Diagnostic Assessments can be billed on the same day. Assessments must be billed separately and provide different outcomes. The LPHA can do the assessment, the evaluation, develop the IPOC and provide the services.

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CORE TREATMENT PSYCHOTHERAPY AND COUNSELING SERVICES

Psychotherapy

Psychotherapy Services are provided within the context of the goals identified in the beneficiary's plan of care. 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 are based on an empirically valid body of knowledge about human behavior. Psychotherapy Services do not include educational interventions without therapeutic process interaction or any experimental therapy not generally recognized by the profession. These services do not include drug therapy or other physiological treatment methods.

Psychotherapy Services are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability; improve their physical, mental, and emotional health; and cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities.

Psychotherapy Service should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues. Psychotherapy Services may be provided in an individual, group, or family setting. The 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.

Individual Psychotherapy (IP)

Purpose

The purpose of this face-to-face intervention is to assist the beneficiary in improving his or her emotional and

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Purpose (Cont'd.)

behavioral functioning. The clinical professional assists the individual in identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.

Service Description

Individual Psychotherapy (IP) is an interpersonal, relational intervention directed towards increasing an individual's sense of well-being and reducing subjective discomforting experience. IP may be psychotherapeutic and/or therapeutically supportive in nature.

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

Treatment should be designed to maximize strengths and to reduce problems and/or functional deficits that interfere with a beneficiary's personal, family, and/or community adjustment. Interventions should also be designed to achieve specific behavioral targets, such as improving medication adherence or reducing substance abuse.

Medically Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

IP must be provided by qualified clinical professionals operating within their scope of practice, as allowed by state law.

Staff-to-Beneficiary Ratio

IP is one professional to one beneficiary.

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Service Documentation

The CSN must document how the therapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. Services must be documented on the CSN with a start time and end time.

Billing Frequency

IP is billed as an encounter. There are three encounter ranges: 16 – 37 minutes, 38 – 52 minutes and 53 or more minutes. There can be one encounter per day with a limit of six encounters per month. Six sessions in any combination can be billed in a month. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions Related to Other Services

IP encounter sessions can only be rendered one time daily. Services can be rendered in a variety of combinations, but only six sessions per month are billable. Only one Individual Psychotherapy session can be billed per day.

Group Psychotherapy (GP)

Purpose

Group Psychotherapy (GP) is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician. The goal of GP is to help beneficiaries with solving emotional difficulties and to encourage the personal development of beneficiaries in the group.

The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified therapeutic issues.

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Service Description

GP involves a small therapeutic group that is designed to produce behavior change. The group must be a part of an active treatment plan and the goals of GP must match the overall treatment plan for the individual beneficiary. GP requires a relationship and interaction among group members and a stated common goal. The focus of the therapy sessions must not be exclusively educational or supportive in nature. The intended outcome of such group oriented, psychotherapeutic services is the management, reduction, or resolution of the identified behavioral health and/or substance abuse problems, thereby allowing the beneficiary to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from GP:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.
- Beneficiaries with the same type of problem that may gain insight by being in a group with others
- Beneficiaries who have similar experiences
- Beneficiaries who need to demonstrate a level of competency to function in a group

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

Staff Qualifications

GP must be provided by clinical professionals operating within their scope of practice, as allowed by state law.

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<i>Service Documentation</i>	The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Staff-to-Beneficiary Ratio</i>	GP requires one professional and no more than eight beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.
<i>Billing Frequency</i>	GP is billed as an encounter. A session must last a minimum of an hour. More than one session can be billed per day; with a limit of eight sessions per month. A session must last a minimum of an hour. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. More than one session can be billed per day
<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions Related to Other Services</i>	GP is an encounter session. Each session must be documented separately.
Multiple Family Group Psychotherapy (MFGP)	
<i>Purpose</i>	Multiple Family Group Psychotherapy (MFGP) treatment will allow beneficiaries and families with similar issues to meet face-to-face in a group with a clinician. The group's focus is to assist the beneficiary and family members in resolving emotional difficulties, encourage personal development, and ways to improve and manage their functioning skills. The group process allows members to offer each other support, share common experiences, identify strategies that

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Purpose (Cont'd.)

have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified therapeutic issues.

Service Description

MFGP involves a small therapeutic group that is designed to produce behavioral change. The beneficiary must be a part of an active treatment plan and the goals of MFP must match the overall treatment plan for the individual beneficiary. MFP requires a relationship and interaction among group members and a stated common goal.

MFGP is directed toward the restoration, enhancement, or prevention of the deterioration of role performance of families. MFGP allows the therapist to address the needs of several families at the same time and mobilizes group support between families. The process provides commonality of the MFGP experience, including experiences with behavioral health and or co-occurring substance use disorders, and utilizes a complex blend of family interactions and therapeutic techniques, under the guidance of a therapist. The intended outcome of such family-oriented, psychotherapeutic services is the management, reduction, or resolution of the identified mental health problems, thereby allowing the beneficiary and family units to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from MFGP:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.
- Beneficiaries with the same type of problem that may gain insight by being in a group with others
- Beneficiaries who have a similar experiences
- Beneficiaries who need to demonstrate a level of competency to function in a group

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<i>Medical Necessity Criteria</i>	Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.
<i>Staff Qualifications</i>	MFGP must be provided by clinical professionals operating within their scope of practice, as allowed by state law.
<i>Service Documentation</i>	The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Staff-to-Beneficiary Ratio</i>	MFGP requires one professional and a minimum of two family units (a minimum of four individuals) and a maximum of up to eight individuals, which includes the beneficiaries and their families. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.
<i>Billing Frequency</i>	MFGP is billed as an encounter. More than one session can be billed per day; with a limit of eight sessions per month. A session must last a minimum of an hour. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions Related to Other Services</i>	MFGP is an encounter session. Each session must be documented separately.

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Family Psychotherapy (FP)

Purpose

The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his or her family unit. The therapist assists family members in developing a greater understanding of the beneficiary's psychiatric and/or behavioral disorder and the appropriate treatment for this disorder, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction.

Service Description

Family Psychotherapy (FP) involves interventions with members of the beneficiary's family unit (*i.e.*, immediate or extended family or significant others) with or on behalf of a beneficiary to restore, enhance, or maintain the family unit.

FP without the client may be rendered 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.

FP tends to be short-term treatment, with a focus on resolving specific problems such as eating disorders, difficulties with school, or adjustments to bereavement or geographical relocation. Treatment should be focused on changing the family dynamics and attempting to reduce and manage conflict. The family's strengths should be used to help them handle their problems.

FP helps families and individuals within that family understand and improve the way they interact and communicate with each other (*i.e.*, transmission of attitudes problems and behaviors) and promotes and encourages family support to help facilitate the beneficiary's improvement. The goal of FP is to get family members to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include the identification and the resolution of conflicts arising in the family environment — including

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<i>Service Description (Cont'd.)</i>	conflicts that may relate to substance use or abuse on the part of the beneficiary or family members; and the promotion of the family understanding of the beneficiary's mental disorder, its dynamics, and treatment. Services may also include addressing ways in which the family can promote recovery for the beneficiary from mental illness and/or co-occurring substance use disorders.
<i>Medical Necessity Criteria</i>	Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.
<i>Staff Qualifications</i>	FP must be provided by clinical professionals operating within their scope of practice, as allowed by state law.
<i>Service Documentation</i>	The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Staff-to-Beneficiary Ratio</i>	FP is one professional to one individual beneficiary and their family unit per encounter.
<i>Billing Frequency</i>	FP is billed as an encounter and can only be rendered once per day. FP with the beneficiary can be rendered four sessions per month and FP without the beneficiary can be rendered four times a month. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

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Special Restrictions Related to Other Services

No restrictions

Crisis Management (CM)

Purpose

The purpose of this 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 or her level of functioning. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care.

Service Description

The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he or 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.

A crisis can be defined as an event that places a beneficiary in a situation that was not planned or expected. Sometimes, these unexpected events can hinder the beneficiary's capacity to function. Clinical professionals should provide an objective frame of reference within which to consider the crisis, discuss possible alternatives, and promote healthy functioning. All activities must occur within the context of a potential or actual psychiatric crisis.

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

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

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Service Description (Cont'd.)

- 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

An evaluation of the beneficiary should be conducted promptly to identify presenting concerns, issues since last stabilization (when applicable), current living situation, availability of supports, potential risk for harm to self or others, current medications and medication compliance, current use of alcohol or drugs, medical conditions, and when applicable, history of previous crises including response and results.

Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion, as it may add to risk, increasing the need for engagement in care. This coordination must be documented in the individual's plan of care.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder; experience acute psychiatric symptoms; or experience psychological and/or emotional changes that result in increased personal distress. Services are also provided to beneficiaries who are, 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.

Staff Qualifications

CM must be provided by qualified clinical professionals as defined in the "Staff Qualifications" in this section.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Documentation

CM is not required to be listed on the plan of care. 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, including safety risk assessment and safety planning
- Active participation and intervention of the staff
- 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

Resolution of the crisis must be clearly documented in the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Staff-to-Beneficiary Ratio

CM requires at least one qualified clinical professional for each beneficiary.

Billing Frequency

CM is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality

Special Restrictions Related to Other Services

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

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

COMMUNITY SUPPORT SERVICES

Psychosocial Rehabilitation Services (PRS)

Community Support Services may only be provided by state agencies or enrolled private organizations.

Purpose

The purpose of this face-to-face service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the beneficiary's living, learning, social, and work environments. PRS is a skill building service, not a form of psychotherapy or counseling. PRS is intended to be time-limited. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are based on medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the beneficiary's IPOC.

Service Description

Psychosocial Rehabilitation Services (PRS) include activities that are necessary to achieve goals in the plan of care in the following areas:

- Independent living skills development related to increasing the beneficiary's ability to manage his or her illness, to improve his or her quality of life, and to live as actively and independently in the community as possible
- Personal living skills development in the understanding and practice of daily and healthy living habits and self-care skills
- Interpersonal skills training that enhances the beneficiary's communication skills, and ability to develop and maintain environmental supports

PRS is designed to improve the quality of life for beneficiaries by helping them assume responsibility over their lives, strengthen living skills, and develop environmental supports necessary to enable them to function as actively and independently in the community, as possible.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Description (Cont'd.)

PRS must be provided in a supportive community environment. Each beneficiary should be offered PRS in a manner that is strengths-based and person-centered.

PRS must provide opportunities for the beneficiary to acquire and improve skills needed to function as adaptively and independently as possible in the community and facilitate the beneficiary's community integration.

Medical Necessity Criteria

Admission Criteria

A H must be met to satisfy criteria for admission into PRS services.

- A. The beneficiary has received a diagnostic assessment, which includes a current DSM diagnosis that requires and will respond to therapeutic interventions specific to the PRS service description.
- B. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and the symptom-related problems interfere with the individual's functioning and living, working, and/or learning environment. (Children under the age of seven may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).
- C. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.
- D. Beneficiary meets three or more of the following criteria as documented on the diagnostic assessment:
 - Is not functioning at a level that would be expected of typically developing individuals their age
 - Is deemed to be at risk of psychiatric hospitalization and/or out-of-home placement

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Admission Criteria (Cont'd.)

- In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
 - Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior
- E. The family/caregiver/guardian agrees to be an active participant, which involves participating in interventions to better understand and care for the beneficiary for the purpose of maintaining progress during and after treatment.
- F. Traditional mental health services (e.g. individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.
- G. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.
- H. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

A-E must be met to satisfy criteria for continued PRS services.

- A. The beneficiary continues to meet the admission criteria.
- B. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the service description.
- C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from PRS, which remains appropriate to meet the beneficiary's needs.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Admission Criteria (Cont'd.)

- D. The family/caregiver/guardian, and others identified by the treatment plan process are actively participating in treatment. The beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.
- E. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).

Staff Qualifications

PRS is provided by qualified staff, under the supervision, of qualified clinical professionals as specified under the "Staff Qualifications" section. Staff providing the service must have, at a minimum, a bachelor's degree.

Service Documentation

PRS must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of PRS addresses. Services must be documented upon each contact with the beneficiary. Additionally, the clinical service notes and other documentation must meet all SCDHHS requirements.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

For beneficiaries age 0 through 15 years of age, the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form must be completed and maintained in the beneficiary's record. In the unlikely event that the beneficiary's family or caregiver is unable or unwilling to be an active participant, this must be clearly documented in the clinical record.

Staff-to-Beneficiary Ratio

PRS can be provided, individually, face-to-face with one participant at a time.

PRS can be provided in small groups of no more than one staff to eight (1:8) participants, regardless of the payer source of the participants in the group. Only staff who meet the staff qualification requirements for PRS are

SECTION 2 POLICIES AND PROCEDURES**REHABILITATIVE BEHAVIORAL HEALTH SERVICES*****Staff-to-Beneficiary Ratio
(Cont'd.)***

considered for the 1:8 ratio. For example: If a group consists of nine children, two staff must be present and actively rendering the service. If two staff are not present and actively rendering the service, the provider cannot be reimbursed for the service as the ratio exceeds 1:8.

Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

Billing Frequency

PRS is billed in 15-minute unit. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for 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

For services rendered to beneficiaries that are residing in a Community Residential Care Facility or Substance Abuse Facility, activities must be above and beyond structured activities required daily by the DHEC licensure requirements. This delineation must be clearly defined, documented, and accessible in the beneficiary record.

***Behavior Modification
(B-Mod)******Purpose***

The purpose of this service is provided to children ages 0 to 21. The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his or her functioning within their home or community. Shadowing (following and observation) a beneficiary in any setting is not reimbursable under Medicaid. Behavior Modification (B-Mod) is intended to be time limited and that intensity of services offered should reflect the scope of impairment.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Purpose (Cont'd.)

Services are based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the beneficiary's IPOC.

Service Description

The goal of Behavior Modification (B-Mod) is to alter behavior that is inappropriate or undesirable of the child or the adolescent. B-Mod involves regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned techniques that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

B-Mod provides the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn life skills.

B-Mod involves the identification of precipitating factors that cause a behavior to occur. New, more appropriate behaviors are identified, developed, and strengthened through modeling and shaping. Intervention strategies that require direct involvement with the beneficiary must be used to develop, shape, model, reinforce and strengthen the new behaviors.

B-Mod techniques allow professionals to build the desired behavior in steps and reward those behaviors that come progressively closer to the goal and allow the beneficiary the opportunity to observe the professional performing the desired behavior. Successful delivery of B-Mod should result in the display of desirable behaviors that have been infrequently or never displayed by the beneficiary. These desirable responses must be reflected in progress notes and show increasing frequency for ongoing behavioral modification.

Medical Necessity Criteria

A-I must be met to satisfy criteria for admission into B-Mod services.

- A. The beneficiary is under 22 years of age.
- B. The beneficiary has received a diagnostic assessment, which includes a current DSM

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Medical Necessity Criteria (Cont'd.)

diagnosis that requires and will respond to therapeutic interventions and which documents the need for B-Mod.

- C. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and must be engaging in one or more of the following behaviors: physical aggression, verbal aggression, object aggression, and/or self-injurious behavior that presents risk of harm to self or others Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).
- D. The beneficiary's behaviors interfere with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting
- E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:
 - Is not functioning at a level that would be expected of typically developing individuals their age
 - Is deemed to be at risk of psychiatric hospitalization or out-of-home placement
 - In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
 - Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior
- F. The beneficiary's behavioral needs require interventions to decrease identified behaviors and to facilitate the beneficiary's success in his or her home and community.
- G. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the beneficiary's needs identified in the DA and IPOC, for the purpose of maintaining progress during and after

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Medical Necessity Criteria (Cont'd.)

treatment

- H. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.
- I. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.

A-E must be met to satisfy criteria for continued B-Mod services.

- A. The beneficiary continues to meet the admission criteria.
- B. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the beneficiary's IPOC. The progress summary must specifically capture progress on each goal listed on the IPOC.
- C. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).
- D. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from B-Mod, which remains appropriate to meet the beneficiary's needs.
- E. The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Service Documentation

The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

B-Mod must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Documentation (Cont'd.)

In addition to the IPOC, a Behavior Modification Plan (BMP) must be included in the beneficiary's clinical record. See below for specific components of the BMP.

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of B-Mod addresses. Services must be documented upon each contact with the beneficiary. Additionally, the clinical service notes and other documentation must meet all SCDHHS requirements, outlined in Section 2 (Documentation Requirements) of this manual.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

For beneficiaries aged 0 through 15, the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form must be completed and maintained in the beneficiary's record.

Beneficiaries receiving B-Mod must have the Parent/Caregiver/Guardian Agreement form signed prior to the initiation of B-Mod services.

- For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by both foster parent and the case worker. In the event the foster parent or the case worker changes during the 90 day authorization period, the new foster parent and/or caseworker must sign the Parent/Caregiver/Guardian agreement for the next 90-day authorization cycle. In the event that there is a refusal or an inability to sign the agreement B-Mod services must not be provided.
- In addition to general documentation requirements, service documentation for B-Mod must identify the presence of the inappropriate and/or undesirable and detail how the behavior was redirected by qualified staff.

A Behavior Modification Plan (BMP) addresses the beneficiary's specific behavioral challenge(s). The BMP supports the beneficiary in learning and utilizing positive behavioral interventions, strategies and supports. The BMP

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Documentation (Cont'd.)

should focus on understanding why the behavior occurred, then focus on teaching an alternative behavior that meets the beneficiary's need(s).

The BMP must remain current and therefore must be amended when a new intervention, strategy or support is warranted or no progress is being made. The BMP must be revised as needed and must always be current.

The BMP must be developed by a team consisting of the beneficiary, family/caregiver and B-Mod provider. The BMP must be consistent with the beneficiary's goals outlined within the IPOC.

Components that must be included in BMP (Including but not limited to):

- Name
- Medicaid Number
- Date of BMP and/or date of revision
- Target Behavior(s):
 - An operational definition of each problem behavior to be decreased
 - An operational definition of each replacement behavior to be increased
 - A measurable objective for each problem behavior and replacement behavior
- Identify the desired behavioral change
- Intervention Strategies: includes specific interventions and strategies to be implemented in addressing the target behavior(s)/goal(s)
- Environmental Changes: includes any changes to the setting or environment necessary to effectively implement the strategies and interventions
- Timelines/Review Dates: includes segments of time during which specific portions of the BMP are to be addressed, as well as specific dates by which specific portions of the BMP are to be reviewed, with regard to progress
- Behavioral Crisis Plan: How will a behavioral crisis be handled?
- Monitoring Progress/Evaluation Methods: includes

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

<i>Service Documentation (Cont'd.)</i>	<p>a description of how progress toward achieving desired outcomes will be monitored and evaluated, including timeframes and data collection</p> <ul style="list-style-type: none"> • Progress Review Date: the date the plan will be reviewed for effectiveness • Names of participants in the creation of the BMP • Signatures of persons who participated in the development of the plan (beneficiary, family/caregiver, and B-Mod staff)
<i>Staff Qualifications</i>	<p>The specific behavior plan must be developed by an LPHA and conform to prevailing standards of practice based on peer-reviewed literature. B-Mod must be provided by qualified clinical professionals and paraprofessionals. B-Mod services rendered by paraprofessionals must be under the supervision of qualified clinical staff, as defined in the “Staff Monitoring/Supervision” section. A Bachelor’s degree or above is required to render B-Mod.</p>
<i>Staff-to-Beneficiary Ratio</i>	<p>B-Mod is provided individually, face-to-face with the beneficiary and a qualified professional or paraprofessional. B-Mod must not be provided in group settings.</p>
<i>Billing Frequency</i>	<p>B-Mod is billed in 15-minute unit. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>
<i>Billable Place of Service</i>	<p>The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary’s rights to privacy and confidentiality.</p>
<i>Special Restrictions Related to Other Services</i>	<p>Services cannot be billed for group activities.</p>
Family Support (FS) (0-21)	

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Purpose

The purpose of this face-to-face service is to enable the family or caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as an engaged member of the beneficiary's treatment team and to develop and/or improve the ability of the family or caregiver to appropriately care for the beneficiary. Family Support (FS) is intended to be time-limited and the intensity of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease over time as the beneficiary's and family/caregiver's skills develop. Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the rehabilitative goals specified in the beneficiary's IPOC.

Service Description

FS is intended to:

- Equip families with coping skills to independently manage challenges and crisis situations related to the beneficiary's behavioral health and/or substance use disorder
- Educate families/caregivers to advocate effectively for the beneficiary in their care
- Provide families/caregivers with information and skills necessary to allow them to be an integral and active part of the beneficiary's treatment team
- Modeling skills for the family/caregiver

Family Support (FS) is a service with the primary purpose of treating the beneficiary's behavioral health and/or substance use disorder.

FS does not include case management activities nor does it include respite care or child care services of any kind.

Medical Necessity Criteria

A-H must be met to satisfy criteria for admission into Family Support services.

- A. The beneficiary is under the age of 22.
- B. The beneficiary has received a diagnostic assessment, which includes a current DSM diagnosis and specific clinical needs that will respond to therapeutic interventions and which documents the need for FS.

SECTION 2 POLICIES AND PROCEDURES**REHABILITATIVE BEHAVIORAL HEALTH SERVICES****Medical Necessity Criteria
(Cont'd.)**

- C. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and the symptom-related problems interfere with the individual's functioning, living, working, and/or learning environment. (Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).
- D. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following: areas: daily living, personal relationships, school/work settings, and/or recreational setting.
- E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:
- Is not functioning at a level that would be expected of typically developing individuals their age
 - Is deemed to be at risk of psychiatric hospitalization and/or out-of-home placement
 - In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
 - Experiences impaired ability to recognize personal or environmental dangers and/or significantly inappropriate social behavior
- F. Family/caregiver agrees to be an active participant in treatment; FS services should provide opportunities for the family/caregiver to acquire and improve skills needed to better understand and care for the needs of the beneficiary (e.g., managing crises, providing education about the beneficiary's diagnosis).
- G. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Medical Necessity Criteria (Cont'd.)

H. The service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure.

A-E must be met to satisfy criteria for continued FS services.

A. There is documentation from the provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals specific to the treatment needs stated in the beneficiary's IPOC.

B. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's Individual Plan of Care (IPOC).

C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, or recreational setting, and is expected to continue to benefit from FS, which remains appropriate to meet the beneficiary's needs.

D. The beneficiary continues to meet the admission criteria.

E. The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Staff Qualifications

FS is provided by, or under the supervision of, qualified professionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law.

Service Documentation

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes should clearly identify the specific goals from the IPOC for which the delivery of FS addresses. Services must be documented upon each contact with the beneficiary and/or family/caregiver. Additionally, the clinical service notes and other documentation must meet all SCDHHS requirements, outlined in Section 2 (Documentation Requirements) of this manual.

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE BEHAVIORAL HEALTH SERVICES

Service Documentation (Cont'd.)

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the needs of the beneficiary.

Beneficiaries aged 0 through 15 must have the Parent/Caregiver/Guardian Agreement form signed prior to the initiation of FS services.

For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by both foster parent and the case worker. In the event the foster parent or the case worker changes during the 90 day authorization period, the new foster parent and/or caseworker must sign the Parent/Caregiver/Guardian agreement for the next 90-day authorization cycle. In the event that there is a refusal or an inability to sign the agreement FS services must not be provided.

The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Staff-to-Beneficiary Ratio

FS requires one qualified staff for each family unit served. If more than one child in a family has met medical necessity for FS they must be served separately. FS will not be reimbursed for group activities.

Billing Frequency

FS is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for 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

Services provided on the behalf of children must include coordination with family or guardians and other systems of care as appropriate.

SECTION 2 POLICIES AND PROCEDURES
REHABILITATIVE BEHAVIORAL HEALTH SERVICES

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SECTION 2 POLICIES AND PROCEDURES**MEDICAID
ADOLESCENT
PREGNANCY
PREVENTION
SERVICES
(MAPPS)**

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) shall be provided in accordance with South Carolina Medicaid guidelines set forth in SCDHHS' Medicaid Enhanced Services Provider Manual and appropriate Medicaid bulletins, which are hereby incorporated for reference.

SECTION 2 POLICIES AND PROCEDURES

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

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SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

The Special Needs Transportation Program is designed to provide transportation to Medicaid-eligible school students with special needs requiring transportation to medically necessary services in school-based settings provided directly by the Local Education Agency (LEA). This population includes but is not limited to children under the age of 21 who have sensory impairments, physical disabilities, intellectual disabilities or related disabilities, and/or developmental disabilities or delays. Each LEA recognized by the State Department of Education (SDE) is responsible for the arrangement and coordination of Special Needs Transportation services.

REQUIREMENTS FOR PARTICIPATION IN SPECIAL NEEDS TRANSPORTATION

In order to participate in the Special Needs Transportation Program, the LEA must meet all participatory requirements set forth in the program's contractual agreement with the SDE. The term "Local Education Agency" refers to any of the local entities that are recognized by SDE as school districts. Information concerning participation in the Medicaid Transportation Program may be obtained by contacting the PSC at (888) 289-0709, submitting an online inquiry at <http://www.scdhhs.gov/contact-us>, or writing to Post Office Box 8206, Columbia, SC 29202-8206.

Special Needs Transportation providers (LEAs) shall provide required transportation services to meet the needs of Medicaid-eligible school students with special needs in a vehicle adapted to serve the needs of the disabled. This shall include a specially adapted school bus used for transporting beneficiaries to and from reimbursable Medicaid services that are provided at a school or other facility when identified in the Individualized Education Plan (IEP).

COVERED SERVICES

Special Needs Transportation reimbursement is available for transportation provided to the following rehabilitative therapy and related health care services:

- Audiological

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

COVERED SERVICES (CONT'D.)

- Physical Therapy
- Occupational Therapy
- Speech and Language Pathology
- Psychological Testing and Evaluation
- Orientation and Mobility (O&M)
- Behavioral Health Services
- Nursing Services for Children Under 21
- Administrative Claiming
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Non-Emergency Transportation

An appropriate Medicaid-reimbursable School-Based Service other than transportation must be rendered on the date of transport to be reimbursable for Special Needs transportation. Medicaid transportation is not reimbursable when the requirement for transportation service is not identified in the IEP.

SPECIAL CIRCUMSTANCES

Beneficiary Escorts

The SDE does not receive an additional reimbursement for an escort to accompany the beneficiary to an authorized medical service. The rate of reimbursement agreed upon in the contract is considered sufficient to cover the cost of an escort, attendant, or other passenger that is required to accompany the Medicaid Special Needs student. The assignment of an escort to a Special Needs bus should be indicated in the student's IEP. If upon arrival at pickup a student requires an escort and one is not present, LEA providers should follow SDE procedures established to respond to such circumstances.

Beneficiary Complaints

Beneficiaries with complaints regarding Special Needs Transportation services should first contact their LEA provider. If the complaint cannot be resolved, a meeting should be scheduled with the LEA, SDE, and the complainant. If the complaint still cannot be resolved, SDE should contact the PSC or submit an online inquiry with the beneficiary's concerns. The complainant should contact SCDHHS directly at 1-888-549-0820.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

Vehicle Requirements

For the purpose of establishing the vehicle requirements relating to Special Needs Transportation services, LEAs will utilize a vehicle adapted to serve the needs of the disabled to include a specially adapted school bus and the current policies and procedures as defined by the State Department of Education, Board of Education in accordance with Section 59-67-20, Code of Laws of South Carolina for the Operation of the Public Pupil Transportation Services Reg. No. R 43-80 (as amended).

DOCUMENTATION

Error Correction Procedures

Please reference page 2-8.

Trip and Passenger Pupil Log Form

A Trip and Passenger Pupil Log Form is used daily by the driver to record route information and other ridership data as required by SCDHHS for billing and claims reimbursement for each Medicaid passenger (pupil) accessing transportation each day. This SDE or LEA form will provide basic information for completion of transportation billing and claims generation for reimbursement for each Medicaid passenger (pupil).

These forms are required to be kept in the provider's files as secure documentation. All information on the form is necessary for performance and financial audit purposes. If you choose to format a different version of the SDE-approved form, you are required to submit it to SDE for approval before using it.

District forms shall include:

1. District Name, Address, Phone Number
2. Route Number (as applicable)
3. Driver (Name)
4. Vehicle Number/License Tag Number/District Number
5. Date
6. Passenger Name

Upon completion, drivers are required to sign the log in the space provided.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

PROGRAM COMPLIANCE REVIEW

A program review will be conducted at least once during the contract year to evaluate compliance with program policies and procedures. Contract compliance reviews are conducted to identify areas where programmatic development or improvement is needed and to ensure that Medicaid policy is being met. The completed review will identify service delivery problems and recommend corrective action utilizing quality assurance methodologies approved by SCDHHS. This is also an opportunity to note program strengths and recognize the dedication and commitment the LEA provides to Medicaid beneficiaries.

During a compliance review, the following will be evaluated:

1. Verification of an appropriate Medicaid-reimbursable service other than transportation has been rendered on the date of transport as compared with the Trip Dispatch/Passenger Log
2. Verification of the requirement for transportation service has been identified in the IEP for a Medicaid-eligible Special Needs student
3. Compliance with policy and procedures of the Medicaid Transportation Program to be reimbursable for Special Needs transportation

Non-emergency contractual transportation services may be provided by the LEAs for Medicaid-eligible students requiring transport off-site to and from Medicaid-reimbursable services. Transportation services must be contracted directly through SCDHHS.