



REHABILITATIVE BEHAVIORAL HEALTH SERVICES (RBHS) PROVIDER MANUAL

January 1, 2024

South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

The South Carolina (South Carolina or State) State Medicaid Plan allows an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d). Rehabilitative Services are medical or remedial services that have been recommended by a Physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South Carolina State Law and as further 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.

SCDHHS encourages the use of “evidence-based practices” and “emerging best practices” that ensure thorough and appropriate screening, evaluation, diagnosis and treatment planning, and fosters improvement in the delivery of behavioral health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as interventions for which systematic empirical research has provided evidence of statistically significant effectiveness.

The National Registry of Evidence-Based Programs and Practices (<https://www.samhsa.gov/ebpresource-center>) and other relevant specialty organizations publish lists of evidence-based practices that Providers may reference.

Rehabilitative Behavioral Health Services (RBHS) are available to all Medicaid beneficiaries diagnosed with mental health and/or a substance use disorder (SUD), as defined by the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) who meet medical necessity criteria. Services are provided to, or directed exclusively toward, the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary’s ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

Eligible beneficiaries may receive RBHS from a variety of qualified Medicaid Providers. Public agencies that contract with SCDHHS as qualified service Providers may render these services directly to an eligible beneficiary.

PROVIDER CHOICE

Beneficiaries shall have free choice of any qualified enrolled Medicaid Provider. The Provider must assure that the provision of services will not restrict the beneficiary’s freedom of choice and it is not in violation of section 1902(a) (23) of the Social Security Act.

REFERRAL PROCESS FOR RBHS

Referrals for services may be made among and between private Providers enrolled in the South Carolina Medicaid Program and State agencies.

Medicaid beneficiaries and/or families may also self-refer for services.

Referrals (Provider to Provider or self-referred) can be done via phone, email, fax, and hard copy mail.

Note: Providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

The rendering of RBHS shall be based on the establishment of medical necessity, shall be directly related to the beneficiary's clinical needs, and shall be expected to achieve the specific goals specified in the beneficiary's Individual Plan of Care (IPOC).

In order to be reimbursed, some services (i.e., Community Support Services [CSS]) listed herein require prior authorization (PA) from the SCDHHS' designated Quality Improvement Organization (QIO).

The following list includes all RBHS:

- **Assessment and Screening Services:**
 - Behavioral Health Screening (BHS)
 - Diagnostic Assessment (DA) Services
 - Psychological Testing and Evaluation
 - Psychological or Neuropsychological Test Administration and Scoring
 - Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) Assessment

Core Services:

- Individual Psychotherapy (IP)
- Group Psychotherapy (GP)
- Multiple Family Group Psychotherapy (MFGP)
- Family Psychotherapy (FP)

- Service Plan Development (SPD)
- Crisis Management (CM) – Medication Management (MM)
- **Community Support Services:**
 - Psychosocial Rehabilitation Services (PRS)
 - Behavior Modification (B-MOD)
 - Family Support (FS)
 - Therapeutic Child Care (TCC)
 - Community Integration Services (CIS)
 - Therapeutic Foster Care (TFC)
 - Peer Support Services (PSS) (To be rendered by the Department of Mental Health (DMH) and Department of Alcohol and Other Drug Abuse Services [DAODAS] Providers only.)
- **Substance Abuse Treatment Services (To be rendered by DAODAS Providers only):**
 - Alcohol and Drug Screening (ADS) and Brief Intervention Services
 - Alcohol and Drug Assessment (ADA)
 - Alcohol and Drug/Substance Abuse Counseling (SAC)
 - Skills Training (ST) and Development Services for Children
- **Medical Services:**
 - Evaluation and Management of Medical Services (E&M)
 - Alcohol and Drug Assessment Nursing Services (ADN)
 - Medication Administration (MA)
 - Vivitrol® Injection (VI)

- Substance Abuse Outpatient Treatment Services
- Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP): Level II.I
- Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization: Level II.5

Residential Substance Abuse Treatment:

- Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification: Level III.2-D
- Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services: Level III.7-D
- Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment: Level III.5-R
- Behavioral Health Short Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment: Level III.7-R
- Behavioral Health Short Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA
- **Evidence-Based Practices:** *(Please refer to Appendices beginning on pg. 166)*
 - Assertive Community Treatment (ACT)
 - Multisystemic Therapy (MST)

MANAGED CARE ORGANIZATION

All RBHS services are covered under the managed care benefit package. If a beneficiary is enrolled with one of the State's contracted Managed Care Organizations (MCOs), all RBHS Providers must receive prior approval from the MCO. SCDHHS allows for MCOs to set PA rules and guidance. Please refer to the managed care policy and procedure manual at: <https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp> for additional information regarding behavioral health and substance abuse services.

The policy herein does not cover services under an MCO. Providers are not allowed to bill for services rendered to a beneficiary covered by a specific MCO unless the provider is credentialed with that MCO. Providers are encouraged to visit the SCDHHS website at: <https://msp.scdhhs.gov/managedcare/> for additional information regarding MCO coverage.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

RBHS are available to all Medicaid beneficiaries diagnosed with mental health and/or SUD(s), as defined by the current edition of the American Psychiatric Association's DSM or the ICD who meet medical necessity criteria. The use of Z-codes is allowed but this is considered a temporary diagnosis. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of treatment is needed. Z-codes may not be used for ages seven and up for longer than six-month duration. The use of Z-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

Medical Necessity

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services. A LPHA must certify that the beneficiary meets the medical necessity criteria for each service. LPHAs authorized to confirm medical necessity can be found under the Staff Qualification section within this manual.

Please refer to the *Reporting/Documentation* section for documentation requirements.

If the Medicaid recipient is in fee-for-service (FFS) Medicaid, the following guidelines must be used to confirm medical necessity. 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 the diagnosis has not been reviewed in 12 or more months, the diagnosis should be confirmed immediately.)
- Made by an LPHA enrolled in the South Carolina Medicaid Program.

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.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Accreditation

All private RBHS Providers must be accredited by one of the following accreditation organizations:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)
- The Joint Commission (TJC)

Private RBHS Providers must also meet the following requirements to be considered fully accredited:

- Each discrete service rendered by private RBHS Providers must be accredited.
 - Please refer to the accreditation crosswalk located on the RBHS webpage at: www.scdhhs.gov for further information concerning services and the above accreditation organizations.

NOTE: RBHS providers enrolled for the specific and sole purpose of providing an Evidence-Based Practice (i.e., Assertive Community Treatment or Multisystemic Therapy) are exempt from the accreditation requirement; however, if providers deliver other RBHS services in addition to the designated EBPs, accreditation is required.

- All locations owned and/or operated by private RBHS Providers in South Carolina and/or the South Carolina Medicaid Service Area (SCMSA) must be accredited.
- Accreditation for each service is a prerequisite for billing of that service. Any claims submitted for services that are not accredited are not reimbursable and may result in termination.

Providers must maintain, and be able to provide upon request, evidence of the accreditation certificate, the accreditation letter identifying the specific services that have been accredited, and the most recent accreditation survey report. Providers must submit evidence of meeting service accreditation requirements to the Office of Behavioral Health on the Accreditation for RBHS Form, located in the RBHS webpage information linked above. The Form can be submitted via the following options:

Email: behavioralhealth004@scdhhs.gov

Fax: +1 803 255 8204

All enrolled private RBHS Providers shall maintain accreditation status during the entire period of enrollment with SCDHHS. This includes, but is not limited to, periods of transition from one accreditation organization to another. Failure to maintain accreditation shall result in termination of enrollment.

Any denial, loss of, or any change in accreditation status must be reported to the Office of Behavioral Health in writing via the Program Changes for RBHS Form within five business days of receiving the notice from the accrediting organization. The written notification shall include information related, but not limited to:

- The Provider's denial or loss of accreditation status.
- Any change in accreditation status.
- The steps and timeframes, if applicable, the accreditation organization is requiring from the Provider(s) to maintain accreditation.

Failure to notify SCDHHS of denial, loss of, or any change in accreditation status may result in termination of enrollment.

If at any time, a Provider loses accreditation, termination of enrollment will occur. The applicant may not reapply for enrollment for one year from the effective date of the termination. Additionally, the applicant must be fully accredited at the time of application after the one-year period.

Location/Zoning Requirements

Providers must be housed in an office that is in a commercially zoned location.

A permanent sign must be affixed externally to the Provider's office to identify the location of the Provider.

Providers must post office hours/hours of operation and emergency contact information for after-hours emergencies and support.

Facility Qualifications

Residential Treatment Providers must follow the guidelines set in the SCDHHS Provider Enrollment Manual (e.g., the business site must be located within South Carolina or the SCMSA, a 25-mile radius of the South Carolina border) and be in compliance with Federal and State requirements (e.g., if applicable, be licensed by the South Carolina Department of Social Services [SCDSS]). Residential facilities are limited to 16 or fewer beds in order to receive Medicaid reimbursement as Federal law prohibits Medicaid payment to Institutions of Mental Disease as described in the Code of Federal Regulations, 42 CFR 435.1009.-101. All 16-bed residential substance abuse facilities

must be licensed with the South Carolina Department of Health and Environmental Control under the regulation of 61-93, the standards for Licensing Facilities that treat individuals for psychoactive substance abuse or dependence. Providers must maintain current licenses as a condition of enrollment.

Business Requirements

Providers must meet the following requirements at all times:

- SCDHHS and the U.S. Department of Health and Human Services 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 beneficiaries 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.
- The applicant must have a current business license or certificate of occupancy for each site located in South Carolina or the SCMSA. Business licenses and certificates of occupancy must be maintained the entire period of enrollment with SCDHHS.
 - If a county, or a municipality within a state, does not issue business licenses or certificates of occupancy, the provider must demonstrate evidence of the following documentation:
 - › Articles of Incorporation and signature pages
 - › Registration with the Secretary of State
 - A new business license and certificate of occupancy must be obtained any time a provider moves locations within South Carolina or the SCMSA.
- Office location(s) and the rendering of any service(s) must be located in South Carolina or within the SCMSA.

Consulting site providers for telehealth psychiatry encounters are not subject to the SCMSA location requirement but must be enrolled in South Carolina Medicaid and have a South Carolina medical license.
- Certificate of insurance indicating the provider maintains Commercial General Liability or Comprehensive Liability Insurance of at least \$1,000,000/per occurrence, \$3,000,000/general aggregate.
- Proof of Worker's Compensation insurance, if provider employs five or more full time staff

- Accept the reimbursement rates established by Medicaid
- Have a computer, Internet access, dedicated landline business phone number, and an email address to conduct business with SCDHHS

To request enrollment information, providers may contact SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709, submit an online inquiry at <http://www.scdhhs.gov/contact-us>, or access the online Medicaid enrollment application on the SCDHHS website. Once enrolled, providers are required to revalidate enrollment every three years.

It is the responsibility of all providers to continuously check the SCDHHS website for information, updates and changes, and provider manuals at <https://www.scdhhs.gov/provider-manual-list>. Providers should also subscribe to SCDHHS Medicaid Bulletins and/or Provider Alerts.

PROVIDER MEDICAID ENROLLMENT AND LICENSING

RBHS Provider Enrollment Guidelines

The Centers for Medicare and Medicaid Services (CMS) strengthened requirements for Medicaid provider screening to prevent fraud, waste, and abuse. CMS requires state Medicaid agencies to screen all provider applications based on a categorical risk level of “limited,” “moderate,” or “high.” This categorization helps the agency align with federal requirements and ensures taxpayer funds are appropriately safeguarded.

When a state Medicaid agency designates a provider type as a “high” categorical risk, the agency must require fingerprint-based criminal background checks (FCBC) for providers and any entity with 5% or more direct or indirect ownership interest in the provider. ***RBHS providers are included in the “high risk” category and as such are required to comply with the CMS regulations (42 CFR Part 455 subpart E) associated with this category.*** The FCBC must be completed during the enrollment process. Additionally, it is vital that provider owners and managing employees understand that they can be held criminally liable for the actions of the providers’ employees, agents, and representatives.

Requirements for enrollment as a “high risk” provider include the following steps:

- Newly enrolling RBHS providers must undergo level 1 and level 2 fingerprint-based criminal history background checks (FCBC) with both the South Carolina Law Enforcement Division and the Federal Bureau of Investigation;
- Must undergo a pre-enrollment site visit;
- May undergo a post-enrollment site visit to verify that the information submitted to SCDHHS is accurate and to determine compliance with federal and state enrollment requirements. (§ 455.432[(a)]);

- Must provide 100% disclosure of ownership to the grandparent level and attest to the disclosure of ownership during the provider enrollment process in accordance with CFR 42 §455.102.

**** In accordance with S.C. Code Ann. §40-75-290 (Supp. 2023, as amended), the above requirements do not apply to state agency providers, mental health counselors who are school district employees, or entities acting on behalf of a state agency, including child-placing agencies and Developmental Evaluation Centers.***

Newly enrolling RBHS providers may learn more about fingerprinting requirements, high-risk provider types, and disqualifying criteria by visiting the list of frequently asked questions (FAQ) on the agency's Provider Enrollment page (<https://www.scdhhs.gov/ProviderRequirements>).

Additional resources and complete instructions for the online Medicaid Provider Enrollment application process are also available on the Provider Enrollment webpage at: <https://www.scdhhs.gov/ProviderRequirements>.

RBHS providers must complete the following additional steps to become enrolled as a Medicaid provider:

When completing the application, providers must select "New Enrollment" and the following options:

Field	Option
Enrollment Type	Organization
Provider Type	Behavioral Health Services
Primary Specialty	Private Rehabilitative Health Services

Applications submitted to SCDHHS by private organizations with any options other than those specified in the table above will be denied.

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

- All Providers must demonstrate evidence of having the following required policies and procedures in place, and these policies and procedures must be maintained and updated as needed during enrollment as a Provider:
 - Confidentiality and protection of health information
 - Consent for treatment

- Record security and maintenance
- Record retention
- Use of secure electronic signatures if Provider uses an electronic health record or electronic medical record program
- Release of information
- Beneficiary's rights and responsibilities
- Prohibition of abuse, neglect and exploitation of beneficiaries
- Code of ethics
- Freedom of choice
- Limited English proficiency
- Compliance program (including fraud, waste, and abuse)
- Admission and discharge of beneficiaries
- Conditions for termination of beneficiaries from services, including:
 - › A list of reasons for termination,
 - › Methods of averting the termination,
 - › Education/consultation with beneficiary and/or family about termination (e.g., resources and options), and
 - › Evidence beneficiary/family informed of termination.
- Personnel practices (including recruiting, hiring and retention of staff as well as maintenance of personnel records)
- Use of volunteers and students/interns
- If the Provider receives annual Medicaid payments of at least \$5,000,000, the Provider must comply with Section 6032 of the Deficit Reduction Act of 2005, Employee Education about False Claims Recovery, and provide Federal False Claims Act education to its employees.

Business Closures

Business Termination Guidelines

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

- A. In cases of voluntary termination or closure, the provider shall provide written notification 30 days prior to the closure to SCDHHS and other appropriate agencies.
- B. Notification shall include the location where beneficiary and administrative records will be stored.
- C. The responsible party must retain administrative and beneficiary records for five years.
- D. Prior to closure, the RBHS provider will notify all beneficiaries and assist them with locating appropriate service providers.
- E. When a provider closes, the owner is responsible for releasing records to any beneficiary who requests a copy of his or her records. The owner is also responsible for the transfer of records to the appropriate State agencies, if applicable.
- F. Even if a provider closes, the provider may be responsible for repayment of any overpayments that occurred during the time the provider rendered treatment to Medicaid beneficiaries.

If a provider does not have any claim activity (fee-for-service or encounter, paid or denied) over the course of an 18-month period, their provider ID will be terminated. This inactivity alone will not qualify as an adverse termination and the provider may re-apply to the South Carolina Healthy Connections Medicaid program should they meet all current requirements.

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.

Staffing Requirements

An organization must include, at minimum, a Chief Executive Officer (CEO) or Administrator, a Clinical Director and two other professional or paraprofessional staff to provide direct services. The Provider must have a designated full-time Administrator (CEO/Director) with clear authority over general administration and implementation of requirements established by the RBHS Medicaid policy, including responsibility to oversee the budget and accounting systems implemented by the Provider, and have the authority to direct and prioritize work, regardless of where performed, and responsibility for the business operation of the entity. During times of absence (e.g., medical leave, vacation, etc.), the Provider must appoint, in writing, a qualified designee with administrative program experience.

The Provider must have a designated full-time Clinical Director responsible for clinical supervision and implementation of clinical services rendered by the private Provider. 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. For private RBHS, Clinical Directors must be South Carolina LPHAs. If the Provider is located in the MSA, they must be licensed at the independent level in the practicing state.

Staff Qualifications

All Providers of RBHS 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, 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 RBHS. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in South Carolina, or the state in which licensed clinical professionals render services and must be operating within their scope of practice.

TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	SERVICES ABLE TO PROVIDE
PROFESSIONALS				
Psychiatrist	Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) and has completed a residency in psychiatry.	Licensed by South Carolina Board of Medical Examiners	40-47-5 et seq.	All Services, except PSS, TFC
Physician	MD or DO	Licensed by South Carolina Board of Medical Examiners	40-47-5 et seq.	All Services, except PSS, PT, TFC
Psychologist	Doctoral degree in psychology.	Licensed by South Carolina Board of Psychology Examiners	40-55-20 et seq.	All Services except E&M, VI, MM, MA, ADN, PSS, TFC
Physician's Assistant (PA)	Completion of an educational program for PAs approved by the Commission on Accredited Allied Health Education Programs.	Licensed by South Carolina Board of Medical Examiners	40-47-905 et seq.	All Services, except PSS, PT, TFC

Pharmacist	Doctor of Pharmacy degree from an accredited school, college, or department of pharmacy as determined by the Board, or has received the Foreign Pharmacy Graduate Equivalency Certification issued by the National Association of Boards of Pharmacy.	Licensed by South Carolina Board of Pharmacy	40-43-10 et seq.	MM
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TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	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.	Licensed by South Carolina Board of Nursing; must achieve and maintain national certification, as recognized by the Board, in an advanced practice registered nursing specialty	40-33-10 et seq.	All Services, except PSS, PT, TFC
Licensed Psycho-Educational Specialist	Master's degree plus 30 course hours of psychopathology, successfully complete the ETS School Psychology Exam (PRAXIS), and be licensed.	Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists	40-75-510 et seq.	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, PTE, PTA, ADA, ADS, CIS, TCC, MST

Licensed Independent Social Worker — Clinical Practice (LISW-CP)	Master's or doctoral degree from a Board-approved social work program.	Licensed by South Carolina Board of Social Work Examiners	40-63-5 et seq.	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, ADA, ADS, CIS, TCC, ACT, MST
Licensed Master Social Worker (LMSW)	Master's or a doctoral degree from a social work program, accredited by the Council on Social Work Education and one year of experience working with the population to be served.	Licensed by South Carolina Board of Social Work Examiners	40-63-5 et seq.	B-MOD, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, ADA, ADS, CIS, TCC, ACT, MST

TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	SERVICES ABLE TO PROVIDE
PROFESSIONALS				
Licensed Marriage and Family Therapist (LMFT)	A minimum of 48 graduate semester hours or 72 quarter hours in marriage and FP along with an earned master's degree, specialist's degree, or doctoral degree. 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.	Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists	40-75-5 et seq.	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, ADA, ADS, CIS, ACT, TCC, MST

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 and Schools, the Association of Theological Schools in the United States and Canada, or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or a regionally accredited institution of higher learning subsequent to receiving the graduate degree.	Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists	40-75-5 et seq.	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, ADA, ADS, CIS, ACT, TCC, , MST
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TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	SERVICES ABLE TO PROVIDE
PROFESSIONALS				
Behavior Analyst	Must possess at least a master's degree, have 225 classroom hours of specific graduate-level coursework, meet experience requirements, and pass the Behavior Analysis Certification Examination.	Behavior Analyst Certification Board	N/A	B-MOD, BHS, CM, DA** FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, ADA, ADS, CIS, TCC,

TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	SERVICES ABLE TO PROVIDE
Certified Substance Abuse Professional (SAP)	Master's degree in counseling, social work, family therapy, nursing, psychology, or other human services field, and/or 250 hours of approved training related to the core functions and certification as an addictions specialist.	South Carolina Association of Alcoholism and Drug Abuse Counselors Certification Commission and/or NAADAC Association for Addiction Professionals	40-75-300	B-MOD, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, ADA, ADS, CIS, ACT, TCC, MST
Licensed Addictions Counselor (LAC)	Master's degree or higher (48 graduate hours) in addictions counseling, social work, family therapy, psychology, or other human services field, with 6 hours Substance Use Disorder/ Addiction Specific Coursework, and a minimum of one hundred twenty (120) hours of supervision by a licensed addictions counselor supervisor or other qualified licensed mental health practitioner approved by the SC licensing board.	Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists	40-75-225	ADA, ADS, BMod, BHS, CIS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, TCC, ACT, MST
Clinical Chaplain	Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister, or rabbi and one year of clinical pastoral education that includes a provision for supervised clinical services and one year of experience working with the population to be served.	Documentation of training and experience	40-75-290	B-MOD, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, , ADA, ADS, CIS, TCC, MST
Qualified Clinical Professional	For employees of service-providing state agencies: 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.		40-75-290	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, ADA, ADS, CIS, ACT, TCC, MST

TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	SERVICES ABLE TO PROVIDE
Mental Health Professional	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.		40-75-290	B-MOD, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, ACT, ADA, ADS, CIS, TCC, MST
SAP	Bachelor's Degree in a health or human services related field and certification as a certified addiction counselor or in the process of becoming South Carolina Association of Alcoholism and Drug Abuse Counselors (SCAADAC) credentialed or be certified by SCAADAC.	SCAADAC Certification Commission	40-75-300 et seq.	B-MOD, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), CIS, TCC,

TITLE OF PROFESSIONAL	LEVEL OF EDUCATION/DEGREE OR EXPERIENCE REQUIRED	LICENSE OR CERTIFICATION REQUIRED	STATE OR LICENSURE LAW	SERVICES ABLE TO PROVIDE
PROFESSIONALS				
Licensed Bachelor of Social Work (LBSW)	Bachelor's Degree in social work. (The practice of baccalaureate social work is a basic generalist practice that includes assessment, planning, intervention, evaluation, mediation, case management, information and referral, counseling, advocacy, supervision of employees, consultation, client education, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Baccalaureate social workers are not qualified to diagnose and treat mental illness nor provide psychotherapy services. Baccalaureate social work is practiced only in organized settings such as social, medical, or governmental agencies and may not be practiced independently or privately.)	Licensed by South Carolina Board of Social Work Examiners	40-63-5 et seq.	B-MOD, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, SPD, CIS, TCC, ACT, MST
Behavior Analyst	A Board-certified associate behavior analyst must have at least a bachelor's degree, 135 classroom hours of specific coursework, meet experience requirements and pass the Associate Behavior Analyst Certification Examination.	Behavior Analyst Certification Board	N/A	B-MOD, BHS, CM, FS, PRS, SAC, ST, ADA, ADS (Assist with developing the SPD), CIS, TCC,
Licensed Registered Nurse (RN)	At a minimum, an associate degree in nursing from a Board-approved nursing education program and one year of experience working with the population to be served.	Licensed by South Carolina Board of Nursing	40-33-10 et seq.	B-MOD, FS, MM, PRS, MA, ST, ADA, ADS, VI, CIS, TCC, ACT
Licensed Practical Nurse	Completion of an accredited program of nursing approved by the Board of Nursing and one year of experience working with the population to be served, a high school diploma or GED equivalent.	Licensed by South Carolina Board of Nursing	40-33-10 et seq.	MM, MA, ADN, ADS, VI

PARAPROFESSIONALS				
Human Service Professional	<p>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 behavioral health issues and treatment.</p> <p>*Must have two years' experience with population served to be eligible to provide MST.</p>	None required	N/A	B-MOD, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), TCC, CIS, ACT, MST*
Child Service Professional	<p>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.</p>	None required	N/A	B-MOD, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), TCC, CIS,
Peer Support Specialist	<p>High school diploma or GED equivalent peer support Providers must successfully complete a pre-certification program that consists of 40 hours of training. The curriculum must include the following topics: recovery goal setting, wellness recovery plans and problem solving, person-centered services and advocacy. Additionally, peer support Providers must complete a minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training.</p>	SC Certification as a Peer Support Specialist	N/A	PSS, ACT

PARAPROFESSIONALS (DAODAS ONLY)				
Substance Abuse Specialist (SAS)	At a minimum, a high school diploma or GED equivalent and have three years of documented direct care experience working with the identified target population or completion of an approved training and certification program.	None required	N/A	PRS, B-MOD, FS, ST,

*Private service Providers must be licensed at an independent level or be under an approved supervision contract if allowable by their respective licensing Board.

**Private service Providers must be LPHAs in order to conduct a DA. Medicaid requires LMSWs to have DAs cosigned by independent LPHAs.

SERVICE KEY					
SERVICE	ABBR.	SERVICE	ABBR.	SERVICE	ABBR.
Assertive Community Treatment	ACT	Family Psychotherapy	FP	Psychosocial Rehabilitation Service	PRS
Alcohol and Drug Assessment *	ADA	Group Psychotherapy	GP	Psychological Testing and Evaluation	PTE
Alcohol and Drug Nursing Assessment*	ADN	Individual Psychotherapy	IP	Psychological or Neuropsychological Test Administration	PTA
Alcohol and Drug Screening *	ADS	Vivitrol® Injection*	VI	Service Plan Development	SPD
Behavior Modification	B-MOD	Medication Administration *	MA	Skills Training and Development *	ST
Behavioral Health Screening	BHS	Medication Management	MM	Substance Abuse Counseling *	SAC
Crisis Management	CM	Medical Evaluation and Management *	E&M	Multiple Family Group Psychotherapy	MFGP
Diagnostic Assessment	DA	Peer Support Service **	PSS	Community Integration Services	CIS
Family Support	FS	Therapeutic Foster Care	TFC	Therapeutic Child Care	TCC
Multisystemic Therapy	MST				

*Service provided by DAODAS only.

**Services provided only by DMH and DAODAS Providers.

Please refer to the Community Support Services (CSS) sections for specific service requirements. Providers are subject to termination or denial of services if they are not in compliance with current policies and procedures.

Who Can Establish Medical Necessity

LPHAs must certify that the beneficiary meets the medical necessity criteria for each service. The LPHA must be enrolled in the South Carolina Medicaid Program. The following professionals are

considered to be licensed at the independent level in South Carolina and can establish and/or confirm medical necessity:

- Licensed Physician
- Licensed Psychiatrist
- Licensed Psychologists
- Licensed Psycho-Educational Specialist
- Licensed APRN
- LISW-CP
- Licensed PA
- LPC
- LMFT
- LAC (master's degree and above)

When medical necessity for services is required to be established and/or confirmed, the professional must be licensed at the independent level in each respective state where the professional renders services to Medicaid beneficiaries outside of South Carolina, but within the SCMSA.

A LMSW is considered a LPHA in South Carolina and can establish and/or confirm medical necessity when employed by a State Agency. For private Providers, a LMSW must have the DA co-signed by an independently LPHA.

LPHAs must be licensed in the state where they render services to the beneficiary.

Out-of-State LPHAs Confirming Medical Necessity

Out-of-State LPHAs must be enrolled in the South Carolina Medicaid Program. The professional must be licensed at the independent level in each respective state where the professional renders services within the SCMSA. The following professionals can establish and/or confirm medical necessity within the state listed:

NORTH CAROLINA	GEORGIA
<ul style="list-style-type: none"> • MD • DO • Nurse Practitioner (NP) • Family Nurse Practitioner • Psychologist • Physician's Assistant (PA) • PA-Certified • LPC • LMFT • Licensed Clinical Social Worker (LCSW) 	<ul style="list-style-type: none"> • MD • DO • APRN-NP • APRN-Clinical Nurse Specialist (APRN-CNS) • APRN-CNS/Psychiatric Mental Health • Psychologist • PA • LPC • LMFT • LCSW

Licensed Professionals

Providers who enroll as a Physician or LPHA must be able to demonstrate evidence of experience working with the population(s) to be served. Any services that are provided by staff who do not meet all of the staff qualification requirements in this manual 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 or within the SCMSA where the services are rendered.

Staff Monitoring/Supervision of Staff

RBHS provided by licensed or certified professionals must follow supervision requirements as required by South Carolina State Law or the state law in which the individual is practicing, for each respective profession.

Staff must be supervised as follows:

Services provided by any unlicensed/uncertified professionals must be clinically supervised by a master's level qualified clinical professional or an LPHA.

- Services provided by master's level clinical professionals must be clinically supervised by an LPHA licensed to practice at the independent level.
- SAPs who are in the process of becoming credentialed must be supervised by a certified SAP or an LPHA.

Licensed and/or master's level clinical professionals have the responsibility of planning and guiding the delivery of services provided by 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 private organization 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 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.

Training

Providers are responsible for ensuring that all staff are appropriately trained, including subcontractors, volunteers, students/interns, and other individuals under the authority of the billing Provider. Providers are responsible for the development and provision of training to their staff when alternative training is not available. Individuals who are qualified based on documented professional behavioral health experience, training or certification, and/or licensure, to conduct such training shall carry out the instruction.

NOTE: The specified training below is not required for providers delivering *only* an Evidence-Based Practice (i.e., Assertive Community Treatment or Multisystemic Therapy) unless they are providing other RBHS services.

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

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 plus an additional 3 hours of “Service Specific Training” for each specific service to be rendered by individual staff (PRS, B-MOD, FS, TCC, CIS, TFC)

Minimum # of Hours Required	Topics/Areas that must be covered	Topics/Areas that must be covered	Topics/Areas that must be covered
TRAINING:	ORIENTATION	CORE SERVICES	COMMUNITY SUPPORT SERVICES
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"> 8 hours minimum, covering the following topics: <ul style="list-style-type: none"> Crisis Response and Intervention IPOC Development Person Centered Values, Principles, and Approaches Childhood/Adolescent Development (if serving) 3 hours minimum for each CSS Service Specific Training, covering the following topics: <ul style="list-style-type: none"> Purpose and Service Description Medical Necessity criteria for all populations served Staff Qualifications Staff-to-Beneficiary Ratio Billing Frequency Billable Place of Service Non-Billable Medicaid Activities Documentation Requirements

Minimum # of Hours Required	Topics/Areas that must be covered	Topics/Areas that must be covered	Topics/Areas that must be covered
TRAINING :	ORIENTATION	CORE SERVICES	COMMUNITY SUPPORT SERVICES
			<p>Modalities</p> <p>Interventions</p> <p>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</p>

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, snowstorm, 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.).

Training records must indicate:

- The name of the training course,
- The instructor's name and signature,
- The training agency or on-line training resource,
- The date(s) of the training,
- The hours of the training,

- Signed attestation for those in attendance (signatures must be legible),
- The outline and content of the training, and
- The completion of certification criteria, as applicable.

Maintenance of Staff Credentials

Providers shall ensure that all staff, including subcontractors, volunteers, students/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.

Providers must maintain documentation which verifies that all staff are properly qualified, screened, trained, and supervised, including subcontractors, volunteers, students and/or interns and other individuals under the authority of the Provider. Providers must maintain and make available upon request, appropriate records and documentation of such qualifications, trainings, and investigations. Failure of the Provider to comply with this provision may result in the immediate termination of enrollment. SCDHHS may, upon good cause shown by the Provider, and within the discretion of SCDHHS, allow the Provider a reasonable amount of time to provide the documents requested.

Providers must maintain signature sheet(s) or electronic signature database(s) that identifies all individuals rendering services by name, signature, credentials, and initials.

The following required documents must be present in each personnel file, as applicable, prior to the start of employment and prior to rendering services to beneficiaries:

- A completed and signed employment application form (including criminal disclosure).
- A completed and signed job description that reflects the service(s) the person is responsible to render.
- College, high school diploma, or GED transcripts from the education institution.
- The degree must be from an accredited college or university listed in the U.S. Department of Education's Office of Post-Secondary Education database at: <http://ope.ed.gov/accreditation/>.
- Copies and primary source verification of all applicable professional licenses and certifications upon the start of employment and annually thereafter.
- Evidence of criminal background checks completed prior to the start of employment, and annually thereafter.

- All criminal background checks must include information for each staff member with no less than a 10-year search. The criminal background check must include Statewide (South Carolina) data, and any other state(s) the worker has resided in within the prior 10 years. In order for Providers to make an offer of employment or retain current employees, the criminal background results shall not indicate any findings or criminal charges against the potential or current employee in the following categories:
 - › Conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children’s Code, S.C. Code Ann. Title 63, Chapter 7).
 - › Felony conviction for any of the following, including guilty pleas and adjudicated pretrial diversions:
 - » Crimes against persons, such as murder, rape or assault, and other similar crimes.
 - » Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
 - » Any felony that placed the Medicaid Program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct).
 - » Any felonies outlined in section 1128 of the Social Security Act.
- Conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner), and
- Evidence of exclusion checks from Medicare or Medicaid Programs completed prior to the start of employment and annually thereafter. The following sources shall be checked for all individuals:
 - South Carolina Excluded Providers list: <https://www.scdhhs.gov/site-page/bureaucompliance-and-performance-review>
 - Office of the Inspector General Provider exclusion database: <https://exclusions.oig.hhs.gov/>
 - Federal System for Award Management: <https://www.sam.gov>
- Evidence of State and national sex offender registries checks completed prior to the start of employment and annually thereafter.

- Results of the sex offender registries checks should not indicate any findings or criminal charges against an individual.
- Evidence of child abuse registry checks completed prior to the start of employment and annually thereafter
- Results of the child abuse registry checks should not indicate any findings or criminal charges against an individual.
- Evidence of professional sanctions checks completed for licensed, certified, and unlicensed staff prior to the start of employment and annually thereafter.
- Results of the professional sanctions checks should not indicate any substantiated findings of abuse or neglect against the individual. This includes:
 - All applicable State licensing/certification Boards.
 - All applicable state Nurse Aide Registries or Health Care Personnel Registries. A list of State entities can be found in the NCSBN Directory of Nurse Aide Registries at: <https://www.ncsbn.org/725.htm>

Maintenance of Fiscal and Medical Records

Adequate and correct fiscal and medical records shall be kept by Providers to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations and policies. All services rendered and claims submitted shall be in compliance with all applicable Federal and State Laws and Regulations, and in accordance with the South Carolina Plan for Medical Assistance, alerts, bulletins, SCDHHS policies, procedures, and Medicaid Provider Manuals.

Service-Specific Staff Qualifications

For Assertive Community Treatment and Multisystemic Therapy, please refer to [Appendices A and B, respectively](#).

Service Plan Development (SPD) of the Individual Plan of Care (IPOC)

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

Staff-to-Beneficiary Ratio

SPD requires at least one professional for each beneficiary.

SPD-Interdisciplinary Team-Conference requires participation from at least one other health and human service agency or Provider involved with the beneficiary.

Beneficiaries are actively involved in the development, revision, coordination and implementation of the SPD.

Behavioral Health Screening (BHS)

BHS must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

BHS requires one qualified clinical professional for each beneficiary served. 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.

Diagnostic Assessment (DA) Services

DA Services must be provided by qualified clinical professionals as defined in the “Staff Qualifications” section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

When the assessment is completed by State agencies, the assessment must be conducted by a qualified clinical professional operating within one’s scope of practice. The professional must be specifically trained to render and review the assessment tool to make a clinically appropriate referral.

When the assessment is completed by private RBHS Providers, the assessment must be conducted by an independently licensed LPHA operating within one’s scope of practice. An LMSW may also complete the DA, which must be cosigned by the independently licensed LPHA. The Provider must be specifically trained to render and review the assessment tool to make a clinically appropriate referral.

Staff-to-Beneficiary Ratio

All assessments require one qualified clinical professional 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.

CALOCUS-CASII Assessment — Community Support Services

CALOCUS-CASII must be administered by a LPHA or a master’s level clinical staff with three years of experience. Providers who currently have approval from SCDHHS to administer the CALOCUS can also administer the CALOCUS-CASII. All new practitioners must have successfully completed training on CALOCUS-CASII and passed a competency test. The training can be obtained through any authorized provider, with the recommended training being from the American Academy of Child

and Adolescent Psychiatry (AACAP). All certifications must then be submitted to SCDHHS for final approval prior to administering the instrument to beneficiaries.

Staff-to-Beneficiary Ratio

CALOCUS assessment requires one qualified clinical professional for each beneficiary served.

Psychological Testing and Evaluation (PTE)

PTE must be provided by a Physician/APRN/PA or a qualified Clinical 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.

When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnosis.

Staff-to-Beneficiary Ratio

PTE services require one professional for each beneficiary.

Psychological or Neuropsychological Test Administration and Scoring (PTA)

PTA must be provided by a physician or a qualified licensed Psychologist under the direction of a physician operating within their scope of practice, as allowed by state law and who have been specifically trained to administer and score the assessment tool.

Staff-to-Beneficiary Ratio

PTA services require one professional for each beneficiary.

Individual Psychotherapy (IP)

IP must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

IP requires one qualified clinical professional to one beneficiary served.

Group Psychotherapy (GP)

GP must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

GP requires one qualified clinical professional and no more than eight beneficiaries (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.

Multiple Family Group Psychotherapy (MFGP)

MFGP must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

MFGP requires one qualified clinical professional for a minimum of two-family units served (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.

Family Psychotherapy (FP)

FP must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

FP is one professional to one individual beneficiary and their family unit per encounter. Only one individual beneficiary can be billed for any one session of FP.

Crisis Management (CM)

CM must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual. Licensed clinical professionals must operate within their scope of practice, as allowed by State Law.

Bachelor's level staff providing this service must have documented training in CM.

Staff-to-Beneficiary Ratio

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

Medication Management (MM)

MM services must be provided by qualified licensed clinical professionals operating within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

MM requires at least one qualified licensed clinical professional for each beneficiary.

Psychosocial Rehabilitation Services (PRS)

PRS must be provided by qualified clinical professionals and paraprofessionals as defined in the Staff Qualifications section of this manual. PRS services rendered by paraprofessionals must be under the supervision of qualified clinical professionals.

A bachelor's degree or above, or a certified SAS currently affiliated with DAODAS is required to render PRS.

Staff-to-Beneficiary Ratio

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

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

Behavioral Modification (B-MOD)

B-MOD must be provided by qualified clinical professionals and paraprofessionals as defined in the Staff Qualifications section of this manual. B-MOD services rendered by paraprofessionals must be under the supervision of qualified clinical staff. A bachelor's degree or above or a certified SAS currently affiliated with DAODAS is required to render B-MOD.

Exclusion: Provider staff directly serving children in TFC placement must have, at a minimum, a high school diploma or GED.

Behavior Modification Plan (BMP)

The specific behavior plan must be developed by an independent LPHA and conform to prevailing standards of practice based on peer-reviewed literature.

Staff-to-Beneficiary Ratio

B-MOD must be provided 1:1; B-MOD must not be provided in group settings.

Family Support (FS) (Ages 0-21)

FS must be provided by qualified professionals as defined in the general Staff Qualifications section of this manual. Staff providing the service must have a bachelor's degree or above, or be a certified SAS affiliated with DAODAS.

Exclusion: Provider staff directly serving children in TFC placement must have, at a minimum, a high school diploma or GED.

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.

Therapeutic Child Care (TCC)

TCC is provided by qualified staff as defined in the general Staff Qualifications section of this manual. TCC Providers must be under the supervision of licensed clinical staff. In addition, at least one clinical staff member must be rostered to provide Trauma-Focused Cognitive Behavior Therapy (TF-CBT) or Parent-Child Interactive Therapy (PCIT) or Child Parent Psychotherapy (CPP). For the initial year of TCC provision, this requirement may be satisfied by a clinician receiving training and supervision in TF-CBT, PCIT or CPP as part of the rostering process. It is also understood that other evidence-based therapeutic models may be included in treatment, as appropriate, based on the individual needs of beneficiaries and their families.

Staff-To-Beneficiary Ratio

TCC can be provided individually, face-to-face with one beneficiary at a time, or provided face-to-face with two to six beneficiaries in a small group (unless State daycare license requirements mandate a smaller ratio), regardless of the payer source of the beneficiaries in the group. Only staff who meet the staff qualification requirements for TCC are considered for the 1:6 ratio. For example: if a group consists of seven 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 1:6.

Community Integration Services (CIS)

CIS must be provided by qualified clinical professionals and/or paraprofessionals as defined in the Staff Qualifications section of this manual. CIS services rendered by paraprofessionals must be under the supervision of qualified clinical professionals and/or LPHAs.

Staff-To-Beneficiary Ratio

Staff to beneficiary ratio of 1:8 or less must be maintained at all times in order to claim reimbursement for the service.

Therapeutic Foster Care (TFC)

TFC services must be rendered in a SCDSS licensed therapeutic foster home provided by Child Placing Agencies contracted and certified by the SCDSS. TFC providers are qualified staff, under

the supervision of qualified clinical professionals as specified under the “Staff Qualifications” section.

Staff-to-Beneficiary Ratio

TFC is provided individually, face-to-face with one beneficiary at a time and must be provided by custodial foster parents. The number of beneficiaries in a therapeutic foster home along with the number of caregivers in that home is determined by the SCDSS and is expressed in licensure and contract language promulgated by SCDSS.

Peer Support Services (PSS)

The peer support specialist must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a certification training program, and he or she must be 18 years of age or older.

Peer Support Specialist must meet the following qualifications:

- Have had a diagnosis of behavioral health or SUD, as defined by the American Psychiatric Association’s Diagnostic and Statistical Manual and received treatment for the disorder.
- Self-identify as having had a behavioral health and/or SUD.
- Be in a recovery program.

Peer support specialists must have the following experience:

- The ability to demonstrate recovery expertise including knowledge of approaches to support others in recovery and dual recovery, as well as the ability to demonstrate his or her own efforts at self-directed recovery.
- One year of active participation in a local or a national mental health and/or substance use consumer movement, which is evidenced by previous volunteer service or work experience.
- Peer support Providers must successfully complete a precertification program that consists of:
 - Forty hours of training including recovery goal setting, wellness recovery plans and problem solving, person-centered services and advocacy.
 - A minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training. All trainings must be approved by SCDHHS or other authorized entity.

Supervision for PSS

Supervision must be provided by a master's level staff or higher or a bachelor's level staff with a CAC II certification.

The supervisor must be available to supervise the peer support specialist and ensure that he or she provides services in a safe, efficient manner in accordance with accepted standards of clinical practice and certification and/or training standards as approved by SCDHHS.

The supervisor is required to chair regularly scheduled staff meetings with the peer support specialists to discuss administrative and individual treatment issues. At a minimum, staff meetings shall occur monthly. Staff meetings are not separately billable under another clinical service, unless the staffing includes a Physician consultation. The supervisor shall review services that address specific program content and assess the beneficiary's needs. Issues relevant to the individual beneficiary will be documented in a staff note and noted in the beneficiary's medical record.

The supervisor is also required to perform at least one evaluation of the beneficiary no later than six months after admission to the program. The evaluation shall be repeated annually to:

- Monitor the recovery process of the beneficiary.
- Monitor the focus of the services provided.
- Ensure that the beneficiary continues to meet the peer support criteria.

The evaluation must be kept in the beneficiary's file and may be billed separately as a follow-up assessment.

Staff-to-Beneficiary Ratio

PSS is provided one-to-one or in a group setting. When rendered in groups, PSS shall not exceed one professional per eight beneficiaries.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

ADS may be provided by qualified clinical professionals who have been specifically trained to review the screening tool and make a clinically appropriate referral. Please refer to the Staff Qualifications section of this manual for a list of qualified clinical professionals authorized to render ADS.

Staff-to-Beneficiary Ratio

ADS 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.

Alcohol and Drug Assessment (ADA)

The assessment must be provided by qualified clinical professionals as defined in the “Staff Qualifications” section of this manual, who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.

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.

Alcohol and Drug/Substance Abuse Counseling (SAC)

SAC services must be provided by a qualified clinical professional or under the supervision of a qualified clinical professional as defined in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

SAC requires at least one professional for each beneficiary or group of up to 16 beneficiaries. 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.

Skills Training (ST) and Development Services for Children

ST and Development services are provided by qualified staff, under the supervision of qualified clinical staff as defined in the Staff Qualifications section of this manual. Effective July 1, 2015, staff providing the service must have a bachelor’s degree or above, or be a certified SAS affiliated with DAODAS.

Staff-to-Beneficiary Ratio

ST and Development is provided face-to-face with the beneficiary. The service can be rendered in groups of one staff to 12 beneficiaries, as appropriate, based on the needs of the beneficiary. The ratio count applies to all beneficiaries receiving services by a Provider, regardless of whether or not the individual is Medicaid-eligible.

Evaluation and Management of Medical Services (E&M)

Services are provided by qualified professionals operating within their scope of practice, as allowed by State Law.

Qualified health care professionals include Physicians, PAs and APRN practitioners. A Physician must be available in the event of an emergency.

Staff-to-Beneficiary Ratio

Services require at least one professional for each beneficiary.

Alcohol and Drug Assessment Nursing Services (ADN)

Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

Services require at least one qualified nursing professional for each beneficiary.

Medication Administration (MA)

Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by State Law.

Staff-to-Beneficiary Ratio

MA requires at least one qualified health care professional for each beneficiary.

Vivitrol® Injection (VI)

A qualified health care professional who is authorized in South Carolina to give an injectable medication can render this service.

Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP): Level II.I

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as identified on the Staff Qualifications Chart.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization: Level II.5

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed within this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification: Level III.2-D

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services: Level III.7-D

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment: Level III.5-R

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Behavioral Health Short Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment: Level III.7-R

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Behavioral Health Short Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

General Staff-to-Beneficiary Ratio Requirements

Staff-to-beneficiary ratios are established for safety and therapeutic efficacy concerns. Ratios must be met and maintained at all times when services are rendered. 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 is subject to recoupment. The ratio count applies to all 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.

When services are provided in a group setting, the Provider must maintain documentation of 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.

PROVIDER MEDICAID ENROLLMENT AND LICENSING**Provider Credentialing****Therapeutic Child Care (TCC)**

In order to provide TCC, enrolled RBHS Providers must apply to become credentialed in TCC.

In order to apply for TCC, Providers must meet the following requirements:

- Hold a South Carolina Department of Social Services (SCDSS) licensure or approval as a daycare facility.
- At least one staff member must be credentialed in TF-CBT, PCIT or CPP.
- Are accredited by one of the following entities in at least one of the applicable standards:
 - Commission on Accreditation for Rehabilitation Facilities:
 - › CYS Manual: Counseling/Outpatient, Early Childhood Development, Intensive Family-Based Services, Intensive Outpatient Treatment and/or Community Transition

- › Behavioral Health BH Manual: Intensive Family Based Services, and/or Outpatient Programs
- COA:
 - › Child and Family Development and Support Services, Day Treatment Services (DTX), Family Preservation and Stabilization Services, Outpatient Mental Health Services (MH), or Services for Mental Health and/or Substance Use Disorders (MH/SUD)
- TJC:
 - › BHC Day Treatment — Child/Youth Category and/or Mental Health — Child/Youth Category

Community Integration Services (CIS)

In order to apply for CIS, Providers must meet the following requirements:

- Providers (entity and clinical director) must have three years of experience serving adults with serious and persistent mental illness (SPMI) or co-occurring SUDs in a structured setting.
- CIS must be facility-based.
- CIS program facility must be open for a minimum of five hours per day, at least five days a week.
- Are accredited in the following:

CARF:

- › Behavioral Health Manual: Community Integration

COA:

- › Vocational Rehabilitation Services, Supported Community Living Services, Services for Substance Use Conditions, MH/SUD, Psychiatric Rehabilitation Services, MH, Adult Day Services, Counseling, Support, and Education Services, and/or DTX

TJC:

- › BHC Day Treatment — Adult, Mental Health — Adult, or Community Integration

Provider Termination

Providers may terminate enrollment upon providing SCDHHS with 30 days' written notice of termination. SCDHHS may terminate enrollment for good cause upon providing 30 days written notice of termination. Notices of termination shall be sent by certified mail, return receipt requested or nationally recognized overnight carrier, and be effective 30 days after the date of receipt.

Providers shall adhere to all applicable Federal and State Laws, rules, and regulations, including but not limited to, the following requirements:

- If the Provider voluntarily decides to (1) terminate the enrollment agreement as an RBHS Provider, or (2) reduce the array of services offered/rendered to beneficiaries, the Provider shall also notify the Division of Behavioral Health via the Voluntary Termination Notification for RBHS Form 30 days prior to closing business or ending any discrete service. The form can be submitted via the following options:

Encrypted Email: behavioralhealth004@scdhhs.gov Fax:
+1 803 255 8204

The notification shall identify:

- › The effective date of the voluntary termination or reduction,
 - › The rationale for the voluntary termination or reduction,
 - › The service(s) to be voluntarily terminated (identify each service to be terminated and population(s) affected for each service to be terminated or reduced),
 - › The number of beneficiaries affected by voluntary termination or reduction,
 - › The plan for discharge or continuity of care for all beneficiaries affected,
 - › The impact on staff,
 - › The records management and security plan, including the location where the beneficiary and administrative records will be stored, and
 - › Other entities notified of voluntary termination or reduction.
- The Provider is obligated to notify beneficiaries of the effective termination date as soon as possible and shall assist all beneficiaries with discharge planning and continuity of care needs; evidence of these efforts shall be retained by the Provider.

- If the Provider is terminated involuntarily by Medicaid, or if the Provider voluntarily terminates its relationship with Medicaid, the Provider is responsible for all beneficiary and administrative records in the event of a post-payment review.
 - Prior to the closure, the Provider will notify all beneficiaries and assist them with locating and transferring care to appropriate service Providers.
 - The Provider is responsible for releasing records to any beneficiary who requests a copy of his or her records.
 - The Provider must also transfer records to the appropriate State agencies, if applicable.
 - All fiscal and medical records shall be retained by the Provider/owner for a period of five-years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the five-years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five-year period, whichever is later.

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COVERED SERVICES AND DEFINITIONS

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. 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 rendered in a cost effective and in the least restrictive setting required by the beneficiary's condition. 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.

PA is required for **all** RBHS CSS' rendered by private Providers. CSS' rendered by private RBHS Providers must be prior authorized by the QIO, with the exception of beneficiaries in foster care. Services for these beneficiaries must be prior authorized by the SCDSS.

All RBHS Providers shall ensure (1) that only the authorized units of services are provided and submitted to SCDHHS for reimbursement and (2) that all services are provided in accordance with all South Carolina Medicaid Program policy requirements.

COVERED SERVICES AND DEFINITIONS

Service Plan Development (SPD) of the IPOC

SPD is interaction between the beneficiary, his or her family and/or other individuals significant to the beneficiary, qualified clinical professionals, treatment Providers and care coordinators which makes up the interdisciplinary team. The purpose of this service is to allow the interdisciplinary team the opportunity to discuss and or review the beneficiary's assessed needs, physical health, personal strengths, weaknesses, social history, and support systems 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 via the development of the IPOC. Beneficiaries and their families must be involved in the planning, developing and choosing of needed services.

The planning process should focus on the identification of the beneficiary's and his/her family's needs, desired goals and objectives. The interdisciplinary team should identify the skills and abilities of the beneficiary that can help achieve their goals, review areas in which the beneficiary needs assistance, support, and decide how the team of professionals can help meet those needs.

The interdisciplinary team is 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 one other health and human service agency or Provider 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 with other entities or support teams. In addition, this service will provide the interdisciplinary team the opportunity to discuss issues that are relevant to the needs of the beneficiary with the beneficiary or 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 family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC. The Physician, LPHA, master's level qualified clinical professional, 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 with other entities or support teams. In addition, this service will provide the interdisciplinary team the opportunity to discuss issues that are relevant to the needs of the beneficiary without the beneficiary or 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 legal representation. The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented

on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

Physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

Service Plan Development (SPD) by Non-Physicians

The purpose of this service is to allow an LPHA master's level qualified clinical professional, or LBSW to review, with other entities or support teams, the issues that are relevant to the needs of the beneficiary with the beneficiary or family member.

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 legal representation. The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

The LPHA, a master's level qualified clinical professional, or LBSW must sign the final document.

Screening and Assessment Services (Rendered by State Agencies and Private Providers) **Behavioral Health Screening (BHS)**

The purpose of this service is to provide early identification of mental health and/or SUD(s) to facilitate appropriate referral for a focused assessment and/or treatment. BHS is designed to identify behavioral health issues and/or the risk of development of behavioral health problems and/or substance abuse.

This face-to-face 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 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.

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.

Diagnostic Assessment (DA) Services

The purpose of this face-to-face assessment is to determine the need for RBHS and establish medical necessity, to confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and needs, and/or to assess progress in treatment and confirm the need for continued treatment. The assessment is also used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

DAs must include the following:

- An evaluation of the beneficiary for the presence of a mental illness and/or SUD.
- This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records
- Clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational records, and history, including past psychological assessment report and records. Initial assessments must include a clinical summary that identifies recommendations for and the prioritization of mental health and/or other needed services.

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

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

Once the initial assessment has been completed and services are deemed to be medically necessary, the development of the IPOC should be next-in the course of the treatment process.

Psychiatric DA without Medical Services (Comprehensive DA)

Identifies the beneficiary's needs, concerns, strengths, and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. The assessment must include a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records to obtain information necessary to establish or support a diagnosis. It also serves to drive the development or revision of the treatment plan and development of discharge criteria. The DA should be completed in one day. If additional time is needed to complete a thorough assessment, billing should occur on another day utilizing the follow-up assessment code.

Psychiatric DA with Medical Services

Identifies the beneficiary's needs, concerns, strengths, and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. The assessment must include a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records to obtain information necessary to establish or support a diagnosis. Psychiatric DA with Medical Services includes the ability to diagnose, treat, and monitor chronic and acute health problems and complete annual physicals and other health maintenance care activities (i.e., ordering, performing, and interpreting diagnostic studies such as lab work and x-rays).

It also serves to drive the development or revision of the treatment plan and development of discharge criteria.

Mental Health Comprehensive Assessment Follow-up

A Mental Health Comprehensive Assessment Follow-up occurs face-to-face with the beneficiary 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 for new or additional services to be added to the course of treatment.

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

CALOCUS-CASII Assessment — Community Support Services

SCDHHS requires the use of the CALOCUS-CASII as the standardized pre-admission criteria for all beneficiaries being considered for RBHS CSS. The assessment must be a face-to-face assessment with the beneficiary.

The CALOCUS-CASII links a clinical assessment with standardized criteria that describes the level of intensity of services needed for a beneficiary. The CALOCUS-CASII rating can be done for any

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

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

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

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

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

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

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

The levels of care are:

Level 1 — Recovery Maintenance and Health Management

Level 2 — Outpatient Services

Level 3 — Intensive Outpatient Services

Level 4 — Intensive Integrated Service without 24-Hour Psychiatric Monitoring

Level 5 — Non-Secure 24-Hour Services with Psychiatric Monitoring

Level 6 — Secure 24-Hour Services with Psychiatric Monitoring

When CALOCUS-CASII score indicates a Level 4, 5 or 6, residential placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered prior to consideration of residential placement. Psychological Testing and Evaluation (PTE)

PTE services involve the use of formal testing procedures using reliable and valid instruments to measure the areas of intellectual, cognitive, adaptive, emotional and behavioral functioning, along with personality styles, interpersonal skills and psychopathology (e.g., Minnesota Multiphasic Personality Inventory [MMPI], Rorschach, and WAIS). Testing and evaluation must involve face-to-face interaction between a Physician/APRN/PA or a licensed psychologist and the beneficiary for the purpose of evaluating the beneficiary's intellectual, emotional and behavioral status. Tests must be standardized, and validated measures recognized by the scientific and professional community as a national standard for professional practice, and may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, motivations, and/or personality characteristics, as well as use of other non-experimental methods of evaluation.

PTE includes integration of beneficiary data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the beneficiary, family member or caregiver.

Psychological or Neuropsychological Test Administration and Scoring (PTA)

PTA services are utilized when the potential of a mental health or co-morbid condition has been established and psychological or neuropsychological testing may determine the presence or absence of such a condition. Test administration requires meeting medical necessity, which is based on the documented diagnostic impressions that justify the need for testing. PTA also requires administration of at least two tests, which may be administered by any method (i.e., paper, verbal, or electronic).

Core Treatment Services (Rendered by State Agencies and Private Providers)

Psychotherapy

Psychotherapy Services are provided within the context of the goals identified in the beneficiary's plan of care. An Assessment must be completed to determine the need for psychotherapy services. 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 Services should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues and may be provided in an individual, group or family setting. The assessments, plans of care, and CSNs must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality.

Providers of core treatment who are not employed by governmental entities must possess a license to practice in psychology, social work, professional counseling, marriage and family therapy, or medicine. Providers who are pursuing their independent license during a supervised period of clinical practice may also render core treatment services, provided that they possess an approved supervision contract with the applicable licensing Board.

All licensed professionals must be in conformance with the relevant practice act(s). By submitting claims to SCDHHS for reimbursement, licensed professionals attest that they are in conformance with the relevant practice act(s) and associate regulations. Any services performed by licensed professionals, to include supervisory relationships, that do not comport with the relevant practice act(s) and regulations are subject to recoupment by the Department, and a referral made to the appropriate Board at South Carolina Department of Labor, Licensing and Regulation.

Individual Psychotherapy (IP)

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

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.

Group Psychotherapy (GP)

GP is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician. The focus of GP is to assist 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 the process is productive for all members and focuses on identified therapeutic issues.

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 psychotherapy 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 or similar needs that may gain insight by being in a group with others with shared experiences.
- Beneficiaries who have a similar experience.
- Beneficiaries need to demonstrate a level of competency to function in a group.

Multiple Family Group Psychotherapy (MFGP)

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 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.

MFGP involves a small therapeutic group that is designed to produce behavioral change. The goals of MFGP must match the overall treatment plan for the individual beneficiary. MFGP 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. The psychotherapy 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 SUDs, 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 experience.
- Beneficiaries need to demonstrate a level of competency to function in a group.

Family Psychotherapy (FP)

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.

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 may be rendered with or without the beneficiary to family members of the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

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 promote and encourage FS 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, but are not limited to, the identification and the resolution of conflicts arising in the family environment, including conflicts that may relate to substance use or abuse on the part of the beneficiary or family members, and the promotion of the family's 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 SUDs.

Crisis Management (CM)

The purpose of this face-to-face or telephonic short-term service is to assist a beneficiary who is experiencing urgent or emergent 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.

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.

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; CM is not a scheduled service.

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

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

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.

Medication Management (MM)

The purpose of this face-to-face service is to train and educate the beneficiary about his or her medication, to determine any physiological and/or psychological effects of medication(s) on the beneficiary, administer necessary medications, and to monitor the beneficiary's compliance with his or her medication regime.

MM is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication. During assessments, attempts should be made to obtain necessary information regarding the beneficiary's health status and use of medications.

MM encompasses those processes through which medicines are selected, procured, delivered, prescribed, administered, and reviewed to optimize the contribution that medicines make to producing informed and desired outcomes of the beneficiary's care.

MM includes two or more of the following services:

- Management, which involves prescribing and then reviewing medications for their side effects.
- Monitoring, which involves observing and encouraging people to take their medications as prescribed (frequently used with people with a poor compliance history).
- Administration, which is the actual giving of an oral medication by a licensed professional.
- Training, which educates beneficiaries and their families on how to follow the medication regime and the importance of doing so.
- Assess the need for beneficiaries to see the Physician.

MM may provide the following:

- Determine the overt physiological effects related to any medication(s).
- Determine psychological effects of medications.
- Monitor beneficiaries' compliance to prescription directions.
- Educate beneficiaries as to the dosage, type, benefits, actions, and potential adverse effects of the prescribed medications.
- Educate beneficiaries about psychiatric medications and substance abuse in accordance with nationally accepted practice guidelines.
- Monitor and evaluate the beneficiary's response to medication(s).
- Perform a medication review to identify, resolve, and prevent medication-related problems, including adverse drug events.
- Document the care delivered and communicate essential information to the beneficiary and/or other service Providers, if appropriate. When the service is provided to children, the service should include communication and coordination with the family and/or legal guardian.

- Provide verbal education and training designed to enhance the beneficiary understanding and appropriate use of the medications.
- Provide information, support services, and resources designed to enhance beneficiary's adherence to medication regimen.
- Coordinate and integrate MM services within the broader health care management services being provided to the beneficiary.

Community Support Services (Rendered by State Agencies or Private Providers — with the exception of PSS)

CSS must be prior authorized prior to being rendered. Please refer to the PA section of this manual regarding PA requirements.

Psychosocial Rehabilitation Services (PRS)

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.

PRS include activities that are necessary to achieve goals in the IPOC in the following areas:

- Independent living skills development related to increasing the beneficiary's ability to manage his or her illness, 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 ST that enhances the beneficiary's communication skills, ability to develop and maintain environmental supports, and ability to develop and maintain interpersonal relationships.

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.

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.

Behavior Modification (B-MOD)

The service is provided to children and adolescents 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 the home or community. Shadowing (following and observation) a beneficiary in any setting is not reimbursable under Medicaid. B-MOD 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 skills develop. 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.

The goal of B-MOD is to alter patterns of behavior that are inappropriate or undesirable of the child or the adolescent. B-MOD involves the utilization of 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 B-MOD.

Family Support (FS)

The service is provided to children and adolescents ages 0 to 21. 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(s) to appropriately care for the beneficiary. 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.

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 SUD.
- 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.
- Model skills for the family/caregiver.

FS is a service with the primary purpose of treating the beneficiary's behavioral health and/or SUD.

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

Therapeutic Child Care (TCC)

The purpose of this face-to-face service is to assist children ages zero to six with severe emotional and/or behavioral disturbances, and to promote or enhance appropriate developmental functioning which fosters social, emotional, and self-regulatory behavioral competence. Services incorporate a combination of psychotherapy and skill building.

TCC is a child-focused, family-centered intervention which targets the relationship between the child and the parent (or primary caregiver). Grounded in attachment theory, services are relationship-based, developmentally appropriate and trauma informed. Services must be evidence-based and include either TF-CBT, PCIT or CPP. The TCC must have documentation of staff certification to provide the evidence-based treatment being utilized as well as a documented plan for fidelity monitoring.

The child and child's family are expected to develop behaviors and skill sets such that the child will not require intensive treatment in the future.

- TCC involves ongoing assessment, treatment activities, and therapeutic structure during program hours.
- Therapeutic group interventions that foster social and emotional competence and self-control.
- Parallel work with the primary caregiver is an essential component of this service. A minimum of one hour per week must be spent with the primary caregiver that includes parent-child interaction to encourage language and play, interpretation of child's behavior and reinforcement of a primary caregiver's appropriate actions and interactions. Parallel work may include activities and services that are not specifically billed to TCC.

It is expected that:

- The child will demonstrate an improved ability to initiate and respond to social interactions in a developmentally appropriate manner.
- The child will show a significant reduction in intense and disruptive problem behaviors that interfere with the child's ability to successfully participate in normal developmental experiences or present a danger to self and/or others.
- The child will develop age-appropriate behavioral competencies that will result in enhanced problem solving, coping strategies, self-control, and more successful interactions with other children and adults.
- The child will demonstrate an enhanced ability to meaningfully perform age-appropriate role functions and to learn from the home and educational environments.
- The child will show significant improvements in mood as evidenced by reductions in excessive irritability and/or sadness.
- The child will demonstrate a reduction in behaviors which previously made the child's behavior unmanageable in the home, school, and community. There will be an increase in the child's ability to be present, interact, and participate in various tasks for longer periods of time.
- The child will demonstrate an increased capability to interact with adults in therapeutic and educational tasks, resulting in increased educational and emotional functioning.
- Improvements in mood will be accompanied by positive changes in self-worth and confidence.

It is expected that parents or primary caregivers of beneficiaries will:

- Learn strategies for managing problem behaviors and interacting effectively with their children.

- Identify and reduce maladaptive patterns and stresses in the home that compound the child's behavioral and emotional challenges.
- Learn to recognize generational patterns impacting their parenting and relationship with their child and take active steps to modify those patterns to the benefit of the child and family.
- Understand the social emotional needs being expressed through behavior and know how to respond to these appropriately.
- Reduce parenting stress and improve confidence in their parenting skills.
- Develop and/ or strengthen the attachment bond with their child.
- Recognize how traumatic experiences can impact their own behavior and their child's behavior and demonstrate ability to recognize potential risks and take action to keep their child safe.
- Demonstrate age-appropriate expectations for their child's social-emotional and behavioral development.
- Consistently and appropriately provide for the child's basic needs for health, safety, comfort, affection and stimulation.

Community Integration Services (CIS)

The purpose of this face-to-face service is to assist adult beneficiaries (18 or older) diagnosed with serious and persistent mental health disorder(s) or co-occurring mental health and SUDs achieve identified behavioral health treatment goals in the environment of their choice.

CIS programs are appropriate for adults with a SPMI or co-occurring SPMI and SUDs who wish to participate in a structured program with staff and peers and have identified behavioral health treatment goals that can be achieved in a supportive and structured environment.

CIS requires that a beneficiary be actively involved in the development and management of his/her overall rehabilitation, including planned goals, objectives and intervention activities included on the IPOC. The beneficiary who is meaningfully involved in CIS programs should be able to articulate his/her individual goals and objectives and to identify ways in which his/her current activities are intended to assist him/her in achieving those goals and objectives and further his/her own recovery.

There must be a collaborative and supportive relationship between the Providers, beneficiary, and family (if family is involved) to work on IPOC goal achievement. The goals of the IPOC should address the following skills development, educational, and pre-vocational activities as necessary:

- Community living competencies (e.g., self-care, cooking, money management, personal grooming and maintenance of living environment).
- Social and interpersonal competencies (e.g., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships).
- Personal adjustment competencies (e.g., developing and enhancing personal abilities in handling life experiences and crises, including stress management, leisure time management, coping with symptoms of mental illness).
- Cognitive and adult role competencies (e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy).
- Prevocational activities (e.g., development of positive work habits and participation in activities that would increase the beneficiary's purpose, confidence and re-engagement in meaningful activities and/or employment, time management; prioritizing tasks, taking direction from supervisors, importance of learning and following the policies/rules and procedures of the workplace, problem solving/conflict resolution in the workplace, communication and relationships with coworkers and supervisors, on-task behavior and task completion skills).

Providers are encouraged to utilize evidence-based best practice models that may include: The Boston Psychosocial Rehabilitation Approach, the Lieberman Model, the International Center for Clubhouse Development approach, the Fountain House model, or blended models/approaches in accordance with current Psychosocial Rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/ evidence-based models and practices for Psychosocial Rehabilitation.

The place of service for CIS must be open for a period of five or more hours per day at least five days per week. CIS maybe provided on weekends or in the evening.

Therapeutic Foster Care

The purpose of this residential, 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 vocational environments. Therapeutic Foster Care (TFC) services are based on medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to support the achievement of the specific rehabilitative goals specified in the beneficiary's Individual Plan of Care (IPOC).

TFC is a treatment-focused form of foster care provided in a family setting by trained caregivers and is a family-based placement option for children and adolescents with serious emotional, behavioral,

or medical needs who can be served in the community with additional intensive support. Youth receiving TFC require behavioral health services and supervision provided in a treatment foster home setting.

TFC services are individualized, trauma-informed care provided to youth with psychological, emotional, and/or behavioral challenges. Eligible beneficiaries are those who are at risk for failure or have failed in regular foster homes, are unable to live with their own families, or are going through a transitional period from residential care as part of the process of return to family and community.

TFC provides a structured environment with a specially trained and clinically supervised therapeutic foster family. This family facilitates the development of skill acquisition and use of strategies and supports that address therapeutic treatment, prevention, recovery and behavior change consistent with age and development for each child served. TFC services are necessary to assist the child in improving and maintaining functioning across life domains.

TFC services include:

- **Treatment planning.** An individualized treatment plan is designed to guide and coordinate the provision of services. Following the creation of the IPOC, CPA treatment teams must meet every 90 days, or more often if necessary, to help ensure that the services are responsive to the changing needs of the child being served. The treatment team should invite the therapeutic foster parents, case managers, biological or other family members as appropriate, clinicians, and others involved in the child's team.
- **Specialized training.** Therapeutic foster care requires highly trained caregivers who are responsible for implementation of the child's treatment plan. Therapeutic foster parents receive additional preservice and ongoing training compared to traditional foster parents. They are also provided more frequent supervision by trained treatment coordinators and clinicians.
- **Family and crisis support.** Therapeutic foster parents and children are provided with de-escalation support that can include crisis planning, respite care, and access to a treatment coordinator or clinician 24 hours a day.
- **Structured activities.** Activities are designed to teach or reteach social skills and coping skills to help children in therapeutic foster care deal effectively with the circumstances or conditions that created the need for treatment.
- **Interventions.** Strategies used by team members include but are not limited to: role modeling in all social contexts, anger management, communication and conflict resolution skill development, crisis avoidance/planning/intervention, behavioral de-escalation, recovery, reinforcement of skill acquisition in the home and community, transition and discharge planning, and self-advocacy.

Peer Support Services (PSS) (To be rendered by DMH and DAODAS only)

The purpose of this face-to-face service is to assist beneficiaries' recovery from mental health and/or substance abuse disorders by sharing similar lived experience and recovery.

This service is person-centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

The qualified peer support specialist gives advice and guidance, provides insight, shares information on services and empowers the beneficiary to make healthy decisions. The unique relationship between the peer support specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of PSS.

The peer support specialist will utilize their own experience and training to assist the beneficiary in understanding how to manage their illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers and work towards their goals. The peer support specialist will also provide ongoing support to keep beneficiaries engaged in proactive and continual follow up treatment.

The peer support specialist actively engages the beneficiary to lead and direct the design of the plan of care and empowers the beneficiary to achieve their specific individualized goals. Beneficiaries are empowered to make changes to enhance their lives and make decisions about the activities and services they receive.

Services are multi-faceted and should emphasize the following:

- Personal safety
- Self-worth
- Introspection
- Choice
- Confidence
- Growth
- Connection
- Boundary setting
- Planning
- Self-advocacy
- Personal fulfillment

- The Helper Therapy Principle
- CM
- Education
- Meaningful activity and work
- Effective communications skills

Due to the high prevalence of beneficiaries with mental health and/or SUDs and the value of peer support in promoting dual recovery, identifying individuals co-occurring disorders who require dual treatment is a priority.

PSS reinforces and enhances the beneficiary's ability to cope and function in the community and develop natural supports. The beneficiary must be willing to participate in the service delivery. Services are structured and planned one-to-one or group activities that promote socialization, recovery, self-advocacy and preservation.

PSS must be coordinated within the context of a comprehensive, individualized POC that includes specific individualized goals. Providers should use a person-centered planning process to help promote beneficiary ownership of the POC.

Such methods actively engage and empower the beneficiary and individuals selected by the beneficiary, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the beneficiary in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

Service interventions include the following:

- Self-help activities that cultivate the beneficiary's ability to make informed and independent choices. Activities help the beneficiary develop a network for information and support from others who have been through similar experiences.
- Self-improvement planning and facilitating specific, realistic activities leading to increased self-worth and improved self-concepts.
- Assistance with substance use reduction or elimination provides support for self-help, self-improvement, skill development, and social networking to promote healthy choices, decisions, and skills regarding SUDs or mental illness and recovery.

- System advocacy assists beneficiaries in making telephone calls and composing letters about issues related to SUDs, or mental illness or recovery.
- Individual advocacy discusses concerns about medications or diagnoses with a Physician or nurse at the beneficiary's requests. Further, it helps beneficiaries arrange the necessary treatment when requested, guiding them toward a proactive role in their own treatment.
- Crisis support assists beneficiaries with the development of a crisis plan. It teaches beneficiaries:
 - How to recognize the early signs of a relapse.
 - How to request help to prevent a crisis.
 - How to use a crisis plan.
 - How to use less restrictive, hospital alternatives.
 - How to divert from using the emergency room.
 - How to make choices about alternative crisis support.
 - Housing interventions instruct beneficiaries in learning how to maintain stable housing or learning how to change an inadequate housing situation.
- Social network interventions assist beneficiaries with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.
- Education and/or employment interventions assist beneficiaries in obtaining information about going back to school or getting job training. Interventions give beneficiaries an opportunity to acquire knowledge about mainstreaming back into full-time or part-time work. Additionally, they are taught how to obtain reasonable accommodations under the Americans with Disabilities Acts (ADA).

Substance Use Disorder (SUD) Treatment Services (Only to be rendered by DAODAS)

SCDHHS and the South Carolina DAODAS have implemented a Statewide system to coordinate alcohol and other drug (AOD) services that are critical to serving eligible Medicaid beneficiaries. AOD services are rendered by Alcohol and Drug Commission Providers through outpatient and residential treatment programs.

SCDHHS has adopted the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC) for the treatment of substance-related disorders as the basis for the beneficiary's

placement in the appropriate levels of care. This manual specifies the policies that SCDHHS requires Providers to meet, in addition to the ASAM criteria.

Beneficiaries must have a diagnosis of a SUD or co-occurring substance use and mental health disorders from the most recent DSM or ICD manual and meet medical necessity requirements before being placed in an AOD outpatient or residential treatment program. Services must be authorized by a Physician or LPHA.

Outpatient and residential services may require a physical examination to be completed within a specified time frame by a qualified health care professional.

Coordination of care must occur when a beneficiary is being served by multiple agencies and/or Providers. Each Provider is responsible for making the effort to identify, during the intake process, whether a beneficiary is already receiving treatment from another Medicaid Provider. Other Medicaid Providers involved in the treatment of the beneficiary must be notified of their need for AOD services. Medically necessary services should never be denied to a beneficiary because another Provider has been identified as the service Provider. Additionally, each Provider should also notify other involved agencies or Providers immediately if a beneficiary in an overlapping situation discontinues their services.

Providers must ensure that staff responsible for the provision of services meets the appropriate licensing, credentialing, certification or privileging standards required for each service or level of care.

DAODAS Providers may render specific services listed in the Core Rehabilitative, Core Treatment, and Community Support sections above. In order to be reimbursed for these services, DAODAS Providers must follow the guidelines under “DAODAS Only Procedure Codes” located within the Procedure Codes link located in the Program Overview section of this manual.

Some DOADAS services may be delivered via telehealth. When rendered by LIPs, associate-level, LMSW, and certified or licensed addiction counselors, the following services are available: alcohol and drug assessments, alcohol and drug counseling, service plan development, peer support service, alcohol and drug screening & brief intervention services, and psychotherapy.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

The purpose of this service is to provide early identification of a SUD or co-occurring substance use and mental health disorders and to facilitate appropriate referral for a focused assessment and/or treatment. ADS is designed to identify beneficiaries who are at-risk of development of behavioral health and/or substance use problems.

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 behavioral health and/or SUD 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 mental illness and/or SUD and motivation for changing behaviors may also be integral parts of the screening.

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 30 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

Alcohol and Drug Assessment (ADA)

The purpose of this face-to-face assessment is to determine the need for rehabilitative services 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 assessment may include, but is not limited to, psychological assessment/testing to determine accurate diagnoses or to determine differential diagnoses.

Initial assessments must be conducted face-to-face with the beneficiary and include an evaluation of the beneficiary for the presence of a behavioral health or SUD.

The 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 ICD.

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

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

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

Once the assessment has been completed and services are deemed to be medically necessary; the development of the IPOC should be next.

The assessment services identify the beneficiary's needs, concerns, strengths and deficits and allow the beneficiary and his or her family to make informed decisions about the treatment. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. 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.

Follow-up Assessment

A follow-up assessment occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any changes in behavior and/or condition, and to monitor and ensure appropriateness of the treatment. Follow-up assessments may also be rendered to assess the beneficiary's progress, response to treatment, and 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.

Alcohol and Drug/Substance Abuse Counseling (SAC)

The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. SAC is focused on exploring and identifying the consequences of continued substance abuse, identifying triggers for substance abuse, and developing alternative coping strategies.

This service provides reinforcement of the beneficiary's ability to function within the confines of society without having to rely on addictive substances. SAC addresses goals identified in the plan of care that involves the beneficiary relearning basic coping strategies, understanding related

psychological problems that trigger addictive behavior, and encouraging the beneficiary to recognize opportunities to change their behavior and how to achieve their goals.

SAC requires face-to-face and goal-oriented interactions between a beneficiary and a clinical professional. The interactions provide the beneficiary with the skills and supports needed to reduce the use of substances, obtain abstinence, and successfully manage their illness. This service supports the beneficiary in achieving and maintaining improved ability to function in his or her daily living.

The goal of SAC is to aid beneficiaries in recovery from SUDs. SAC serves to educate beneficiaries about substance abuse and cultivate the skills needed to attain and sustain progress on identified goals; such as skills needed to manage anger or to cope with the urge to use substances by altering thoughts and actions that lead to substance abuse.

Interventions should focus on helping the beneficiary to develop the motivation to change substance-abusing behaviors and pursue life goals. Interventions should also focus on improving communication and conflict resolution skills and developing healthy boundaries.

SAC allows the clinical professional to listen to, interpret, and respond to the beneficiary's expression of physical, emotional, and/or cognitive problems and help them to develop the skills and supports needed to live a satisfying life without substance abuse. SAC explores issues coexisting with and contributing to substance use or abuse, such as, delinquent behavior and/or mental health concerns (e.g., depression, anger, anxiety, interpersonal conflicts, poor self-esteem, and anger management).

Substance Abuse Group — Counseling

Groups serve as a forum to share information about managing day-to-day without using illicit substances and may address major developmental issues that contribute to addiction, interfere with recovery or contribute to relapse.

A qualified clinical professional may meet with the beneficiary and one or more family members to identify and address substance abuse issues in a family setting. SAC should actively involve members of the beneficiary's immediate family, extended family, or significant others as determined appropriate. In a group setting, SAC allows the clinical professional to meet the needs of several beneficiaries at the same time and mobilize group support.

Skills Training (ST) and Development Services for Children

The purpose of this service is to provide ST and Development to children, with the primary target population of beneficiaries 0 to 6 years of age. The service is intended to restore functioning that the beneficiary either had or would have achieved if normal development had not been impaired by risk factors of SUD, or co-occurring substance use and mental health disorders. This face-to-face service provides activities that will restore or enhance targeted behaviors and improve the child's ability to function in his or her living, learning and social environments. ST and Development is a

form of skills building support. It is not a form of psychotherapy or counseling. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn and utilize needed life skills.

ST and Development is a means to affect behavioral changes to reduce the risk of or actual impaired performance in school, family and social relationships, work opportunities, recreational opportunities, etc. Services involve regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned activities that promote the development of healthy coping skills, adaptive interactions with others and appropriate responses to environmental stimuli.

Through interaction with appropriately trained and qualified staff, activities will focus on skill deficits and provide the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment.

This service includes activities identified during the assessment and is necessary to achieve the goals in the plan of care.

ST and Development interactions include the following:

- Skills activities designed to promote age-appropriate behavior and to improve the beneficiary's functioning within the home or social environments.
- Basic living skills development designed to help the beneficiary learn and practice daily, healthy living habits and age-appropriate self-care skills.
- Interpersonal ST designed for age-appropriate and normal development of the beneficiary to improve communication, problem-solving and self-management.

Successful delivery of ST and development should result in the display of age-appropriate and desirable behavior that has been infrequent or never displayed.

ST included services provided in a small group based on the assessed needs and level of functioning of the beneficiary.

Medical Services

Evaluation and Management of Medical Services (E&M)

The purpose of the service is to make medical decisions for treatment and/or referral for services after a medical assessment. The service is delivered face to face, which includes time spent performing an examination to obtain the beneficiary's medical history.

Physical Examination

A physical examination is a face-to-face interaction between a qualified medical health care professional and the beneficiary. The professional must assess the beneficiary's status and provide diagnostic evaluation and screening. The physical examination is one mechanism used to provide referrals for AOD rehabilitative services. The physical examination may include a tuberculosis test, as deemed necessary by the health care professional.

The examination may also be used to determine the following:

- Medical necessity for initiating AOD rehabilitative services.
- The need for specialized medical assessment.
- The need for a referral to other health care Providers.

Physical examinations must include the following:

- A brief medical history of the beneficiary to include hospital admissions and surgeries; allergies; present medication information about shared needles, sexual activity, sexual orientation; and history of hepatitis, cirrhosis or liver diseases.
- A history of the beneficiary's and their family's involvement with alcohol and/or other drugs.
- An assessment of the beneficiary's nutritional status.
- An examination including, but not limited to, vital signs; inspection of the ears, nose, mouth, teeth and gums; inspection of the skin for recent or old needle marks and tracking; and abscesses or scarring from healed abscesses.
- A general assessment of the beneficiary's cardiovascular system, respiratory system, gastrointestinal system and neurological status.
- A screening for anemia (A hematocrit or hemoglobin test may be used when the Physician has access to the equipment.).

Evaluation for New Patients

A new patient is one who has not received any professional services from the health care professional or another qualified health care professional of the exact same specialty and sub-specialty who belongs to the same group practice, within the past three years.

The evaluation of a new patient requires the following three components:

- A detailed history
- A detailed examination

- A medical decision

Counseling and/or coordination of care with other Physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem and includes the beneficiary's and/or their family; the encounter should last at least 30 minutes.

Evaluation for Established Patients

An established patient is one who has received professional services from a qualified health professional or another qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

The evaluation of an established patient requires two of the three key components below:

- An expanded problem-focused history.
- An expanded problem-focused examination.
- A medical decision making of low complexity.

Counseling and/or coordination of care with other Physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem and includes the beneficiary and/or their family. The encounter should last at least 15 minutes.

Alcohol and Drug Assessment Nursing Services (ADN)

ADN are provided as a face-to-face interaction between a qualified health care professional and the beneficiary.

Services may be rendered to beneficiaries as a discrete service; this service is also included in the bundled service packages.

Components of the service include, but are not limited to, the following:

- Providing medical assessment(s)
- Assessing and/or monitoring the beneficiary's physical status
- Assessing and/or monitoring the beneficiary's response to treatment
- Providing MM
- Assessing the need for referrals to other health care systems
- Monitoring the beneficiary's mental behaviors

- Verifying the beneficiary's medications, which may have been prescribed as oral or injection
- Assessing the need for the beneficiary to see the Physician
- Monitoring for overt side effects related to any medication
- Monitoring for psychological effects of the medications
- Monitoring for interactions of psychiatric medications, prescribe medications and substance abuse

Medication Administration (MA)

The purpose of this service is to allow a health care professional to administer an injection to the beneficiary. The medical record must substantiate the medical necessity for this treatment.

MA is rendered in response to a Physician, PA or APRN order. The order must be documented on a Physician Medical Order (PMO) Form. The qualified health care professional must ensure the form is properly completed and included in the medical record to confirm the initial and any subsequent contacts with the beneficiary.

Vivitrol® Injection (VI)

The purpose of the treatment is to restore, maintain, or improve a beneficiary's behavior or SUD.

The qualified health care professional must ensure the injection medication order is properly completed and included in the medical record to confirm the initial and any subsequent administration to the beneficiary.

Substance Abuse Outpatient Treatment Services

To provide services all Providers must meet appropriate federal and state licensure and all requirements outlined in the SCDHHS Provider Enrollment Policy and this manual.

Substance abuse treatment facilities must follow the Rehabilitative Health Provider requirements. Providers with a facility rendering services 24 hours per day, seven days per week are limited to 16 or fewer beds in order to receive Medicaid reimbursement (Federal law prohibits Medicaid payment to institutions of Mental Disease as described the Code of Federal Regulations, 42 CFR 435.1009.-101) and must follow the manual requirements.

Medicaid beneficiaries will have free choice of any qualified enrolled Medicaid Provider. The Provider must assure that the provision of services will not restrict the beneficiary's freedom of choice and it is not in violation of section 1902(a) (23) of the Social Security Act.

The purpose of this array of services is to provide intervention for the treatment and management of SUDs or co-occurring substance use and mental health disorders in an outpatient or residential treatment settings. Services must have a rehabilitative and a recovery focus designed to promote

skills for coping with and managing behavioral health and/or substance use symptoms and behaviors. Services must address the beneficiary's lifestyle, disposition and behavioral problems that have the potential to undermine the participation and successful completion of the treatment. Treatment services assist the beneficiary with managing withdrawal from substances of abuse and achieving abstinence, effectively responding to or avoiding identified precursors or triggers that would put them at-risk of use and relapse in their natural environment. Participation in services that provide supportive counseling, focused therapeutic interventions, emotional and behavioral management, problem solving, social and interpersonal skills, psychotherapy services, Psychosocial Rehabilitation, FS and MM and daily and independent living skills in order to improve functional stability to adapt to community living.

The beneficiary must be assessed to establish medical necessity for the treatment of services. The beneficiary must meet the diagnostic criteria for a SUD or co-occurring substance use and mental health disorders as defined by the current edition of the DSM or ICD to establish medical necessity for treatment services. The Provider should refer to the most current ASAM-PPC-2R as the basis for the beneficiary placement in the appropriate level of care.

Outpatient Substance Abuse Treatment includes an array of services delivered in an outpatient setting consistent with the beneficiary's treatment needs. The treatment must be rehabilitative and recovery focused and designed to promote coping skills to manage substance abuse symptoms and behaviors. Services are delivered on an individual or group basis in a wide variety of settings.

Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP): Level II.I IOP services are provided to beneficiaries who are in need of more than discrete outpatient treatment services or as an alternative to residential treatment. The appropriate level of care takes into consideration the beneficiary's cognitive and emotional experiences that have contributed to substance abuse or dependency. IOP allows the beneficiary opportunities to practice new coping skills and strategies learned in treatment, while still within a supportive treatment relationship and their "real world" environment.

The IOP service is comprised of the following services:

- IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following services may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, PTR, AOD Assessment, AOD Assessment Nursing Services, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

Length of Stay Criteria/Continued Stay Criteria

IOP generally provides 9–19 hours of programming per week based on the beneficiary's plan of care. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment. The amount, frequency and intensity of the services must reflect the needs of the beneficiary and must address the goals and objectives of the beneficiary's plan of care. The 19 hours can be exceeded via transfer to another level of service when services provided at this level have been insufficient to address the beneficiary's needs, and the beneficiary meets the ASAM criteria for another level of service.

Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization: Level II.5 The treatment program is a structured and supervised intense treatment program that provides frequent monitoring/management of the beneficiary's medical and emotional concerns in order to avoid hospitalization. The program has access to psychiatric, medical, and laboratory services. Intensive services at this level of care provide additional clinical support in a community setting.

These conditions will provide the beneficiary with the opportunity to practice skills learned in treatment and apply them in their natural environment.

The Day Treatment/Partial Hospitalization program is comprised of the following services:

- IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, PTR, AOD Assessment, AOD Assessment Nursing Services, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

Length of Stay Criteria/Continued Stay Criteria

Day Treatment/Partial Hospitalization generally provides a minimum of 20 hours of programming per week based on IPOC. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment.

Discharge/Transition Criteria from Outpatient Programs

Beneficiaries should be considered for discharge or transfer to another level of care when any of the following criteria are met:

- The beneficiary's level of functioning has significantly improved.
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC.
- The beneficiary has achieved the goals as outlined in the IPOC or reached maximum benefit.

- The beneficiary has developed the skills and resources needed to transition to a lower level of care.
- The beneficiary requested to be discharged from treatment and is not imminently dangerous to self or others.
- The beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).
- 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 discharged from a particular level of care.

Residential Substance Abuse Treatment

Residential Substance Abuse Treatment Services include an array of services consistent with the beneficiary's assessed treatment needs, with a rehabilitative and recovery focus designed to promote coping skills and manage substance abuse symptoms and behaviors in a residential setting. Services include Physician monitoring, nursing care, and observation as needed, based on clinical judgment.

In accordance with the Code of Federal Regulations, 42 CFR 435.1009.-101, these services are not available for beneficiaries residing in an institution of more than 16 beds.

Medicaid will not reimburse for the following:

- Room and board services, including custodial care,
- Educational, vocational and job training services,
- Habilitation services,
- Services to inmates in public institutions as defined in 42 CFR §435.1010,
- Services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010,
- Recreational and social activities, and
- Services that must be covered elsewhere in the State Medicaid Plan.

The beneficiary must be assessed to establish medical necessity for the treatment of services. The beneficiary must meet the diagnostic criteria for a SUD or co-occurring substance use and mental

health disorders as defined by the current edition of the DSM or ICD to establish medical necessity for treatment services. The Provider should refer to the most current ASAM-PPC-2R as the basis for the beneficiary placement in the appropriate level of care.

Residential Substance Abuse Treatment includes an array of services delivered in a residential setting consistent with the beneficiary's treatment needs. The treatment must be rehabilitative and recovery focused and designed to promote coping skills to manage substance abuse symptoms and behaviors. Services are delivered on an individual or group basis in a wide variety of settings.

Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification: Level III.2-D

The program relies on established clinical protocols and services delivered by staff, which provide 24-hour supervision, observation and support for beneficiaries who are intoxicated or experiencing withdrawal. Staff will supervise self-administered medications for the management of substance use or alcohol withdrawal. However, the full resources of a medically monitored residential detoxification service are not necessary.

The program is comprised of the following services:

- AOD Assessment Nursing Services, IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, PTR, AOD Assessment, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

The following services are included in the program:

- 24-hour medical observation, monitoring and treatment.
- Emergency medical services available, as needed.
- Referral to medically managed detox, if clinically appropriate.
- Laboratory screening, as needed.
- Medication ordered by a qualified health care professional.
- Physical examination within 48 hours after admission for beneficiaries in 24-hour facilities.
(**Exception:** If a client is admitted after 5:00 pm on Friday, a 24-hour facility has until close-of business the next workday to obtain the admission physical examination.)

Length of Stay/Continued Stay Criteria

Beneficiaries whose intoxication and/or withdrawal is sufficient to warrant 24-hour support; treatment typically lasts 3–5 days. The duration of treatment varies with the severity of the beneficiary's illness and response to treatment.

The following guidelines are used to determine length of stay:

- The beneficiary's withdrawal signs and symptoms are sufficiently resolved and symptoms can be safely managed at a less intensive level of care.
- The beneficiary's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification is indicated.
- The beneficiary may be transferred to a more intensive level of care or the addition of other clinical services are needed when the following occurs:
 - The Beneficiary is unable to complete detoxification at this level of care despite an adequate trial.
 - Symptoms complicating the withdrawal indicate the need to transfer the beneficiary to another level of care.

Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services: Level III.7-D

The program provides 24-hour supervision, observation and support for beneficiaries who are intoxicated or experiencing withdrawal in a residential setting.

At this level of care, Physicians are available 24 hours per day and are available to assess the beneficiary within 24 hours of admission (or sooner, if medically necessary) and must be available to provide onsite monitoring of care and further evaluation on a daily basis.

Primary emphasis is placed on ensuring that the beneficiary is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal), assessing for adequate bio-psychosocial stability, intervening immediately to establish bio-psychosocial stability and facilitating effective linkage to other appropriate residential and outpatient services.

An RN or other qualified nursing specialist will be present to administer a Nursing Admission History. A nurse is responsible for overseeing the monitoring of the beneficiary's progress and MA on an hourly basis, if needed.

The program is comprised of the following services:

- AOD Assessment Nursing Services, IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, Psychological Testing evaluation and reporting, AOD Assessment, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

The following services are included in the program:

- 24-hour medical observation, monitoring and treatment.
- Emergency medical services available, as needed.
- Laboratory screening, as needed.
- Medication order by a qualified health care professional.
- Physical examination within 24-hours after admission or sooner.

Length of Stay/Continued Stay Criteria

Treatment typically lasts 3–5 days, and duration of treatment varies with the severity of the beneficiary's illness and response to treatment. The five days may be exceeded by continued receipt of the service based on medical necessity, and/or transfer to another level of service when services provided at this level have been insufficient to address the beneficiary's needs, and the beneficiary meets the ASAM criteria for another level of service. The following guidelines are used to determine length of stay:

- The beneficiary's withdrawal signs and symptoms are sufficiently resolved to be safely managed at a less intensive level of care.
- The beneficiary's withdrawal signs and symptoms have failed to respond to treatment and have intensified.

Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment: Level III.5-R

The program is designed to promote abstinence from substances and antisocial behavior and to effect an overall change in the lifestyle, attitude and values of persons who have significant social and psychological problems. The defining characteristics of these beneficiaries are found in their emotional/behavioral and cognitive conditions (Dimension 3) and their living environments (Dimension 6). This service provides comprehensive, multi-faceted treatment to beneficiaries who have multiple deficits and psychological problems (including serious and persistent mental disorders) in a residential setting.

The program is comprised of the following services:

- AOD Assessment Nursing Services, IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, PTR, AOD Assessment, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

The following services are included in the program:

- 24-hour medical observation, monitoring and treatment.
- Emergency medical services available, as needed.
- Laboratory screening, as needed.
- Medication order by a qualified health care professional.
- Physical examination within 24-hours after admission.
- The provision of priority admission for pregnant women, as needed.

Length of Stay/Continued Stay Criteria

Treatment hours consist of six hours a day, Monday through Friday and five hours a day, Saturday and Sunday. Level III.5-R is based on the severity of the beneficiary's illness, and response to treatment. The duration of treatment tends to be longer than in more intensive medically managed levels of care; the average length of stay is three months.

Transfer to a higher level of care is warranted when services are insufficient to address the beneficiary's needs and he or she meets the criteria for a higher level of care.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment: Level III.7-R

The program provides a planned regimen of professionally directed services that are appropriate for beneficiaries whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that residential care is required.

The beneficiaries of this service have functional deficits effecting ability to manage intoxication/withdrawal, bio-medical symptoms and complications, and/or emotional, behavioral or cognitive conditions and complications that interfere with or distract from recovery efforts.

The program is comprised of the following services:

- AOD Assessment Nursing Services, IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, Psychological Testing Evaluation and Reporting, AOD Assessment, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

The following services are included in the program:

- 24-hour medical observation, monitoring and treatment.
- Emergency medical services available, as needed.
- Laboratory screening, as needed.
- Medication order by a qualified health care professional.
- Physical examination within 24 hours after admission and provide face-to-face evaluations at least once a week.
- An RN will be responsible for overseeing the monitoring of the beneficiary's progress and MA.

Length of Stay/Continued Stay Criteria

The duration of treatment varies with the severity of the beneficiary's illness and response to treatment. The treatment program must provide at least six hours of clinical services, Monday through Friday and five hours on the weekends. The average length of stay is 30 days.

The beneficiary must be discharged from Level III.7. R by the Physician or reviewed by the Physician before the beneficiary is transferred to a lesser level of care within the same treatment system.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA

The program is designed to provide a regimen of 24-hour medical monitoring, evaluations and addiction treatment in a residential setting. The program functions under a defined set of policies, procedures and clinical protocols. The program is focused toward children and adolescent beneficiaries, whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe that they require residential treatment. However, for this level of service, the beneficiary does not need the full resources of an acute care general hospital or a medically managed residential treatment program.

Treatment program may include the following activities:

- Activities designed to develop and apply recovery skills and promote development of a social network supportive of recovery.

- Enhance the beneficiary's understanding of addictions.
- Promote successful involvement in regular productive daily activity.
- Enhance personal responsibility and developmental maturity.
- Promote successful reintegration into community living.

The program comprises the following services:

- AOD Assessment Nursing Services, IP, FP, GP, AOD/SAC, PSS, PRS, FS and MM.

The following may be billed as discrete services:

- Psychiatric Diagnostic Evaluation, PTR, AOD Assessment, AOD Screening, SPD, E&M, Crisis Intervention, VI and MA.

The following services are included in the program:

- 24-hour medical observation, monitoring and treatment.
- Emergency medical services available, as needed.
- Laboratory screening, as needed.
- Medication order by a qualified health care professional.

Physical examination within 24-hours after admission and provide face-to-face evaluations at least once a week.

- The beneficiary must have an RN who is responsible for overseeing the monitoring of the beneficiary's progress and MA.

Length of Stay/Continued Stay Criteria

The treatment program must provide at least six hours of clinical services, Monday through Friday and five hours on the weekends. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment. The average length of treatment maybe up to six months.

The beneficiary must be discharged from Level III.7. RA by the Physician or reviewed by the Physician before the beneficiary is transferred to a lesser level of care within the same treatment system.

Discharge/Transition Criteria from Residential Services

Beneficiaries should be considered for discharge or transfer to another level of care when any of the following criteria are met:

- The beneficiary's level of functioning has significantly improved.
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC.
- The beneficiary has achieved the goals as outlined in the IPOC or reached maximum benefit.
- The beneficiary has developed the skills and resources needed to transition to a lower level of care.
- The beneficiary requested to be discharged from treatment and is not imminently dangerous to self or others.
- The beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).
- 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 discharged from a particular level of care.

Evidence-Based Practices

For Assertive Community Treatment and Multisystemic Therapy, please refer to [Appendices A and B, respectively](#).

Telehealth

Telehealth and audio-only modalities are available for select behavioral health services including telephonic assessments, crisis intervention, individual and family psychotherapy, psychiatric diagnostic assessments, nursing services, service plan development, and medication management. These services are available for providers enrolled under CHMC, RBHS, or LIP categories and include physicians, nurse practitioners, and physician assistants, Licensed Psychologists (and postdoctoral pending licensure), Licensed Professional Counselors (and LPC-associate), Licensed Independent Social Workers, Licensed Marriage and Family Therapists (and LMFT-associate), Licensed Addiction Counselors, and Licensed Psycho-Educational Specialists.

- *Consulting site providers for telehealth psychiatry encounters are not subject to the SCMSA location requirement but must be enrolled in South Carolina Medicaid and have a South Carolina medical license.*

Associate-level providers should continue to request reimbursement under supervising clinician's enrollment and follow other billing guidance as articulated in this manual.

Services rendered via telehealth must include a GT modifier.

NON-COVERED SERVICES

The following is a list of activities that are not Medicaid-reimbursable under the RBHS 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, including:

- Transportation of beneficiaries.
- Transportation and/or travel time.
- 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.).
- 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 PA 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.
- Medicaid intake processing.
- Completion of and monitoring of PA requests for Medicaid services.
- Required Medicaid utilization review.
- Early and Periodic Screening, Diagnostic, and Treatment 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 PSS.

Residential Substance Abuse Treatment

In accordance with the Code of Federal Regulations, 42 CFR 435.1009.-101, these services are not available for beneficiaries residing in an institution of more than 16 beds.

SERVICE-SPECIFIC MEDICAL NECESSITY CRITERIA

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.

The following medical necessity criteria must be met for each service:

Service Plan Development (SPD) of the IPOC

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or SUD. The results of the DA and/or screening tool must support the need for services.

Behavioral Health Screening (BHS)

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of a mental health and/or SUD(s) are eligible for this service.

Diagnostic Assessment (DA) Services

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of mental health and/or SUD(s) are eligible for this service.

Psychological Testing and Evaluation (PTE)

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of a mental health and/or SUD(s) are eligible for this service, provided that there is a clear, documented reason that the testing is needed (e.g., differential diagnosis, atypical symptomatology, prior/current mental health treatment is ineffective).

Psychological or Neuropsychological Administration and Scoring (PTA)

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of a mental health disorder and/or SUD(s) are eligible for this service, provided that there is a clear, documented reason that the testing is needed (e.g., differential diagnosis, atypical symptomatology, prior/current mental health treatment is ineffective).

Individual Psychotherapy (IP)

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or SUD(s). 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.

Group Psychotherapy (GP)

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or SUD(s). 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.

Multiple Family Group Psychotherapy (MFGP)

Beneficiaries eligible for these services must have a diagnosis of mental illness and/or SUD(s). 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.

Family Psychotherapy (FP)

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or SUD(s). 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.

Crisis Management (CM)

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or SUD(s); 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.

While a DA is required prior to rendering core services, crisis management can have two services billed prior to the DA ONLY when provided by RBHS providers in a school setting.

Medication Management (MM)

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or SUD(s). The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services. The beneficiary must be on medication prescribed by a Physician or being educated on how to take their medication appropriately.

Psychosocial Rehabilitation Services (PRS)

Admission Criteria for Adults (age 22 and older)

A–G must be met to satisfy criteria for admission into PRS services:

- A. The beneficiary has received a DA, and has been diagnosed with a SPMI, which includes one of the following diagnoses: bipolar disorder, major depression, a diagnosis within the spectrum of psychotic disorders and/or SUD.
- B. The beneficiary has a SPMI and/or SUD and the symptom-related problems interfere with the individual's functioning and living, working and/or learning environment.
- C. As a result of the 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. Traditional mental health services (e.g., individual/family/group therapy, MM, 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.

- E. Beneficiary meets three or more of the following criteria as documented on the DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is at-risk of psychiatric hospitalization, homelessness, and/or isolation from social supports due to the beneficiary's SPMI and/or SUD.
 - iii. Exhibits behaviors that require repeated interventions by the mental health, social services and/or judicial system.
 - iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.
- F. Beneficiary is expected to benefit from the intervention and identified needs would not be better met by any other formal or informal system or support.
- G. The service is recommended by a LPHA acting within the scope of his/her professional licensure.

Continued Service Criteria for Adults (age 22 and older) 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. 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.
- D. The beneficiary and others identified by the treatment plan process are active beneficiaries in the creation of the treatment plan and discharge plan and 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 and/or sustained over the time frame outlined in the beneficiary's IPOC.

Admission Criteria for Children (age 0–21)

A-I must be met to satisfy criteria for admission into PRS services:

- A. The beneficiary has received a DA, which includes a DSM diagnosis that requires and will respond to therapeutic interventions specific to the PRS service description.
- B. The beneficiary has a SPMI, serious emotional disturbance (SED) and/or 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 DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement.
 - iii. In the last 90 days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.
 - iv. Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior.
- E. The family/caregiver/guardian agrees to be an active beneficiary, 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, MM, 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 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.
- I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for PRS (private providers only):

- i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI).
- ii. For beneficiaries age 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the Child Behavior Check List (CBCL).
- iii. For beneficiaries 6–18 years, has been assigned a minimum CALOCUS-CASII composite score of 17.

Continued Service Criteria for Children (ages 0–21) 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.
- 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 IPOC.

Behavior Modification (B-MOD)

Admission Criteria for Children and Adolescents (ages 0–21).

A–J 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 DA, which includes a current DSM diagnosis that requires and will respond to therapeutic interventions and which documents the need for B-MOD.
- C. The beneficiary has a SPMI, SED and/or 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

seven 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 DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is deemed to be at-risk of psychiatric hospitalization or out-of-home placement.
 - iii. In the last 90 days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.
 - iv. Experiences impaired ability to recognize personal and/or environmental dangers and/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 treatment.
- H. Beneficiary is expected to benefit from the intervention and needs would not be better met clinically by any other formal or informal system or support.
- I. The service is recommended by a LPHA acting within the scope of his/her professional licensure.
- J. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for B-MOD (private providers only):
 - i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the PSI.
 - ii. For beneficiaries age 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the CBCL.

- iii. For beneficiaries 6–18 years, has been assigned a minimum CALOCUS-CASII composite score of 17.

Continued Service Criteria for Children and Adolescents (ages 0–21)

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 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.

Family Support (FS)

Admission Criteria

A–I must be met to satisfy criteria for admission into FS services: A.

The beneficiary is under the age of 22.

- B. The beneficiary has received a DA, which includes a current DSM diagnosis and specific clinical needs that will respond to therapeutic interventions and which documents the need for FS.
- C. The beneficiary has a SPMI, SED and/or SUD, and the symptom-related problems interfere with the individual's functioning, 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.
- 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 DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement.
 - iii. In the last 90-days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.
 - iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.
- F. Family/caregiver agrees to be an active beneficiary 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.
- H. The service is recommended by a LPHA acting within the scope of his/her professional licensure.
- I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for FS (private providers only):
 - i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the PSI.
 - ii. For beneficiaries age 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the CBCL.
 - iii. For beneficiaries 6–18 years, has been assigned a minimum CALOCUS-CASII composite score of 17.

Continued Service Criteria

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 IPOC.
- 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 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.

Therapeutic Child Care (TCC)

Admission Criteria

A–J must be met to satisfy criteria for admission into TCC services:

- A. The beneficiary must be under the age of six at the time of admission.
- B. The beneficiary has been diagnosed with a serious emotional disorder (SED), or an applicable Z-code diagnosis, per the current DSM.
- C. The beneficiary requires and is expected to respond to therapeutic interventions specific to the TCC service description.
- D. The beneficiary must be exhibiting moderate to severe behavioral problems that significantly impair the beneficiary's ability to function at an age-appropriate developmental level.
- E. 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 treatment.
- F. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweighs any potential harm.

- G. The beneficiary is exhibiting behavioral problems that prohibit placement in a traditional preschool or childcare setting and/or the behaviors, coupled with parental stress levels, leave the child at risk for abuse and neglect.
- H. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for TCC:
 - i. For beneficiaries from birth until 1.5 years, has scored in the 75th percentile or above on the PSI.
 - ii. For beneficiaries ages 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the CBCL.

Continued Service Criteria

A–E must be met to satisfy criteria for continued TCC 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.
- C. The beneficiary has shown improvement and is expected to continue to benefit from TCC, which remains appropriate to meet the beneficiary's needs.
- D. The beneficiary and others identified by the treatment plan process are active beneficiaries in the creation of the treatment plan and discharge plan and are actively participating in treatment. The beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.
- E. Desired outcome or level of functioning has not been restored or sustained over the timeframe outlined in the beneficiary's IPOC.

Community Integration Services (CIS)

Admission Service Criteria

A–H must be met to satisfy criteria for admission into CIS services: A.

The beneficiary is 18 years or older.

- B. The beneficiary has been diagnosed with a SPMI, which includes one of the following diagnoses: bipolar disorder, major depression, a diagnosis within the spectrum of psychotic disorders or an SPMI with a co-occurring SUD.

- C. As a result of the SPMI or co-occurring SUD, the beneficiary has a moderate to severe functional impairment that limits role performance and/or skill deficits in three or more of the following areas: social, educational/vocational, daily living and/or self-maintenance, relative to the person's cultural environment.
- D. Traditional mental health services (e.g., individual/family/group therapy, MM, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating.
- E. Beneficiary meets three or more of the following criteria as documented on the DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is at-risk of psychiatric hospitalization, homelessness or isolation from social supports due to the beneficiary's SPMI or co-occurring disorders.
 - iii. Exhibits behaviors that require repeated interventions by the mental health, social services or judicial systems.
 - iv. Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior.
- F. Without the support of a CIS program, the beneficiary will be unable to function in the community.
- G. The beneficiary is not at imminent risk of harm to self, others and/or property.
- H. The beneficiary is expected to benefit from the interventions and needs would not be better met by any other formal or informal system or support.

Continued Service Criteria

A–E must be met to satisfy criteria for continued CIS services:

- A. The beneficiary continues to meet the admission criteria.
- B. There is adequate 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 at least two of the following areas: social, educational/vocational, daily living and/or self-maintenance, relative to the person's cultural environment.
- D. The beneficiary is expected to continue to benefit from CIS, which remains appropriate to meet the beneficiary's needs.

- E. Withdrawal of CIS may result in loss of rehabilitation gains or goals obtained by the beneficiary.

Peer Support Services (PSS)

Admission Criteria

- Beneficiary has been diagnosed with a SPMI, and/or a SUD.
- Beneficiary meets two or more of the following criteria as a result of the mental illness:
 - Has had significant difficulty independently and consistently accessing behavioral health services (e.g., relies on emergency department services, has had two or more inpatient admissions over the last year),
 - Is being released from incarceration, or being discharged from a hospital or facility-based program,
 - Has had severe functional impairment that interferes with activities of daily living, including hygiene, nutrition, finances, home maintenance, child care, or difficulties with other community service needs, such as housing, transportation or legal issues,
 - Has experienced significant challenges meeting educational or employment goals,
 - Lives in unsafe or temporary housing,
 - Does not have sufficient family or other social support, or the supports that are in place are insufficient to help ameliorate or manage his or her condition.
- Beneficiary is assessed to be at low risk of serious harm to self or others.
- Beneficiary has demonstrated a need for assistance with community living and the service is recommended by a LPHA acting within the scope of his/her professional licensure.
- The service, including frequency of the service, is recommended as a result of the DA,
- Beneficiary has an IPOC that addresses mental health concerns and any co-occurring general medical condition,
- The person is expected to benefit from the intervention and needs would not be better clinically met by any other formal or informal system or support.

Continued Service Criteria

- Beneficiary is eligible to continue this service if:

- The beneficiary continues to meet admission guidelines for this level of care, or
- The IPOC, current or revised, can be reasonably expected to improve the presenting mental illness, and objective behavioral indicator of improvement are documented in the beneficiary's progress notes, or
- Beneficiary is actively involved in the Peer Support process, and participating in interventions, or
- Beneficiary does not require a higher level of care, and no other intervention level would be appropriate, or
- Beneficiary is making some progress, but the interventions need to be modified so that greater gains can be achieved.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of an SUD or co-occurring substance use and mental health disorder are eligible for this service.

Alcohol and Drug Assessment (ADA)

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of an SUD or co-occurring substance use and mental health disorders.

Alcohol and Drug/Substance Abuse Counseling (SAC)

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

Skills Training (ST) and Development Services for Children

Beneficiaries 0 to 6 years of age who have been identified as having or are at-risk of a SUD and/or co-occurring SUD and mental illness are eligible for this service. The results of the screening and/or assessment tool must indicate a functioning level that supports 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.

Evaluation and Management of Medical Services (E&M)

All beneficiaries who have been identified as having or are at-risk of a diagnosis of a SUD or co-occurring substance use and mental health disorders.

Alcohol and Drug Assessment Nursing Services (ADN)

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of a SUD or co-occurring substance use and mental health disorders.

Medication Administration (MA)

Beneficiaries eligible for this service must have a diagnosis of a SUD or co-occurring substance use and mental health disorders. Providers must have a prescription or medical order from a qualified health care professional to administer the prescription drug Vivitrol®.

Vivitrol® Injection (VI)

Beneficiaries eligible for these services must have a SUD or co-occurring substance use and mental health disorders.

Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP): Level II.I

Beneficiaries eligible for these services must have a diagnosis of a SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions listed below:

- Direct admission to Level II.I is warranted for the beneficiary who meets specifications on Dimension 2 (if any biomedical conditions or have existing substance use problems), on Dimension 3 (if any emotional, behavioral, cognitive conditions or problems exist), and on one specification of Dimension 4, 5 or 6.
- Transfer to Level II.I is warranted for a beneficiary who has met essential treatment objectives at a more intensive level of care and requires Level II.I service intensity in at least one dimension.
- Transfer to Level II.I may be warranted when services provided at Level I have been insufficient to address the beneficiary's needs or when motivational interventions provided at Level I have prepared the beneficiary for participation in a more intensive level of service, and the beneficiary meets criteria for that level.

Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization: Level II.5

Beneficiaries eligible for these services must have a diagnosis of SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions below:

- Direct admission to Level II.5 is warranted for the beneficiary who meets specification on Dimension 2 (if any biomedical conditions or problems exist) and specifications in one of Dimensions 4, 5 or 6.
- Transfer to Level II.5 is warranted for the beneficiary who has met treatment objectives at a more intensive level of care and requires Level II.5 service intensity in at least one dimension.

- Transfer to Level II.5 may be warranted when services provided at Level I or Level II.I has been insufficient to address the beneficiary's needs. In addition, transfer to this level is appropriate when motivational interventions provided have prepared the beneficiary for participation in a more intensive level of care.

Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification: Level III.2-D

Beneficiaries eligible for these services must have a diagnosis of a SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions:

- The beneficiary is experiencing signs and symptoms of withdrawal or there is evidence that withdrawal is imminent.
- The beneficiary is assessed as not being at-risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service.
- The beneficiary is assessed as not requiring medication but requires this level of service to complete detoxification and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure.

Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services: Level III.7-D

Adult beneficiaries eligible for these services must have a diagnosis of a SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with the appropriate documentation reflecting applicable medical necessity on each of the ASAM dimensions:

- The beneficiary is experiencing signs and symptoms of severe withdrawal, or there is evidence that a severe withdrawal syndrome is imminent and assessed as manageable at this level of care.
- There is strong likelihood that the beneficiary (who requires medication) will not complete detoxification at another level of care, enter continued treatment or self-help recovery.

Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment: Level III.5-R

Adult beneficiaries eligible for these services must have a diagnosis of a SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM Dimensions:

- The beneficiary has no withdrawal signs or symptoms, or withdrawal can be safely managed in this level of care.
- Biomedical problems are stable or not severe enough to warrant hospital treatment but are sufficient to distract from treatment or recovery efforts.
- Emotional, behavioral or cognitive conditions render the beneficiary unable to control substance use and the resulting level of dysfunction precludes participation in less structured level of care.
- The beneficiary has not reached the motivational stage of change required due to intensity and chronicity of the substance use problem.
- The beneficiary has not developed insight into connection between substance use and life problems and blames external factors for his or her problems.
- The beneficiary does not recognize relapse triggers and is not committed to continuing care.
- The beneficiary is unable to control substance use, little ability to interrupt the relapse process.
- The beneficiary is experiencing addiction symptoms and is unable to employ skills to prevent a relapse.
- The beneficiary is in a crisis situation with imminent danger of a relapse.
- The beneficiary continues to use substances despite recent active participation in the treatment program at a less intensive level of care.
- The beneficiary's living environment is characterized by high risk of victimization, criminal behavior, antisocial norms and values, or other factors that make it unlikely he or she will be able to achieve or maintain recovery at a less intensive level of care.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment: Level III.7-R

Beneficiaries eligible for these services must have a diagnosis of a SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM PPC-2 admission criteria for this level of care placement, which require the beneficiary to meet specifications in at least two of the six dimensions:

- At least one criterion must be in Dimension 1, 2 or 3. These dimensions are acute intoxication and/or withdrawal potential; biomedical conditions and complications; or emotional, behavioral, or cognitive conditions and complications. Beneficiaries with a greater severity of illness in these dimensions require use of more intensive staffing patterns and support services due to functional deficits.
- Dimensions 4, 5 and 6 address readiness' to change, relapse, continued use or continued problem potential and recovery potential. A problem in at least one of the dimensions puts the beneficiary at-risk of use and/or continued use of illicit substance(s) and/or at-risk of harm to themselves or from others. This is in addition to a combination of deficits in Dimensions 1, 2 or 3, which indicates a need for the intensity of services in Level III.7-R.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA

Beneficiaries eligible for these services must have a diagnosis of a SUD or co-occurring substance use and mental health disorders.

The beneficiary must meet ASAM PPC-2 admission criteria specifications in at least two of the six dimensions below:

- At least one criterion must be in Dimension 1, 2 or 3: Acute Intoxication and/or withdrawal potential, Biomedical Conditions and complications or Emotional, Behavioral or Cognitive Conditions and Complications.
 - The beneficiary may have problems that require direct-medical or nursing services; however, problems in Dimension 3 are the most common reason for admission to Level III.7.RA.
- Dimensions 4, 5 and 6 addresses readiness to change, relapse, continued use or continued problem potential and recovery potential.
 - A problem in at least one of the dimensions that puts the beneficiary at-risk of use/continued use of illicit substance(s) and/or risk of harm, to themselves or from others.
- Placement decisions are based on the symptomatic functional impairment rather than any specific categorical diagnosis.
 - The beneficiary may be admitted directly to Level III.7.RA programs or transferred from a less intensive level of care as symptoms become more severe, or
 - The beneficiary may be transferred from a Level IV program when that level of intensity is no longer required.

Evidence-Based Practices

For Assertive Community Treatment and Multisystemic Therapy, please refer to [Appendices A and B, respectively](#).

5

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Quality Improvement Agent (QIO) Authorization

This section applies to private RBHS Providers required to obtain approval for CSS through the SCDHHS designated QIO (KEPRO) for FFS beneficiaries. Providers must follow the PA guidelines as outlined by SCDHHS before billing Medicaid. All services must be determined medically necessary as approved by the QIO. **Note:** *For Assertive Community Treatment and Multisystemic Therapy prior authorization/continued stay processes, please refer to Appendices A and B, respectively.*

The PA request form can be found on the QIO web portal at <https://www.scdhhs.gov/pressrelease/services-performed-kepro-quality-improvement-organization-qio-sc-medicaid>. The PA request form must be submitted to the QIO with the required documentation. To receive reimbursement from Medicaid, all PA requests must be faxed to or submitted via the web portal to the QIO for approval. If PA requests are submitted via fax, a fax cover sheet must be included with the request along with supporting documentation such as SCDHHS forms and/or clinical documentation to the QIO.

The Provider will be notified via a QIO approval letter if the PA request is approved. The Provider must download the approved document(s) from the web portal and shall maintain letter(s) in the beneficiary's clinical record. The Provider may contact the QIO for additional information as follows:

Customer Service: +1 855 326 5219

Fax: +1 855 300 0082

Provider issues email: atrezzoissues@KEPRO.com

Providers must ensure that all services are provided in accordance with all SCDHHS policy requirements. If SCDHHS or its designee determines that services were reimbursed when there was not a valid approval letter from the QIO in the beneficiary's file, the Provider payments will be subject to recoupment.

All RBHS Providers shall ensure (1) that only the authorized units of services are provided and submitted to SCDHHS for reimbursement and (2) that all services are provided in accordance with all South Carolina Medicaid Program policy requirements.

CSS' rendered by private RBHS Providers to child and adolescent beneficiaries must be prior authorized by the QIO, with the exception of beneficiaries in foster care. Services for these beneficiaries must be prior authorized by the SCDSS.

Please refer to chart below for documentation requirements for PA based on the referral source (i.e., State agencies, self, private Provider).

REFERRAL SOURCE: STATE AGENCY	
Initial Prior Authorization	Continued Service Prior Authorization
For the initial authorization period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries, based on the medical necessity documented on: the RBHS Referral Form, the QIO PA request form, and supporting documentation, as applicable.	<p>For the continued service authorization period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries, based on the medical necessity documented on:</p> <ul style="list-style-type: none"> • The most recent 90-day progress summary, • A current IPOC, • the QIO PA request form, • Parent/Caregiver/Guardian Agreement to Participate in CSS' form, and supporting documentation, as applicable. <p>*Note, if beneficiary needs continued services after 365 days, an updated DA is required to be submitted to the QIO.</p>

REFERRAL SOURCE: SELF OR OTHER ENTITY — DOCUMENTATION OF OR PRIOR AUTHORIZATION

Initial Prior Authorization	Continued Service Authorization
<p>For the initial PA period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries. Initial authorizations are required annually, and must be based on the following information:</p> <ul style="list-style-type: none"> • The QIO PA Request Form • The DA • For beneficiaries ages 0–18, the age-appropriate assessment tool: <ul style="list-style-type: none"> – PSI (birth to 1.5 years), or – The Child Behavior Check List (1.5–5 years), or – CALOCUS-CASII administered by a qualified clinical professional with a CALOCUS-CASII SCDHHS Provider certification (ages 6–18) 	<p>For the continued service PA period, Medicaid may cover up to 90 days for child and adolescent beneficiaries, and up to 180 days for adult beneficiaries, based on the medical necessity documented on:</p> <ul style="list-style-type: none"> • The QIO PA Request Form • The most recent 90-day progress summary • A current IPOC • For beneficiaries 15 years of age and under: <ul style="list-style-type: none"> – Parent/Caregiver/Guardian Agreement to Participate in CSS' form, and supporting documentation, as applicable. <p>*Note, if beneficiary needs continued services after 365 days, an updated DA is required to be submitted to the QIO.</p>

REFERRAL SOURCE: SELF OR OTHER ENTITY — DOCUMENTATION OF OR PRIOR AUTHORIZATION

Initial Prior Authorization	Continued Service Authorization
<p>For beneficiaries 15 years of age and under: Parent/Caregiver/Guardian Agreement to Participate in CSS' form, and supporting documentation, as applicable.</p>	

Requests for each continued service prior authorized period must be submitted to the QIO, 10 business days prior to the expiration of the current authorization. The QIO will process and either approve or deny service authorization(s) within five business days of receipt, pending complete submission of all required information.

When CSS' are added to a current approved course of treatment, each discrete service must be prior authorized by the QIO. Medicaid may cover additional services based on the medical necessity documented on:

- The most recent DA
- The age-appropriate assessment tool, administered and scored by a qualified clinician:
 - PSI (birth to 1.5 years), or
 - The Child Behavior Check List (1.5–5 years), or
 - CALOCUS-CASII administered by a qualified clinical professional with a CALOCUS-CASII SCDHHS Provider certification (ages 6–18).
- The QIO PA Request Form
- The Parent/Caregiver/Guardian Agreement to Participate in CSS' (for child beneficiaries)
- The IPOC
- The most recent 90-day progress summary

Should a beneficiary's treatment needs change with respect to the type of and/or frequency of each CSS, the private Provider must receive confirmation from the referring state agency to change the service type and/or frequency. Evidence of the state agency's confirmation of such changes may be included in a letter or email correspondence. This evidence shall be maintained in the beneficiary's clinical record.

COORDINATION OF CARE

It is the responsibility of all service Providers to coordinate care among all entities that render services to beneficiaries.

If a beneficiary is receiving treatment from multiple service Providers, there should be evidence of care coordination in the beneficiary's clinical record. Coordination of care serves to promote continuity of care and ensure there is no duplication in services or billing. Duplicated services cannot be reimbursed under Medicaid and Providers shall make every effort to contact other service Providers involved in the current course of treatment for the beneficiary to ensure services are complimentary to one another and not duplicative in nature. In the event separate RBHS Providers render services to the same beneficiary, coordination of care is essential to ensure the IPOCs are not in conflict with one another or the desired outcomes of the beneficiary.

OTHER SERVICE LIMITATIONS

FFS Service Limit Exceptions Process

There may be clinical exceptions to the service limits when the number of units or encounters allowed may not be sufficient to meet to the complex and intensive needs of a beneficiary. On these occasions, requests for frequencies beyond the service limits may be submitted directly to the SCDHHS for approval. The table below identifies the required documentation for these requests.

REQUIRED DOCUMENTATION FOR REQUESTS

- Most recent DA
- IPOC
- The most recent SPD note
- All CSNs for all services rendered to beneficiary during the previous 90-days of request, including PMA and SPD notes
- Parent/Caregiver/Guardian Agreement to Participate in CSS' form, as applicable • QIO approval letter
- Fax cover sheet for RBHS exceptions (if applicable)
- RBHS Exception Request Form

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

Requests can be submitted to SCDHHS via the following methods:

- Fax: "Attn: RBHS Exceptions" to +1 803 255 8204
 - A fax cover sheet must be included with the fax
- Encrypted email to: behavioralhealth004@scdhhs.gov

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

Out-of-Home Placement

In accordance with the Code of Federal Regulations, 42 CFR § 435.1009-1011, RBHS 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 PRTF receive a per diem payment that is considered all-inclusive for the psychiatric care. RBHS provided to beneficiaries in these settings are not Medicaid reimbursable.

Third-Party Liability (TPL)

TPL refers to the responsibility of parties other than Medicaid to pay for health insurance costs. Medicaid is always the payer of last resort, which means that Medicaid will not pay a claim for which someone else may be responsible until the party liable before Medicaid has been billed. All Providers must pursue the availability of third-party payment sources.

Payment sources include, but are not limited to, Medicare, private health insurance, worker's compensation and disability insurance.

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REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

All RBHS 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.

NOTE: *For Assertive Community Treatment and Multisystemic Therapy documentation requirements, please refer to Appendices A and B, respectively.*

An index as to how the clinical record is organized must be maintained and made available upon request. 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:

- Comprehensive DA(s)
 - Other assessments (as applicable)
 - Assessment tool(s), administered and scored by a qualified clinician (as applicable):
 - PSI (birth to 1.5 years), or
 - The Child Behavior Check List (1.5–5 years), or
 - CALOCUS-CASII administered by a qualified clinical professional with a CALOCUS-SCDHHS Provider certification (ages 6–18)
- (Exclusion to assessment tools: State agencies directly rendering RBHS and all Providers directly rendering services to beneficiaries in foster care.)
- Parent/Caregiver/Guardian Agreement to Participate in CSS' form (as applicable)
 - Signed, credentialed or functional titled, and dated IPOCs — initial, reviews and reformulations

- BMP, as applicable
- Signed, credentialed or functional titled and dated 90-day Progress Summaries
- Signed, credentialed or functional titled and dated CSNs
- RBHS State Agency Referral Form (as applicable)
- QIO approval letter (as 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 to Examinations and Treatment

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

Legibility

All clinical documentation must be 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., RN, LPC, etc.), or functional title (if not licensed or in possession of a degree from a higher institution of learning [e.g., Human Service Professional]), 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 the Administrative and Billing Provider Manual for the use of electronic signatures and/or exceptions.)

Error Correction

Clinical records are legal documents. Staff should be extremely cautious in making alterations to the records. In the event that errors are made, staff must 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.
- 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, documentation shall be completed within 10 business days of the date of service.

Abbreviations and Symbols

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

Documenting Medical Necessity

Medical necessity must be documented on a DA administered by a qualified LPHA. The LPHA's name, professional title, signature and date must be listed on the document to confirm medical necessity. If the LPHA is an LMSW, a co-signature by an independently licensed LPHA is required of private Providers.

The DA must be completed prior to any RBHS services being rendered. The only exception to this requirement is crisis management services. Two crisis management services are allowed prior to a DA being required WHEN PROVIDED BY RBHS PROVIDERS IN A SCHOOL SETTING. If a placement is necessary for TFC, the DA must be completed within 14 days of placement.

The DA 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 or ICD criteria.

The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended. Additional required elements of the DA can be referenced in the DA Service description located in this manual.

Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative services.

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

The DA must be maintained in the Medicaid beneficiary's clinical record.

If SCDHHS or its designee determines that services were reimbursed when evidence of medical necessity, as outlined in this manual, was not documented and maintained in the beneficiary's record, payments to the Provider shall be subject to recoupment.

INDIVIDUAL PLAN OF CARE

The 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, 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 of the beneficiary 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 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.

When State agencies refer beneficiaries to private RBHS Providers for services, the private RBHS Providers must adhere to the recommendations for services and specific frequencies set forth by the respective State agency.

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.

The IPOC must include the following components:

Beneficiary Identification Name
and Medicaid ID number.

Presenting Problem(s)

Statements that outline the beneficiary's specific needs that require treatment services. Statements that validate the need for treatment services based on medical necessity.

Psychiatric Diagnosis(es)

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 and objectives should reflect input from the beneficiary and beneficiary's family, as applicable, and should be written so that they are observable, measurable, individualized (specific to the beneficiary's problems and/or needs) and realistic.

Goals are global statements that should reflect positive resolution to the beneficiary's identified needs and should include outcome measure(s) or expectation(s).

Objectives (short-term goals) are similar to and directly related to specified goals but are highly specific and reflect small attainable steps to achieve goals.

The beneficiary's culture, community, support systems, environmental factors, and developmental and intellectual factors should be considered in the formulation of objectives.

Specific Interventions

A list of specific therapeutic interventions (actions, activities, methods, etc.) used to meet the stated goals and objectives must be included. The identification of modalities to be used (e.g., CBT, DBT, Motivational Interviewing, Psychoeducation, etc.) should be included as part of the interventions.

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, FS, 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 an individualized and specific planned frequency. The frequency must be appropriate to the needs of the beneficiary and beneficiary's family, as applicable, and shall not exceed medical necessity.

- Example: PRS frequency should be identified as the following:
 - PRS — 3 hours per day/2 days per week or PRS — 12 units per day/2 days per week
 - Should not be listed as PRS — Up to 20 hours a week.

Criteria for Achievement

Outline how success for each goal and objective will be demonstrated. Criteria must be reasonable, attainable and measurable, must include target dates and must indicate a desired outcome to the treatment process.

Target Dates

A timeline for completion that is individualized to the beneficiary and their goals and objectives. Target dates should reflect projected incremental change over the course of a year, and should not uniformly reflect the annual expiration date of the IPOC.

Contact Information

Emergency contacts, including phone numbers, must be listed.

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 and guardian must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC. The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

Authorized Signature(s)

An LPHA, master's level qualified clinical profession staff or LBSW, 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 is present during the IPOC meeting. If a separate signature sheet is completed, it must be kept with the IPOC.

The IPOC must be signed, titled and signature dated by the 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 DA.

Services Not Required on the IPOC

The following services are not required to be listed on the IPOC:

- DA
- CM
- SPD
- BHS

IPOC — CORE TREATMENT AND CSS

Duration:

- The initial IPOC must be completed, signed, titled, and signature dated by the LPHA, master's level qualified clinical professional, or LBSW within 30 calendar days of the DA.
- Core Treatment Services may be rendered prior to the completion of the IPOC, provided the services are medically necessary.
- If the IPOC is not completed and signed within 30 days, services rendered are not Medicaid reimbursable.

Addendum:

- When services are added or frequencies of services are changed in an existing IPOC, the addendum must include the signature and title of the clinician who formulated the addendum and the date it was

IPOC — CORE TREATMENT AND CSS

formulated. All service changes must meet medical necessity criteria for each discrete service to be added.

- The IPOC must be signed and dated by the reviewing LPHA or master's level qualified clinical professional to confirm changes.
- When space is unavailable on the current IPOC, a 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.

Reformulation:

- The maximum duration of the IPOC is 365 calendar days from the date of the signature of the LPHA, or master's level qualified clinical professional on the IPOC.
- Prior to termination or expiration of the treatment period, the LPHA or master's level qualified clinical professional must review the IPOC with the beneficiary and evaluate the beneficiary's progress with respect to each of the beneficiary's treatment goals and 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 LPHA or master's level qualified clinical professional responsible for the treatment is required.
- The IPOC must include the date of reformulation, the signature and title of the LPHA or master's level qualified professional authorizing services and the signature date.
- There should be evidence in the clinical record regarding the involvement of the beneficiary and the beneficiary's family, if applicable, in the reformulation of the IPOC.
- Copies of the reformulated IPOC must be distributed to all involved beneficiaries within 10 business days.

90-Day Progress Summaries

The 90-day Progress Summary is a periodic evaluation and review of a beneficiary's progress toward the achievement of goals and objectives, overall response to treatment services, the appropriateness of services rendered, and the need for the beneficiary's continued participation in the treatment.

The progress summary shall be completed at least every 90 calendar days from the signature date on the initial IPOC, and at least every 90 days thereafter.

The progress summary must be completed and signed by the LPHA, or other qualified clinical professional. The progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.

It is the responsibility of the current treatment Provider to complete the 90-day Progress Summary. If a beneficiary is transferred to a new Provider during the 90-day period, the discharging Provider must submit clinical documentation, including a discharge summary, to the receiving Provider to ensure a continuity of care.

The LPHA, or other qualified clinical professional will review and document the following:

- The beneficiary's name and Medicaid ID number.
- The beneficiary's progress toward treatment goals and objectives. Any barriers to progress should also be identified.
- The appropriateness and frequency of the services provided. Failure to provide the recommended services and their frequency should also be explained.
- The need for continued treatment.
- Recommendations for continued services or discharge of services as outlined in the success criteria for each objective.

Service Plan Development (SPD) of the IPOC

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

- All individuals present for the service planning.
- The development, staffing, review and monitoring of the plan of care.
- Discharge criteria and/or achievement of goals.

- Confirmation of medical necessity and recommendations for services, including frequencies of services.
- Establishment of one or more diagnoses, including co-occurring SUD, if present.

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.

CLINICAL SERVICE NOTES

Clinical Service Notes (CSNs)

The purpose of the CSNs 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. Evidence of rendering services must be documented on CSNs. A CSN is required for each contact or service, for each date of service, for each beneficiary (if service was rendered in a group setting) and must be written and signed by the qualified staff who provided the service. Each CSN must support both the type of service billed and the number of units billed. Every CSN must be individualized to reflect treatment/service and interventions with a specific beneficiary, for each date of service, for each service rendered to the beneficiary and/or family. The content of CSNs shall not be duplicated, be it among the records of beneficiaries served by the Provider and/or among dates of service for any one beneficiary served by the Provider. If CSNs are not completed and maintained in accordance with the requirements in this manual, payments to the Provider shall be subject to recoupment.

The CSN must include the following information:

- The beneficiary's name and Medicaid ID number.
- The date of service.
- The name of the rehabilitative service (or its approved abbreviation) and the corresponding procedure code.
- The number of units of service rendered.
- The date of service in a month, day and year format.
- Document the start time and end time for each service delivered. (Exclusion: Clubhouse program CSNs and foster parent CSNs are not required to reflect start and stop times.)

- Location where the service was rendered. (Refer to the Billable Code/Location of Service section of this manual for additional information.)
- The manner in which the service was delivered: individual or group; if the service is provided in a group setting, the number of beneficiaries must be identified on the CSN.
- Be typed and/or handwritten — documentation must be legible.
- Be kept in chronological order.
- Abbreviations must be decipherable — if abbreviations are used, the Provider must maintain a list of abbreviations and their meanings and the list must be made available to SCDHHS upon request.
- Reference individuals by full name, title and agency or Provider affiliation at least once in each note, as applicable.
- Identification of other beneficiaries by name shall not be included.
- Be signed, credentialed or functionally titled, and signature dated (month/date/year) by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with these standards.
- Billing modifiers must match the credentials of the individual rendering the service.
- Be completed and placed in the beneficiary's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service.

Providers must maintain adequate documentation to (1) support the number of units or encounters billed and to (2) support each service billed.

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative 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 treatment objective(s) and/or goal(a) on the IPOC, unless there is an unexpected event that needs to be addressed.
- The detailed summary of the interventions (e.g., action steps, tools used, techniques utilized, etc.) and involvement of qualified staff with the beneficiary and/or family during each contact or session/meeting (only time spent rendering the intervention or treatment can be billed — see the

Covered Services section for additional information). If an evidenced-based practice was utilized, it should be clearly indicated.

- The individualized response of the beneficiary and/or beneficiary's family, as applicable, to the interventions and/or treatment rendered at each contact or session/meeting.
- The general progress of the beneficiary to include observations of their conditions/mental status. Progress should reflect detailed individualized information about the beneficiary over the course of treatment and shall not reflect general categories of progress or general statements of progress in treatment (e.g., Phrases such as "moderate" or "not making progress", without providing detailed information to support the identification of these will not meet this standard).
- The future plan for working with the beneficiary and the beneficiary's family, as applicable. This should reflect the plan of action for the next and foreseeable future sessions/meetings with the beneficiary (e.g., statements such as "will continue to meet with person as per IPOC" will not meet this standard).

Availability of Clinical Documentation

CSNs and other service documentation should be completed and placed in the clinical record immediately following the delivery of a service, but no later than five business days from the date of service. Any documentation completed and placed in the clinical records for any billed activity after this deadline shall be subject to recoupment.

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

Quality Improvement and Monitoring

All Providers should self-monitor adherence to applicable Federal and State Laws and Regulations and in accordance with the South Carolina Plan for Medical Assistance, alerts, bulletins, SCDHHS policies, procedures and Medicaid Provider Manuals. Any findings of non-compliance, as a result of self-monitoring activities shall be communicated to and monetarily remitted to SCDHHS.

SCDHHS, or its designees, will conduct reviews to ensure that Providers are in compliance with applicable laws, regulations and policies. Other authoritative entities may conduct reviews of RBHS Providers, including the State Auditor's Office, the South Carolina Attorney General's Office, United States Department of Health and Human Services, Government Accountability Office and/or their designees. Upon request, information must be furnished regarding any claim for payment to SCDHHS. All Providers must grant access to SCDHHS, or its designees, to records for reviews and/or investigations for the purposes of reviewing, copying and reproducing documents. Failure of the Provider to comply with this provision may result in the immediate termination of enrollment.

SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS

Behavioral Health Screening (BHS)

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Services must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Documentation must:

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

Diagnostic Assessment (DA) Services

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

In addition to the assessment itself, the DA service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs. The DA should be completed in one day. If additional time is needed to complete a thorough assessment, billing should occur on another day utilizing the follow-up assessment code.

Psychiatric DA without Medical Services (Comprehensive DA)

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

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Beneficiary's demographic information:
 - Age
 - Date of birth
 - 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) and hospitalizations.
- Psychological history including previous psychological assessment/testing measures, reports, etc.
- Substance use history including previous diagnoses, treatment (including medication) and hospitalizations.
- Exposure to physical abuse, sexual assault, antisocial behavior or other traumatic events.
- Physical health history, including current health needs and potential high-risk conditions.
- Medical history and medications, including history of past and current medications.
- Family history, including relationships with family members, and involvement of individuals in treatment and services, family psychiatric and substance use history.
- Mental status.
- 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 RBHS.
- Planned service type and frequency of each recommended rehabilitative service.

- Referrals for external services, support or treatment.
- Signature or co-signature of the LPHA who can establish medical necessity. The DA is considered complete when the LPHA signs the document.

Psychiatric DA with Medical Services (rendered by medical professionals only) Includes the components listed above as well as the medical components listed below.

Additional components of a Psychiatric DA with Medical Services include:

- Medical history and medications.
- Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent SUDs.
- Diagnose, treat, and monitor chronic and acute health problems.
- This may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays.

Mental Health Comprehensive Assessment Follow-up

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

Documentation must include the following components:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Include the outcome of the assessment
- Identify any referrals resulting from the assessment
- The diagnostic code and the diagnosis

In addition to the assessment itself, the diagnostic assessment service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

CALOCUS-CASII Assessment — Community Support Services

Assessments must be documented in a manner which addresses all of the necessary components and clearly establishes medical necessity. When submitting a claim for the CALOCUS assessment, documentation of the scoring instrument and supporting clinical documentation is required.

In addition to the CALOCUS Form itself, the service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Psychological Testing and Evaluation (PTE)

Services must be documented on a CSN with a start time and end time. The CSN must include the purpose of the test, the results of the PTE and/or refer to the completed test. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

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 must include:

- Beneficiary's name and Medicaid ID number.
- Name of the tests that were conducted (e.g., MMPI).
- Test results and interpretation.
- Identify recommendations or referrals based on test results.
- The diagnoses code and the diagnosis, if applicable.
- Documentation must support the number of units billed.

Psychological or Neuropsychological Test Administration and Scoring (PTA)

Services must be documented on a CSN with a start time and end time. The CSN must include the name of the tests administered and/or scored and mode of administration and/or scoring (i.e., on paper, verbally, or electronically). At least two tests must be listed in the CSN to qualify for this service. The documentation must meet all SCDHHS requirements for CSNs.

Copies of test results must be filed in the beneficiary's clinical record and include the beneficiary's name and Medicaid ID number.

Individual Psychotherapy (IP)

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

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

Group Psychotherapy (GP)

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

All psychotherapy services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Multiple Family Group Psychotherapy (MFGP)

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

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

Family Psychotherapy (FP)

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

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

Crisis Management (CM)

CM is not required to be listed on the IPOC.

Services must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs. A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and stop time, as well as the duration.
- All beneficiaries 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.

Medication Management (MM)

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

MM must be documented on CSNs with start and stop times identified. Additionally, the documentation must meet all SCDHHS requirements for CSNs. The following items must be recorded on CSNs:

- Medications the beneficiary is currently taking, or reference to the Physician's order or other document in the medical record that lists all the medications prescribed to the beneficiary.
- All benefits and side effects of new medications being prescribed or for medications that is potentially dangerous.
- Any change in medications and/or doses and rationale for any change, if applicable.
- Documentation of any medications being prescribed.
- Follow-up instructions for the next visit.

Psychosocial Rehabilitation Services (PRS)

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 CSNs. 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 CSNs 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 aged 0 through 15 years of age, the Parent/Caregiver/Guardian Agreement to

Participate in CSS' 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 beneficiary, this must be clearly documented in the clinical record.

Refer to the Clinical Service Note section of this manual regarding services being rendered in a group to ensure that requirements are met.

Behavior Modification (B-MOD)

The beneficiary's IPOC and treatment process must 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.

The qualified staff providing the service is responsible for completing and signing the CSNs. The notes must 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 CSNs and other documentation must meet all SCDHHS requirements, outlined in the Documentation Requirements section 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 CSS 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 the foster parent. In the event the foster parent changes during the 90-day authorization period, the new foster parent must sign the Parent/Caregiver/Guardian Agreement for the next 90-day authorization cycle. In the event there is a refusal or an inability to sign the agreement BMOD 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.

In addition to the IPOC, a BMP must be included in the beneficiary's clinical record.

BEHAVIOR MODIFICATION PLAN (BMP)

A 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 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 if 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 a description of how progress toward achieving desired outcomes will be monitored and evaluated, including timeframes and data collection.
- Progress Review Date: the date the plan will be reviewed for effectiveness.
- Names of beneficiaries in the creation of the BMP.
- Signatures of persons who participated in the development of the plan (beneficiary, family/caregiver and B-MOD staff).

Family Support (FS)

The qualified staff providing the service is responsible for completing and signing the CSNs. 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 CSNs and other documentation must meet all SCDHHS requirements, outlined in the Documentation Requirements section of this manual.

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 the foster parent. In the event the foster parent changes during the 90-day authorization period, the new foster parent 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.

Therapeutic Child Care (TCC)

TCC must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary. Services must be documented upon each contact with the beneficiary. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

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

The qualified staff providing the service is responsible for completing and signing the CSNs. The notes should clearly identify the specific goal(s) from the IPOC which the delivery of TCC addresses.

In addition to documentation for TCC, the Parent/Caregiver/Guardian Agreement to Participate in CSS Form must be completed and maintained in the beneficiary's record.

Community Integration Services (CIS)

CIS must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary. Services must be documented upon each contact with the beneficiary. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

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.

The qualified staff providing the service is responsible for completing and signing the CSNs. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of CIS addresses.

Therapeutic Foster Care (TFC)

TFC must be listed on the IPOC and identified by level based on SCDSS' assignment. Specific goals for the TFC placement and criteria for achievement must be included on the IPOC.

Documentation from SCDSS assigning a level of care must be maintained in the recipient's medical record.

TFC foster parents are responsible for completing and signing daily entries on a TFC grid that logs daily interventions and assessments. When needed, additional notes should clearly identify issues not included in the grid. Services must be documented daily.

A "Parent/Caregiver/Guardian Agreement" is not required for TFC but is required for other services as specified in the RBHS Documentation Requirements.

Required Elements of a Service Grid

When a grid is used to document a service, it shall be completed per event, or at least per date of service, to reflect the service provided. Any service grid shall include all the following required elements:

- Name of the individual.
- Medicaid ID number.
- Full date [month/day/year] that the service was provided.

- Goals addressed.
- A letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed.
- A number or symbol as specified in the appropriate key that reflects the assessment of the individual's progress toward goals.
- Initials of the individual providing the service. The initials shall correspond to a full signature and initials on the signature log section of the grid.
- A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the individual's response to the interventions provided and progress toward goals. Each entry in the comment section must be dated. Entries in this section are not required but may be included when necessary for documentation when matters of a non-routine nature occur or are not included in the grid key.

Providers who use an electronic health record (EHR) system must maintain documentation in a beneficiary's specific record that clearly addresses each of the above elements. Additionally, providers with EHRs that have document management capabilities may elect to scan paper grids into a beneficiary's specific record.

Peer Support Services (PSS)

PSS must be documented in the IPOC with a planned frequency and should be documented upon contact with the beneficiary. The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goals from the IPOC for which the delivery of this service addresses.

Billable services must be documented in units on the beneficiary's CSN. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Providers shall submit an annual report to the SCDHHS program manager within 60 calendar days after the close of the state fiscal year. This report should include summaries of the service provision and the service evaluation and outcome criteria, and the number of beneficiaries participating in the service.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs ADS results should be documented during or immediately following the screening session with the beneficiary. The completed

screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must contain the following:

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

Alcohol and Drug Assessment (ADA)

Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs. The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

The documentation must include the outcome of the assessment, identify any referrals resulting from the assessment and support the number of units billed.

Documentation must include components of the assessment and the following:

- Beneficiary's name and Medicaid ID number.
- Beneficiary demographic information.
- Presenting complaint or source of distress.
- The diagnose code and diagnoses.
- Medical history and medications.
- Family history.
- Psychological and/or psychiatric treatment history including previous psychological assessment/testing measures, reports, etc.
- Substance use history for beneficiary and family.
- Mental status.
- Exposure to physical abuse, sexual abuse, anti-social behavior or other traumatic events.
- A 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 mental disorder that meets the current edition DSM criteria.

- The specific rehabilitative service(s) recommended.
- Include the outcome of the assessment.
- Identify any referrals resulting from the assessment.
- Documentation must support the number of units billed.

Alcohol and Drug/Substance Abuse Counseling (SAC)

Documentation must indicate how the counseling session applies to the identified beneficiary's treatment goals. Documentation must be signed off by a BA staff with CAC II or higher credentialed staff. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Skills Training (ST) and Development Services for Children

The CSN must document how ST and Development applies to the beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs. The service must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary or immediately afterwards.

The staff providing the service is responsible for completing and signing the documentation. Documentation must be signed off by a BA staff with CAC II or higher credential staff.

In addition to general documentation requirements, the documentation of this service must include the inappropriate or undesirable behavior of the beneficiary and how the behavior was redirected.

Evaluation and Management of Medical Services (E&M)

The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis and prescribed treatment. The record must reflect the level of service billed.

Alcohol and Drug Assessment Nursing Services (ADN)

The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis and prescribed treatment.

Services must be documented on the CSN or nursing progress form and signed by a qualified health care professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for CSNs. A nursing discharge form must be completed when the beneficiary moves to another level of service.

Medication Administration (MA)

MA must be listed in the plan of care and PMO and be documented on a CSN as the service to be rendered.

The Provider of the service must include the following items on the CSN in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- A list of the beneficiary's current prescribed medications and over-the-counter medications.

Note: Providers can reference a PMO or other documentation in the medical record that lists all the medications prescribed to the beneficiary.

- The quantity and strength of the dosage given.
- The injection route (I.M., I.D., I.V.).
- The injection site.
- The side effects or adverse reactions of medications.
- All benefits of the medications being prescribed.
- Any change in medications and/or doses and the rationale for any change, if applicable.
- Follow-up instructions for the next visit.

Vivitrol® Injection (VI)

Injectable Medication is required to be listed on the PMO. The injection must be documented on the CSN as the service. The documentation should include the following items in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- The medication administered.
- The quantity and strength of the dosage given.
- The injection route (I.M., I.D., I.V.).
- The injection site.
- The side effects or adverse reactions of the medication.

Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP): Level II. The CSN must identify the service being provided and list all of the components of the treatment. The

staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinical service notes and progress update.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization: Level II.5

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, CSNs, and progress update or continued stay authorization form.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification: Level III.2-D

An assessment and physical will be documented to substantiate medical necessity, diagnosis and placement in appropriate level of care. A Withdrawal Assessment — Clinical Institute Withdrawal Assessment of Alcohol (CIWA-Ar) will be used to monitor the client's withdrawal from substances.

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, CSNs, and progress update or continued stay authorization form.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services: Level III.7-D

A Nursing Admission History and a Medical Evaluation will be provided upon initial contact to establish medical necessity and admission to appropriate level of care. A Withdrawal Assessment — CIWA-Ar will be used throughout detox to assess the severity of withdrawal symptoms and measure progress toward discharge/transfer to treatment services.

The CSN must identify the services being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, CSNs and progress update.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment: Level III.5-R

An assessment and medical evaluation will be used to establish medical necessity, diagnosis and placement in appropriate level of care.

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, CSNs, and progress update or continued stay authorization form.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment: Level III.7-R

An assessment and medical evaluation will be used to establish medical necessity, diagnosis and placement in appropriate level of care.

The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinically service notes and progress update.

A bachelor's level staff, with a CAC II or higher, must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA

An assessment and medical evaluation will be used to establish medical necessity, diagnosis and placement in appropriate level of care. The CSN must identify the service being provided and list all of the components of the treatment. The staff assigned to the beneficiary is responsible for checking those services provided and writing a summary of those services.

The IPOC should list the specific short-and long-term goals and objectives addressing the expected outcome of treatment.

The development of a discharge plan is required to provide guidelines to the beneficiary on what is expected to continue in the program and guidance on how to maintain stability in their natural environment.

Providers must maintain medical records that include a copy of the individual treatment plan, medical and clinical assessments, clinically service notes and progress updates.

A bachelor's level staff, with a CAC II or higher must sign for the services to be rendered and qualified health care professionals must sign for the treatment as listed by their scope of practice.

DISCHARGE SUMMARY

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

- The beneficiary's 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 requested to be discharge from treatment (and is not imminently dangerous to self or others).
- 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:

- Date of discharge from program.
- Each RBHS service(s) the beneficiary received.
- Start and end date of each service.
- Presenting concerns/condition and diagnosis(es) at time of admission.
- 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.).
- Medications prescribed or administered, if applicable.
- Attempts to contact beneficiary/family, if discharge is unplanned.

EMERGENCY SAFETY INTERVENTION

The Emergency Safety Intervention policy applies to any community-based Provider that has policies prohibiting the use of seclusion or restraints, but who may have an emergency situation requiring staff intervention. Providers must have a written policy and procedure for emergency situations and must ensure that direct care staff are prepared and trained in the event of an emergency.

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

- Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring the beneficiary's safety. For more information on selecting training models, review the Project Rest

Manual of Recommended Practice, available at

<http://frcdsn.org/wpcontent/uploads/2014/04/Manual-of-Recommended-Practice.pdf>.

- Providers must have a comprehensive written policy that governs the circumstances in which seclusion or restraints are being used that adheres to all State Licensing Laws and Regulations (including all reporting requirements).

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

REPORTING CHANGES

Reporting Business Changes

SCDHHS requires a Provider to report any change in enrollment or contractual information (e.g., mailing or payment address, physical location, telephone number, specialty information, change in group affiliation, ownership, etc.) to the Provider Service Center (PSC) within 30 days of the change. This updated information must be submitted on the business letterhead with an authorized signature. Updates can be submitted via fax or mail. The Provider will not be able to make any updates over the telephone. Updates will be processed within 10 days of receipt. Please refer to the SCDHHS Provider Administrative and Billing Manual for contact information.

Reporting Program Changes

SCDHHS requires that a Provider report programmatic change(s) to the Division of Behavioral Health. This updated information must be submitted on the Program Changes for RBHS Form within 10 days of the change. The Provider will not be able to report any changes over the telephone. The form can be submitted via the following options:

Email: behavioralhealth004@scdhhs.gov Fax:
+1 803 255 8204

The following program changes must be reported by the Provider:

- Change in Administrator (CEO/Director).
- Change in Clinical Director.
- Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time.
- Adverse events concerning staff licensure.
- Any change in accreditation status as identified in the Accreditation section of this manual including, but not limited to, all re-accreditation survey results.
- Any change in facility license.

- Other changes which affect compliance with Medicaid requirements.

If the Provider's and/or the Administrator's name(s) changes, the Provider must submit a new Disclosure of Ownership and Control Interest Statement Form and an updated W-9 Form to the PSC. Refer to the SCDHHS website for the Disclosure Form. Questions concerning the W-9 Form should be directed to PSC.

Providers planning to or currently operating a child/family care facility for Medicaid beneficiaries must ensure compliance with all state and federal mandates. Providers are encouraged to contact the SCDSS for information regarding registry and/or licensing requirements. Providers out of compliance are subject to termination.

Providers should reference the South Carolina Children's Code of Laws — Title 63 to ensure compliance with State Licensing and Child Welfare Regulations. Information can be located on the web at <http://www.scchildcare.org>.

Behavioral Health Quality Assurance Reviews

Periodic quality assurance reviews will be conducted by the SCDHHS Behavioral Health Quality Assurance Team. If the team finds the provider is not compliant with certain Medicaid policies and regulations, they may require a Corrective Action Plan (CAP) to correct these deficiencies. If the team requests a CAP, the provider must submit a Corrective Action Plan (CAP) within 15 business days of receiving the Summary of Findings. No extensions will be granted unless expressly stated in writing from a member of the SCDHHS Behavioral Health Quality Assurance Team. A template of the CAP can be found in the Forms section. If, after review of the CAP, SCDHHS determines that a modification is necessary, the provider must respond with an amended CAP within five business days from the date of notice. Once the CAP is accepted by SCDHHS, the provider must sign, date and return the CAP, along with any requested documentation, within five business days of receipt. Failure to comply with the terms of this section could result in sanctions that could include, but not be limited to, the suspension or termination of a provider's enrollment in the South Carolina Medicaid Program.

7

BILLING GUIDANCE

SERVICE UNIT CONTACT TIME

SCDHHS has adopted the Medicare 8-Minute Rule for services. This means that when indicated by any discrete RBHS service, a Provider may not bill for a service of less than eight minutes. The actual minutes billed by any one Provider in a day shall not exceed the daily unit limits. If any RBHS 15-minute service is performed for seven minutes or less on any day, the service is not reimbursable.

The expectation is that a Provider's direct beneficiary contact time for each unit will average 15 minutes in length. If a Provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

UNITS	TIME
1	Equal to 8 minutes but less than 23 minutes
2	Greater than/equal to 23 minutes, but less than 38 minutes
3	Greater than/equal to 38 minutes, but less than 53 minutes
4	Greater than/equal to 53 minutes, but less than 68 minutes
5	Greater than/equal to 68 minutes, but less than 83 minutes
6	Greater than/equal to 83 minutes, but less than 98 minutes
7	Greater than/equal to 98 minutes, but less than 113 minutes
8	Greater than/equal to 113 minutes, but less than 128 minutes
9	Greater than/equal to 128 minutes, but less than 143 minutes
10	Greater than/equal to 143 minutes, but less than 158 minutes
11	Greater than/equal to 158 minutes, but less than 173 minutes
12	Greater than/equal to 173 minutes, but less than 188 minutes
13	Greater than/equal to 188 minutes, but less than 203 minutes
14	Greater than/equal to 203 minutes, but less than 218 minutes

15	Greater than/equal to 218 minutes, but less than 233 minutes
16	Greater than/equal to 233 minutes, but less than 248 minutes

USE OF Z -CODES

The use of Z-codes is allowed but this is considered a temporary diagnosis for ages 7 and older. The use of Z-codes is not time limited for children ages 0 to 6 of age. Z-codes can be used in any diagnosis field on the claim form.

BILLABLE CODE/LOCATION OF SERVICE

The following list provides the codes most commonly used:

03 — School

11 — Clinician or Doctor's Office

12 — Home

14—Group Home (to be used for QRTPs only)

19 — Off Campus Hospital

22 — Outpatient Hospital

23 — Emergency Room

53 — Community Mental Health Center

55 — Substance Abuse Residential Facility

57 — Non-Residential Substance Abuse Facility

99 — Other Unlisted Facility (excluding recreational settings)

SERVICE-SPECIFIC BILLING GUIDANCE

Refer to the procedure codes information (linked in the Program Overview section above) associated with this manual for additional information regarding procedure codes and frequencies for the services listed below.

Service Plan Development (SPD) of the IPOC

SPD-Interdisciplinary Team Conference with and without client/family present is billed as an encounter.

SPD by a non-Physician is billed in a 15-minute unit.

Special Restrictions Related to Other Services

State agencies that refer SPD to qualified Providers may designate and authorize the Provider to develop the plan of care. Providers should ensure that other health and human service agencies or Providers involved with the beneficiary receive a copy of the IPOC.

Service Plan with or without client/family and Mental Health SPD services cannot be billed on the same date of service. Assessment services cannot be billed on the same date of service as SPD services. The assessment must be completed prior to the development of the IPOC.

DAODAS Providers should continue to only utilize Mental Health SPD — Non-Physician for IPOC development for Medicaid FFS Providers and those members enrolled directly with an MCO. The LBSW is not authorized to sign the IPOC.

Behavioral Health Screening (BHS)

BHS is billed in 15-minute units for a maximum of two units per day.

Billable Place of Service

Services must be administered in a 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.

Excluded settings include acute care hospitals and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

BHS shall not be billed on the same date of service as Psychiatric Diagnostic Evaluation without Medical (Comprehensive DA — Initial) and/or CALOCUS-CASII.

Diagnostic Assessment (DA) Services

The initial and follow-up DAs are billed as an encounter.

The initial assessment may be rendered once every six months.

The follow-up assessment may be rendered up to 12 times in a year.

Billable Place of Service

Services must be administered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

The DA with medical cannot be rendered or billed on the same day as the DA 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 re-assessed.

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

CALOCUS-CASII Assessment — Community Support Services

The CALOCUS-CASII assessments are billed as an encounter. One encounter can be reimbursed every six months.

Billable Place of Service

CALOCUS-CASII assessments must be administered in a 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.

Excluded settings include PRTFs (unless prior approved for retro-eligibility) and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Psychological Testing and Evaluation (PTE)

PTE is billed as a 60-minute unit with add-on codes for additional time spent.

Billable Place of Service

Services must be administered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

The evaluating psychologist should inquire about and review any prior testing (e.g., psycho-educational, psychological, developmental and/or neuropsychological) that may have been administered, and request copies for review prior to conducting a new battery. If prior testing cannot be reviewed, the Provider should document their attempts to access the information and offer an explanation pertaining to the clear medical necessity for a new assessment. Attempts should be made to determine when tests were previously administered to ensure that test exposure is not a factor in the outcome of the evaluation. If an assessment has been conducted in the last 90 days, 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 DA must be completed before the PTE has been conducted.

The PTE and DA can be billed on the same day. The assessments must be billed separately.

Psychological or Neuropsychological Test Administration and Scoring (PTA)

PTA is billed as a 30-minute unit with an add-on code for additional 30-minute units.

Billable Place of Service

Services must be administered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Individual Psychotherapy (IP)

IP is billed as an encounter. There are three encounter ranges based on amount of time spent with the beneficiary. 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.

Billable Place of Service

Services must be rendered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Group Psychotherapy (GP)

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.

Billable Place of Service

Services must be rendered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Multiple Family Group Psychotherapy (MFGP)

MFGP is billed as an encounter. A session must last a minimum of an hour and more than one session can be billed per day, with a limit of eight sessions per month.

Billable Place of Service

Services must be rendered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Family Psychotherapy (FP)

FP is billed as an encounter and can only be rendered once per day. A session must last a minimum of an hour. FP with the beneficiary can be rendered four sessions per month; FP without the beneficiary can be rendered four sessions per month.

Billable Place of Service

Services must be rendered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

When multiple members of a family are identified beneficiaries, reimbursement for FP shall be for only one of the beneficiaries present in the session, not all beneficiaries.

Crisis Management (CM)

CM is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a 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.

Excluded settings: acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

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

Medication Management (MM)

MM is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a 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.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

MM cannot be reimbursed with IP with the E&M codes when rendered to a beneficiary on the same-day.

Psychosocial Rehabilitation Services (PRS)

PRS is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a 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.

PRS is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same-Day Service Restrictions

CSS' are defined as the following five services: Psychosocial Rehabilitation, B-MOD, CIS, TCC and FS services.

SCDHHS will only reimburse for one RBHS CSS per day. For example, FS — B-MOD will not be reimbursed on the same-day as PRS or FS.

Exception: Individual (1:1) PRS may be provided on the same day as CIS.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

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 South Carolina Department of Health and Environmental Control (DHEC) licensure requirements. This delineation must be clearly defined, documented and accessible in the beneficiary record.

Behavior Modification (B-MOD)

B-MOD is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a setting that is convenient for the beneficiary, affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

B-MOD is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions and residential settings of any type of more than 16 beds and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same-Day Service Restrictions

CSS are defined as the following five services: Psychosocial Rehabilitation, B-MOD, FS Services, CIS and TCC.

SCDHHS will only reimburse for one RBHS CSS per day. For example, B-MOD will not be reimbursed on the same day as PRS or FS.

Exceptions to any same-day service restrictions are noted under the specific service.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

Family Support (FS) (0–21)

FS is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a setting that is convenient for the beneficiary, affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.

FS is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same-Day Service Restrictions

CSS are defined as the following five services: Psychosocial Rehabilitation, B-MOD, FS Services, CIS, and TCC.

SCDHHS will only reimburse one RBHS CSS per day. For example, B-MOD will not be reimbursed on the same-day as PRS or FS.

Exceptions to any same-day service restrictions are noted under the specific service.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

Services provided on the behalf of the beneficiary must include coordination with family/caregiver and other systems of care as appropriate. FS must not be rendered with more than one family unit at a time.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

Therapeutic Child Care (TCC)

TCC is billed as a 15-minute unit.

TCC services must be rendered in a SCDSS licensed or approved daycare facility that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Same-Day Service Restriction

Only one RBHS CSS will be reimbursed on any date of service. A private RBHS Provider, or multiple private RBHS Providers, shall not be reimbursed for services when more than one CSS is provided to a beneficiary and/or family on the same date of service. Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

Community Integration Services (CIS) CIS

is billed as a 15-minute unit.

Billable Place of Service

Services must be provided in an approved community-based facility that is open for operation at least 25 hours per week.

Same-Day Service Restrictions

CSS are defined as the following five services: Psychosocial Rehabilitation, B-MOD, FS Services CIS and TCC.

SCDHHS will only reimburse for one RBHS CSS per day. For example, B-MOD will not be reimbursed on the same-day as PRS or FS.

Exception: CIS may be provided on the same as individual (1:1) PRS.

Therapeutic Foster Care

TFC is billed as a daily, per diem unit with a limit of up to 31 units per month based on the calendar days in the month. TFC shall be at the level assigned by the South Carolina Department of Social Services to place a child in a therapeutic foster home.

TFC services must be rendered in a SCDSS licensed therapeutic foster home provided by Child Placing Agencies contracted and certified by the SCDSS. TFC providers are qualified staff, under the supervision of qualified clinical professionals.

Same-Day Service Restrictions

TFC is an inclusive service and may not be provided on the same day as Psychosocial Rehabilitative Services (PRS). Conversely, PRS may not be provided on the same day as TFC.

Peer Support Services (PSS)

PSS is billed in 15-minute units with 16 units billed 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 CSNs.

Billable Place of Service

The only excluded settings are acute care hospitals. PSS 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.

As a group service, PSS may operate in the same building as other day services. However, with regard to staffing, content, and physical space; a clear distinction must exist between day services during the hours the PSS is in operation. PSS do not operate in isolation from the rest of the programs in the facility.

Special Restrictions Related to Other Services

PSS cannot be billed for Medicaid beneficiaries that reside in an acute care hospital facility.

PSS can only be provided by DMH and DAODAS.

Evidence-Based Practices

Billing guidance, including places of service and special restrictions for Assertive Community Treatment (ACT) and Multisystemic Therapy (MST) may be found in Appendices A and B, respectively.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

ADS is billed as an encounter. Twelve encounters are allowed in a year; only one encounter code is allowed per day.

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 in Relationship to Other Services

An AOD initial assessment without a physical examination cannot be billed on the same date of services as an AOD structured screening and brief intervention service.

Alcohol and Drug Assessment (ADA)

The initial and follow-up assessments are billed as an encounter. A session should last a minimum of 60 minutes. One encounter is allowed every six months and coordination of care should occur

between Providers. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

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 Restriction in Relationship to Other Services

Assessment with medical cannot be rendered or billed on the same day as the Assessment without medical. Efforts should be made to determine whether another DA has been conducted in the last 90 days and information should be updated as needed. If a DA has been conducted within the last 90 days, efforts should be made to access those records. Services are rendered by the staff listed in the procedure code information associated with this manual.

Alcohol and Drug/Substance Abuse Counseling (SAC)

Individual counseling is billed in a 15-minute unit. Group counseling is billed as an encounter. A group session should last at a minimum of 60 minutes. If the session lasts longer than 60 minutes, this time is not billable; only one encounter code is allowed per day.

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.

Skills Training (ST) and Development Services for Children ST

and Development is billed in a 15-minute unit.

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 in Relationship to Other Services

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

Evaluation and Management of Medical Services (E&M)

Services are billed as an encounter, only one encounter code is allowed per day.

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 where the beneficiary and the professional will have an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

New patient and established patient services are allowed one per day, per service. Established patient services encounters should last at least 15 minutes.

When a beneficiary receives an E&M service on the same day as a psychotherapy service by the same medical professional, Providers must document both the E&M and psychotherapy codes. The difference in the services must be significant and documented separately on the CSN.

Only one EM encounter is allowed per day when the IP services are used.

A nurse is responsible for assisting in monitoring the beneficiary's medical treatment and MA.

Alcohol and Drug Assessment Nursing Services (ADN)

When billed as a discrete service, AND services are billed in a 15-minute unit.

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 where the beneficiary and the professional will have an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services

Nursing services may be billed when providing discrete services, IOP or day treatment/partial hospital services.

Medication Administration (MA)

MA is billed as an encounter and must be billed with the injection code. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

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 where the beneficiary and the professional will have an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.

Special Restrictions in Relationship to Other Services MA

is billed in conjunction with the VI service.

Vivitrol® Injection (VI)

The injectable procedure code is billed as an encounter and is rendered only one time a month to the beneficiary.

Billable Places 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 health care professional and that affords an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.

Special Restriction in Relationship to Other Services

A qualified healthcare professional must provide a prescription for the injection.

The MA code is billed in conjunction with the injection code. Both services are documented on the same CSN but must be billed separately.

Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP): Level II.I IOP services are billed as an hourly inclusive rate.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a 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 in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis Intervention, and E&M Services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization: Level II.5

Alcohol and/or Drug Treatment Outpatient — Day Treatment/Hospitalization services are billed as an hourly inclusive rate.

Billable Place of Service

The only excluded settings are acute care hospitals. Services can be rendered in a 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 in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis Intervention, and E&M Services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification: Level III.2-D

Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis Intervention, and E&M Services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services: Level III.7-D

Services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16-bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis Intervention, and E&M Services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment: Level III.5-R

Behavioral Health Long Term Residential — Clinically Managed High-Intensity Residential Treatment Services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis Intervention, and E&M Services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment: Level III.7-R

Behavioral Health Short Term Residential — Medically Monitored Intensive Residential Treatment services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a 16 bed or less substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis Intervention, and E&M Services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

Behavioral Health Short-Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA. Services are billed at a daily per diem rate.

Billable Place of Service

Services can only be rendered in a substance abuse facility.

Special Restrictions in Relationship to Other Services

All services must be authorized except for DAs, AOD Assessment, AOD Screening, AOD Nursing Assessment, SPD, Crisis intervention, E&M services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

APPENDICES: EVIDENCE-BASED PRACTICES (EBP)

APPENDIX A

ASSERTIVE COMMUNITY TREATMENT (ACT)

Purpose

Assertive Community Treatment (ACT) is a best practice community-based treatment for beneficiaries with severe mental illness (SMI). ACT services are based in the community and assist beneficiaries with decreasing psychiatric hospitalizations and involvement with law enforcement while increasing their community living skills. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes ACT as an evidence-based best practice for adults and transition age youth (i.e., 18-26 years) that is no more expensive than other community-based care and has high satisfaction scores among individuals who receive the service and their family members.¹

Service Definition and Tool for Measurement of ACT

ACT is an intensive non-residential treatment and rehabilitative mental health service provided in accordance with the fidelity model of the Tool for Measurement of ACT (TMACT). ACT provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for beneficiaries with SMI who require a higher level of community care and have not been well supported in lower level of care options.

Services are offered 24 hours per day, seven days per week, in a community-based setting that may include the beneficiary's home, a shelter, or even on the street. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance use disorders, peer support, and integrated treatment and skill building to achieve and maintain educational or vocational success. Typically, beneficiaries served through ACT have a serious and persistent psychiatric disorder and a treatment history characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, substance use, and lack of engagement in traditional outpatient services. Crisis intervention and planning are critical components of this service.

One of the fundamental charges of ACT is to be the first line (and generally sole provider) of all the behavioral health services that beneficiaries may need. Thus, a higher frequency and intensity of

¹ SAMHSA. ACT: The Evidence. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services, 2008.

community-based contacts and a low beneficiary to staff ratio is required. Services are flexible and appropriately adjusted based on the beneficiary's evolving needs over time. Because an ACT team often works with beneficiaries who may passively or actively resist services, an ACT team is expected to thoughtfully carry out planned assertive engagement techniques including rapport -building strategies, facilitating meeting basic needs, and motivational interviewing techniques. These techniques are used to identify and focus on the beneficiary's life goals and what the beneficiary is motivated to change. Likewise, it is the team's responsibility to monitor the beneficiary's mental status and provide needed supports in a manner consistent with the beneficiary's level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care. The team promotes self-determination, respects the beneficiary as an individual in their own right, and engages peers in promoting hope that the beneficiary can recover from mental illness and regain meaningful roles and relationships in the community.

Medical Necessity

Eligibility Criteria

ACT services require prior authorization and shall be covered for a beneficiary with diagnoses of schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), or bipolar disorder, as defined by the current edition of the Diagnostic and Statistical Manual (DSM). These illnesses more often cause long-term psychiatric disability; ***beneficiaries with other psychiatric illnesses are eligible depending on the level of the long-term disability from their mental illness.*** Diagnosis must reflect a serious and persistent mental illness and the need for treatment, and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.

Beneficiaries ages 18 - 21 must meet medical necessity under Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Beneficiaries with a primary diagnosis of a substance use disorder, intellectual developmental disorder (intellectual disability), borderline personality disorder, and traumatic brain injury are not eligible for ACT.

The beneficiary has significant functional impairment as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene) or persistent or recurrent difficulty performing daily living tasks without significant support or assistance from others such as friends, family, or relatives.

2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (e.g., meal preparation, household tasks, budgeting, or childcare tasks and responsibilities).
3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing or utilities).

In addition, has one or more of the following problems which are indicators of continuous high service needs:

1. High use of acute psychiatric hospitalization (two or more admissions during the past 12 months) or psychiatric emergency services.
- ii. Intractable (persistent or recurrent) severe psychiatric symptoms (e.g., affective, psychotic, suicidal, etc.).
- iii. Coexisting mental health and substance use disorders of significant duration (more than six months).
- iv. High risk or recent history of criminal justice involvement (e.g., detention, incarceration, probation, frequent contacts with law enforcement, etc.).
- v. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness.
- vi. Residing in an inpatient or supervised community residence but clinically assessed as able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
- vii. Difficulty effectively using traditional office-based outpatient services.

Continued Stay

The beneficiary shall be approved for continued stay if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's treatment plan, or the beneficiary continues to be at risk for relapse based on current clinical assessment, history, or the tenuous nature of the functional gains.

One of the following applies:

1. The beneficiary has achieved current treatment plan goals and additional goals are indicated as evidenced by documented symptoms.
2. The beneficiary is making satisfactory progress toward meeting goals, and there is documentation that supports continuation of ACT will be effective in addressing the goals outlined in the treatment plan.
3. The beneficiary is making moderate progress, but the specific interventions in the treatment plan need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible.

4. The beneficiary fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the treatment plan (e.g., the beneficiary's diagnosis must be reassessed to identify any unrecognized co-occurring disorders and treatment recommendations should be revised based on the findings).
5. If the beneficiary is functioning effectively with ACT and discharge would otherwise be indicated, the ACT team services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision must be based on either of the following:
 - a. The beneficiary has a documented history of regression in the absence of ACT team services or attempts to titrate ACT team services downward have resulted in regression.
 - b. There is an epidemiologically sound expectation that symptoms will persist, and ongoing outreach treatment interventions are needed to sustain functional gains.

Discharge Criteria

Beneficiary shall meet at least one of the following:

1. The beneficiary and team determine that ACT services are no longer needed based on the attainment of goals as identified in the person-centered plan and a less intensive level of care would adequately address current goals. Standards for transitioning to less intensive services should be consistent with the standards noted in Operations and Structure 9 (OS9) on the TMACT OS subscale.
2. The beneficiary moves out of the catchment area, and the ACT team has facilitated the referral to either a new ACT provider or other appropriate mental health service in the new place of primary private residence and has assisted the beneficiary in the transition process. The ACT team shall maintain documentation of the referral process.
3. The beneficiary and, if appropriate, the legally responsible person chooses to withdraw from services and documented attempts by the program to re-engage the beneficiary have not proven to be successful.
4. The beneficiary has not demonstrated significant improvement following reassessment, several adjustments to the treatment plan over a minimum of a three-month period and all engagement strategies have been documented with no demonstrable results, and:
 - a. Alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement as determined by the team's clinical judgment.
 - b. The beneficiary's behavior has worsened, such that continued treatment is not anticipated to result in sustainable change as determined by the team's clinical judgment.
 - c. Or, more intensive levels of care are indicated by the team's clinical judgment.

Staff Composition and Qualifications

ACT teams require an adequate number of staff members with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with beneficiaries. In addition, ACT staff must have attitudes and values that are compatible with ACT philosophy — compassion and respect for beneficiaries with SMI and their experiences, understand and believe in recovery concepts and clients determining their own goals, and beneficiary and family involvement in all activities that shape the quality of ACT services. Although ACT teams have some flexibility with team membership/roles and have the ability to deploy variations of staffing combinations and options, team members must meet State licensing requirements. For example, for teams with two psychiatric care providers, it is expected that each provider meet all of the listed roles and responsibilities. Staffing for ACT teams should include the below roles and team members:

- Team Leader
- Psychiatric Care Provider — psychiatrist, Advanced Practice Registered Nurse (APRN), Nurse Practitioner (NP), and Physician Assistant (PA)
- Nursing — APRN, Licensed Registered Nurse (RN), and Licensed Practical Nurse (LPN)
- Qualified Mental Health Professional
- Mental Health Provider
- Substance Use Disorder Licensed or Certified Professional
- Vocational Success Specialist
- Certified Peer Support Specialist (CPSS)
- Administrative Assistant

Team Leader

In collaboration with the psychiatric care provider(s), the ACT team shall be staffed with one full-time team leader whose primary responsibility is to provide clinical leadership and oversight to the ACT program and manage the team operations and staffing. The team leader shall be a licensed mental health professional holding any of the following licenses: Licensed Psychologist, Licensed Independent Social Worker-Clinical Practice (LISW-CP), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Psychiatric NP, and/or Clinical Nurse Specialist certified as an advanced practice psychiatric clinical nurse specialist.

The team leader shall have three years of clinical experience with SPMI, with a minimum of two years post-graduate school.

The full-time team leader is responsible for:

1. Overseeing the administrative operations of the team.

2. Providing clinical oversight of services in conjunction with the psychiatric care provider as well as clinical supervision for staff team members.
3. Supervising staff team members to assure the delivery of best and ethical practices.
4. Providing direct services to ACT service beneficiaries where a therapeutic relationship is developed between ACT service beneficiaries and the team leader.

Example roles include:

1. Assuming an active role in screening referrals and assessing beneficiaries at intake.
2. Acting as a lead clinician and working closely with a select group of service beneficiaries who can benefit from the team leader's clinical expertise.
3. Modeling behaviors through service provision for the purpose of clinical supervision.
4. Participating in person-centered planning meetings.
5. Working with beneficiary's natural supports.

The team leader is exclusively dedicated to the ACT team, with no responsibilities to other roles outside of the ACT team. Only one qualified professional (QP) shall assume the role as team leader.

Psychiatric Care Provider

The psychiatric care provider's minimal full-time equivalent (FTE) is determined by the number of service beneficiaries. Part-time psychiatric care providers shall have designated hours to work on the team, including sufficient blocks of time on consistent days in order to carry out their clinical, supervisory, and administrative responsibilities. The role of a psychiatric care provider is to be filled by a psychiatrist(s), APRN, or shared by a psychiatrist, an NP, or a PA under the supervision of the psychiatrist. APRNs with prescription authority and a Drug Enforcement Administration (DEA) registration are also authorized to prescribe medications and can fill this role. This position does not count towards the ACT team's staff to beneficiary ratio.

No more than two psychiatric care providers may share this role. If a PA is one of the psychiatric care providers, then the team psychiatrist must assume at least half of the minimum FTE require given the team size. All psychiatric care providers are to be integrated on the team by providing direct services to the beneficiaries.

The ACT team psychiatrist shall be board eligible or certified by the American Board of Psychiatry and Neurology and licensed to practice in the State. The ACT team's psychiatric NP shall be currently licensed as a NP in the State with at least three years of fulltime experience treating individuals with SPMI, and/or the ACT team's PA shall be currently licensed as a PA in the State with at least three years fulltime experience treating individuals with SPMI.

Psychiatric care providers are FTE members of the team and shall perform the following activities in the community in support of both the beneficiaries and the ACT team staff:

1. Regularly sees the beneficiaries for the assessment and treatment of the beneficiary's symptoms and response to medication including side effects. Frequency will vary for each beneficiary, with the majority seen within four to six weeks of their last appointment. Less frequent visits should only occur when there are unusual circumstances present (e.g., when the beneficiary has been difficult to find).
2. The ACT team's psychiatrist provides clinical supervision and oversight of the psychiatric services when delivered by the NP or PA.
3. Collaborates with the team leader in sharing overall clinical responsibility for monitoring beneficiary treatment and clinical supervision to the team.
4. Actively collaborates with nurse(s) to develop and implement medication administration policies and procedures as well as oversee the medical care of beneficiaries, including regular screenings for medical conditions and assessment of wellness and health management.
5. Educates nonmedical team members on psychiatric and nonpsychiatric medications, their side effects, and health related conditions; provides diagnostic and medication education to beneficiary, with medication decisions based on shared decision making.
6. Regularly participates in daily team meetings and treatment planning meetings; attends daily team meetings in proportion to time allocated on the team.
7. Provides brief therapy (formal or informal).
8. Provides psychiatric back-up to the program after-hours and weekends.²

Nurse

The nurse's minimal FTE is determined by the number of service beneficiaries. An ACT team shall be staffed minimally with one RN or APRN that has a minimum of one year experience working with adults with SMI and a working knowledge of psychiatric medications, regardless of team size. Additional nursing staff can be RNs, APRNs, or LPNs. No more than two staff can share a 1.0 FTE.

Nursing staff are responsible for performing the following key roles, with LPNs responsible for tasks within their scope of practice and under the supervision of an ACT team RN:

1. Manages the medication system in conjunction with the psychiatrist, administers and documents medication treatment.
2. Manages a secure medication room to support the dispensing of medications, which includes both oral and intramuscular psychotropic medications for beneficiaries in need of such support.

² May be on a rotating basis as long as other psychiatric care providers who share on-call shifts/duties have access to beneficiary's current status and medical records/current medications.

3. Screens and monitors the beneficiary for medical problems and side effects.
4. Engages in health promotion, prevention, and education activities.
5. If the beneficiary is in agreement, develop strategies to maximize taking medications as prescribed (e.g., reviewing home environment to find cues to remind beneficiary to take medications and work with beneficiary and psychiatric care providers to scale back the number of times medications are taken each day).
6. Communicating and coordinating services with other medical providers.
7. Educating the team in monitoring psychiatric symptoms and medication side effects.
8. Regularly participates in daily team meetings and treatment planning meetings and attends daily team meetings in proportion to time allocated on the team.

Qualified Mental Health Professional (QMHP)

The QMHP position shall be staffed with a minimum LISW-CP, LMFT, LPC, or Licensed Psychologist, and 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.. Interventions and services provided should be grounded in evidence--based practices (EBPs) tailored to meet the needs of ACT beneficiaries, and can include:

- Individual and group therapy
- Completion of screening and assessments for referrals
- Using assertive engagement and outreach techniques to engage beneficiaries in services
- Leading Instructional Continuity Plan (ICP) development and revisions
- Working with a beneficiary's natural supports
- Family psychoeducation

Mental Health Provider (MHP)

ACT Teams may include either a Mental Health Professional or a Mental Health Services Provider:

- a. **Mental Health Professional** – a masters or doctoral degree in a human services field and minimum of one year experience working with the population to be served.

-OR-

- b. **Mental Health Services Provider**— must have a minimum of a bachelor's degree in a human services field and three years of experience working with the population to be served.

If either of the providers is licensed (e.g., LBSW, LMSW, LPC-A, LMFT-A), years of experience may be reduced to one year for the mental health services provider and waived for the mental health professional. Interventions and services provided should be grounded in psychiatric rehabilitation; reflect the education, experience, and scope of practice of the staff; and can include:

- Direct supports focusing on housing and tenancy skill development.
- Carry out rehabilitation and support functions.
- Facilitate training of independent living skills.
- Establish access to community services and agencies.
- Assist individuals in establishing support networks in the community.
- Coordinate services with the beneficiary, team, and community resources.
- Facilitates the person-centered planning process for beneficiaries assigned to them.
- Regularly participates in daily team meetings and treatment planning meetings and attends daily team meetings in proportion to time allocated on the team.
- Individual and group therapy
- Completion of screening and assessments for referrals
- Using assertive engagement and outreach techniques to engage beneficiaries in services
- Leading ICP development and revisions
- Working with a beneficiary's natural supports
- Family psychoeducation

Substance Use Disorder Licensed or Certified Professional

The ACT team shall be staffed with a 1.0 FTE substance use disorder certified professional who shall be a Licensed Addiction Counselor (LAC), Master Addiction Counselor (MAC), or a master's level Certified Addictions Counselor (CAC). No more than two substance use specialists may share this role.

The responsibilities of the substance use disorder professional are as follows:

1. Conducts comprehensive substance abuse assessments considering the relationship between substance use and mental health.
2. Assesses and tracks beneficiary's stages of change readiness and stages of treatment.
3. Uses outreach and motivational interviewing techniques to work with beneficiaries in earlier stages of change readiness.
4. Facilitates access to 12-step groups and other community supports.

5. Uses cognitive behavioral approaches and relapse prevention to work with beneficiaries in later stages of change readiness.
6. Ensures that the team's treatment approaches are consistent with beneficiary's stages of change readiness.
7. Facilitates the person-centered planning process for beneficiaries assigned to them.
8. Serves as a consultant and educator to fellow ACT team members on the topic of integrated dual disorder treatment.
9. Regularly participates in daily team meetings and treatment planning meetings and attends daily team meetings in proportion to time allocated on the team.

Vocational Success Specialist

A team shall be staffed with a full-time vocational success specialist. The vocational success specialist shall have a minimum of a bachelor's degree in a human services field, at least one years' experience working with adults with SMI, and at least six months experience providing employment or educational supports. Preference is for someone who has at least one year of experience providing employment services or has advanced education that involved field training in vocational services. The vocational success specialist shall provide evidence-based employment strategies.. Beneficiaries receiving ACT services shall have immediate access to vocational services from the ACT team. Vocational success specialists shall not refer beneficiaries to receive any type of vocational services or linkage by providers outside of the ACT team, with the exception of referrals to the South Carolina Vocational Rehabilitation Department (SCVRD) in cases where the ACT team cannot provide needed supports for the beneficiary to obtain or maintain employment, or to support educational goals (e.g., need for adaptive technology to support employment, reimbursement of tuition and fees for education or certification related to employment goals). The primary outcome of vocational services is management of symptoms and behaviors that allows for competitive employment — defined as jobs that pay at least minimum wage, which anyone can apply for and are not set aside for persons with disabilities. This may include temporary and seasonal jobs.

The responsibilities of the vocational success specialist are as follows:

1. Engages the beneficiary on the topic of school or work and how their symptoms might impact opportunities for school and competitive employment.
2. Completes a vocational assessment that is focused on beneficiary's strengths, preferences, and on-the-job assessments, where appropriate; identifies symptoms and behavioral issues that could interfere with future work efforts.
3. Conducts job development, where the vocational success specialist builds relationships with local businesses and educates them about the services that the vocational success specialist provides, collects information about positions, and ideally determines potential for job carving options.

4. Supports individualized job placement or other options available according to beneficiary's preferences, per evidence-based employment models.
5. Provides ongoing supports by encouraging the beneficiary in learning job skills, navigating a workplace, and managing work relationships with other employees and supervisors.
6. Provides benefits counseling directly as well as connects beneficiaries to experts for more extensive benefits counseling as needed, including development of Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Work Incentives.
7. Facilitates the Individual Plan of Care (IPOC) process for beneficiaries assigned to them.
8. Serves as a consultant and educator to fellow ACT team members on the topic of evidence-based employment models.
9. Regularly participates in daily team meetings and treatment planning meetings and attends daily team meetings in proportion to time allocated on the team.

Vocational success specialists on ACT teams shall be the main provider of employment services for ACT beneficiaries and with the support and assistance from all ACT team members (e.g., all team members may provide ongoing support to beneficiaries who are employed). ACT vocational success specialists shall collaborate and consult with vocational program staff to enhance job development opportunities and business networking opportunities as appropriate.

Peer Support Specialist (PSS)

Each ACT team has at least 1.0 FTE PSS. No more than two individuals can share this position. This professional's life experience with mental illness or substance abuse and behavioral health services provides expertise that professional training cannot replicate. To ensure that the experience of the peer specialist is commensurate with those served by ACT, for this position, the PSS must have *lived experience* and a personal recovery story specific to primary mental illness. The PSS is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision making abilities of beneficiaries.

1. The responsibilities of the PSS are as follows: Provides coaching, mentoring, and consultation to the beneficiary to promote recovery, self-advocacy, and self-direction.
2. Promotes wellness management strategies, which includes delivering manualized interventions (e.g., Wellness Recovery Action Plan [WRAP®] or Illness Management and Recovery).
3. Assists beneficiaries in developing psychiatric advance directives.
4. Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience; provides consultation to team members to assist in understanding of recovery and the role of the CPSS, promoting a culture in which beneficiaries' points of view and preferences are recognized, understood, respected, and integrated into treatment.
5. Serves as an active member of the ACT team, equivalent to other team members, which includes facilitating the IPOC process for beneficiaries assigned to them:

- a. Supports and empowers the individual to exercise their legal rights within the community.
- b. Regularly participates in daily team meetings and treatment planning meetings and attends daily team meetings in proportion to time allocated on the team.

Additional Staff

The additional clinical staff may include licensed mental health professionals. These individuals shall have the knowledge, skills, and abilities required by the population and age to be served to carry out rehabilitation and support functions. Activities of these additional staff may include a range of psychosocial rehabilitative interventions and case coordination tasks. Specialization is encouraged in areas such as: psychiatric rehabilitation, therapy, and additional supports in the areas of substance abuse counseling, housing, vocational services, etc.

Program Assistant

The full-time office-based program administrative assistant position is assigned to solely support the ACT team. This position does not count towards the ACT team's staff to beneficiary ratio.

The ACT program assistant provides a range of supports to the team including:

1. Organizing, coordinating, and monitoring all non-clinical operations of the ACT team, including:
 - a. Managing medical records.
 - b. Operating and coordinating the management information system.
 - c. Maintaining accounting and budget records for beneficiary and program expenditures.
 - d. Entering and tracking team performance and beneficiary outcome data as well as running reports on such data.
 - e. Providing support to the team by receiving calls and responding to office walk-ins, triaging, and coordinating communication between the team and individuals.
 - f. Actively participating in the daily team meeting, assisting with organizational record-keeping, and scheduling activities.

Staff Competencies, Services, and Supports

The ACT team shall have staff with sufficient individual competence, professional qualifications, experience to provide the care coordination, service coordination, crisis assessment and intervention, and symptom assessment and management. The intensity of intervention and support shall vary to meet the changing needs of beneficiaries with SPMI, to support beneficiaries in normal community settings, and to provide a sufficient level of service as an alternative to hospitalization or more restrictive levels of care. ACT services are delivered continuously and *titrated*, meaning that when a beneficiary needs more services, the team provides them. Conversely, when the beneficiary

needs less services, the team lessens service intensity. Services provided by an ACT team include but are not limited to the following:

- Assertive Engagement
- Benefits and Finance Support
- Employment Services
- Assessment and Treatment Planning
- Co-occurring Substance Use Disorder Treatment
- Family Psychoeducation and Support
- Social Skills and Support
- Crisis Assessment and Intervention
- Housing Access and Support
- Medication Education, Assistance, and Support
- Mental Health CPSS
- Referral to and coordination with Physical Health Services
- Psychiatric Rehabilitation and Assistance with Activities of Daily Living
- Symptom Management
- Evidenced-based Supportive Therapeutic Interventions and Psychotherapy
- Wellness Self-management and Prevention
- Service and Resource Acquisition
- Support to Facilitate Recovery
- Service Coordination
- Crisis Planning and Intervention
- Care Coordination

Team Size and Staff Ratios

Certification as an ACT team in fidelity with the TMACT is required. In compliance with TMACT fidelity (scoring at least a 3.0) or having provisional certification for no more than 18 months, ACT teams may provide any component of the services list from above and must employ and utilize the qualified practitioners necessary to maintain fidelity. ACT service providers must meet the following requirements:

Team Size	Number of Individuals Served	Ratio
Small	Up to 50	1:8
Large	51–129	1:9

Required staffing ratios are based on team size as noted in the table below. Other than the team leader role, staffing, and team composition is flexible based on the narrative above.

Staff	Small Team	Large Team
Team Leader	1.0	1.0
NP, PA, and APRN	0.2	0.4
Psychiatric Care Provider	0.2	0.4
RN	1.4	2.0
LPN	-	0.9
Substance Use Disorder Professional	1.0	1.0
Peer Specialist	1.0	1.0
Vocational Success Specialist	1.0	1.0
QMHP	0.5	1.0
MHP	1.0	2.0
Administrative Assistant	1.0	1.0

The service components that are eligible for Medicaid reimbursement must be delivered by providers who are Medicaid-approved and within professional scope for those services.

Staff Training Suggestions

Below is a recommended list of training topics for ACT teams.

- Benefits Counseling
- Cognitive Behavioral Therapy for Psychosis
- Culturally and Linguistically Appropriate Services

- IPS-SE EBP
- Family Psychoeducation
- Functional Assessments and Psychiatric Rehabilitation
- Integrated Dual Disorders Treatment EBP
- Limited English Proficiency, Blind or Visually Impaired, and Deaf and Hard of Hearing Accommodations
- Medication Algorithms
- National Alliance on Mental Illness Psychoeducational Trainings
- Psychiatric Advanced Directives
- Recovery Oriented Systems of Care: Policy and Practice
- SSI/SSDI Outreach, Access, and Recovery/Stepping Stones to Recovery
- Understanding Permanent Supportive Housing EBP, such as the SAMHSA EBP Tool
- The Pathway's Model to End Homelessness for People with Mental Illness and Addiction
- Evidence-based Models and Trauma Informed Care
- Wellness and Integrated Health Care, Wellness Management and Recovery Interventions

Service Documentation

Each provider is responsible for developing the IPOC. When the State agency refers for services and does not provide the IPOC, the ACT team must develop the IPOC. When State agencies refer beneficiaries to non-Department of Mental Health (DMH) ACT providers for services, the non-DMH ACT providers must adhere to the recommendations for services and specific frequencies set forth by the respective State agency. IPOC documentation must meet all South Carolina Department of Health and Human Services requirements and include IPOC components as described in the manual in Section 2 on pages 2–57. 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.

Billing Guidance

Billing Frequency

Billing is covered under code H0040 with a U1 modifier for small teams and a U3 modifier for large teams and is set on a per diem rate. ACT per diems may only be billed on days when the ACT team has performed a face-to-face service with the beneficiary or a family member. Only one per diem may be billed per beneficiary per day, at minimum nine per diems a month, no more than 15 per month.

For an ACT team per diem to be generated, a 15-minute or longer face-to-face contact that meets all requirements outlined below must occur. A 15-minute contact is defined as lasting at least eight minutes. Group contacts alone are not permitted as a face-to-face contact for generating an ACT per diem rate. Group psychotherapy or group therapy is a form of [psychotherapy](#) in which one or more therapists treat a small group of clients together as a group.

Practitioners may not bill for services included in the ACT per diem and also bill for that service outside of the per diem for enrolled beneficiaries.

At any time during the 12-month period of fidelity level certification, the State approved fidelity evaluators can request additional information to assess any questions that may arise regarding any TMACT fidelity metric. At the time of request, all subsequent billing will be pended subject to verification of the identified TMACT fidelity metric. If the additional review reveals that the fidelity score for any identified metric falls below the standards for OS, Core Team (CT), and Core Practice 1 (CP1) for the current certification level, the team will have 90 days to demonstrate capacity at a level above the required minimums for each identified metric. If such capacity is not demonstrated to the satisfaction of the State approved fidelity evaluators, the program will not be able to bill H0040 and will instead bill the appropriate Rehabilitative Behavioral Health Services (RBHS) code(s) for services rendered until at least basic fidelity level is achieved.

Reimbursement of Employment Services

ACT includes non-job specific vocational training, employment assessments, and ongoing support to maintain employment. Strategies from the IPS model are recommended, with a focus on managing one's symptoms for the purpose of obtaining/maintaining meaningful employment. ACT may also pay for the medical services that enable the beneficiary to function in the workplace, including ACT services such as a psychiatrist's or psychologist's treatment, rehabilitation planning, therapy, and counseling that enable the beneficiary to function in the workplace.

Billing Guidance and Restrictions

ACT teams that meet fidelity may bill per diems per month per individual when all other requirements for a visit are met (e.g., a face-to-face service with the client or family member). Medically necessary care consistent with the fidelity model should be delivered even if beyond the minimum number of units permitted to be billed under this reimbursement strategy.

The following activities may not be billed:

- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.

- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed for ACT. Additional medical transportation for service needs not considered part of ACT services may be covered by the transportation service through the State Plan. Medical transportation to ACT providers may be billed to the transportation broker.
- Covered services that have not been rendered.
- Services provided before the department, or its designee (including the Managed Care Organization) has approved authorization.
- Services rendered that are not in accordance with an approved authorization.
- Services not identified on the beneficiary's authorized ACT Treatment Plan.
- Services provided without prior authorization by the department or its designee.
- Services not in compliance with the ACT service manual and not in compliance with fidelity standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's ACT participant-directed treatment plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved ACT service description.
- Changes made to ACT that do not follow the requirements outlined in the provider contract, service manual, or ACT fidelity standards.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.

Billable Place of Service

There are no place of service restrictions. The ACT team is expected to meet with the beneficiary in their environment at times of the day/week that honor the beneficiary's preferences and meet the beneficiaries at home, in homeless shelters, streets, or hospitals. *Note: Other than psychiatry services, when necessary, ACT is not intended to be provided via telehealth.*

Indirect Costs

All other contacts, meetings, travel time, training, payment for fidelity reviews, etc. are considered indirect costs and are accounted for in the build-up of the per diem rate.

Special Restrictions in Relationship to Other Services

The following services must not be provided concurrently with ACT:

- Individual or Family Psychotherapy
- Outpatient Medication Management
- Outpatient Psychiatric Services
- Psychosocial Rehabilitation after a 30-day Transition Period
- Partial Hospitalization
- Nursing Home Facility
- Medicaid-Funded Evidence-Based Supported Employment or Long-Term Vocational Supports

The following services may be provided concurrently with ACT services **only** if deemed medically necessary:

- Opioid Treatment
- Detoxification Services
- Facility-Based Crisis Stabilization (i.e., walk-in crisis stabilization center or unit for purpose of diversion from Emergency Department, 23-hour stay)
- Evidence-Based Supportive Employment or Long-Term Vocational Supports (non-day Transition Period)
- Group Psychotherapy
 - A time-limited group with a specific goal identified on the IPOC is permissible as long as medical necessity is met and there is justification of why the goal cannot be met by the providers in the ACT team.

Fidelity

The below table shows the staff to beneficiary ratios as well as FTEs for small and large teams.

Staff	Small Team	Large Team
Staff: Beneficiary Ratio	1:8	1:9

Staff	Small Team	Large Team
FTE Base Fidelity	6.0	7.0
FTE High Fidelity	7.0	10.0

Provisional Fidelity Level

A new ACT team can be certified at a provisional fidelity level for six months if it has submitted the required documentation to the State approved fidelity evaluation team. At that time, the ACT team must undergo a mock fidelity review by the State approved fidelity evaluation team and achieve an average TMACT fidelity score of 2.0 or greater. In order to achieve a provisional fidelity level, the team must also achieve minimum fidelity rating scores on certain aspects of TMACT fidelity:

- A minimum average rating of 3.0 across the following items from the OS subscale must be achieved:
 - OS1 — Low ratio of consumers to staff
 - OS5 — Program size
 - OS6 — Priority service population
 - OS10 — Retention rate
- A minimum average rating of 3.0 on the entire CT subscale must be received.
- A minimum rating of 3.0 on CP subscale CP1 community-based services must be received.

ACT teams may remain at the provisional fidelity level for no more than 24 months. Once the two years of provisional fidelity is completed, the State Medicaid Authority may place any ACT team not reaching basic fidelity on a corrective action plan not to exceed 90 days. During that time, the team may **not** bill using H0040, and will bill the appropriate RBHS code(s) for the services rendered.

Basic Fidelity Level

ACT teams must have an overall TMACT fidelity score of at least 3.0 to meet the basic fidelity level. The team must also achieve the following minimum fidelity rating scores on certain aspects of TMACT fidelity:

- A minimum average rate of 3.0 across the following items from the OS subscale must be achieved:
 - OS1 — Low ratio of consumers to staff
 - OS5 — Program size
 - OS6 — Priority service population
 - OS10 — Retention rate

- A minimum average rating of 3.0 on the CT subscale must be received.
- A minimum rating of 3.0 on CP subscale CP1 — community-based services item must be received.

ACT teams remain at the basic fidelity level for 18 to 24 months before rater reevaluation.

Moderately High Fidelity Level

ACT teams scoring an overall TMACT fidelity score of at least 3.5 when all other requirements are met (e.g., a face-to-face service with the client or family member) are considered moderately high fidelity. In addition to the average score, teams must meet the following specific TMACT requirements:

- A minimum average rate of 3.5 across the following items from the OS subscale must be achieved:
 - OS5 — Program size
 - OS9 — Transition to less intensive services
 - OS10 — Retention rate
- A minimum rating of 4.0 on OS subscale OS6 — Priority service population must be received.
- A minimum average rating of 4.0 on the CT subscale must be received.
- A minimum rating of 4.0 on CP subscale CP1 — community-based services item must be received.
- A minimum average rating of 3.0 on the Person-Based Planning (PP) subscale must be received.

ACT teams remain at the moderately high fidelity level for 30 to 36 months before rater reevaluation.

High Fidelity Level

ACT teams scoring a TMACT fidelity score of at least 4.2 when all other requirements are met (e.g., a face-to-face service with the client or family member) is considered high fidelity. In addition, teams must meet the following specific TMACT requirements (similar to level two teams):

- A minimum average rate of 4.0 across the following items from the OS subscale must be achieved:
 - OS5 — Program size
 - OS9 — Transition to less intensive services
 - OS10 — Retention rate

- A minimum rating of 5.0 on OS6 — Priority service population.
- A minimum average rating of 4.0 on the CT subscale must be received.
- A minimum rating of 4.0 on CP1 — community based services item must be received.
- A minimum average rating of 3.7 on the following subscales:
 - PP subscale
 - Specialist team subscale
 - EBPs subscale

ACT teams remain at the high fidelity level for 30-36 months before rater reevaluation.

The following chart is a quick reference guide indicating the fidelity level by scoring range and length of time at each level of fidelity before reevaluation. Teams are due for re-evaluation at the end of that timeframe.

NOTE: TMACT re-evaluation timeframes start from the date the team receives their final score, not from date of rater evaluation. Additionally, start-up teams are allowed 6 months before the initial TMACT fidelity rating and the start of the 24 month timeframe for provisional fidelity.

Fidelity Level	TMACT Scoring Range	Timeframe for Reevaluation
Provisional	2.0 - 2.9	24 months
Basic	3.0 - 3.6	18-24 months
Moderately High	3.7 - 4.1	30-36 months
High	4.2 - 5.0	30-36 months

APPENDIX B

MULTISYSTEMIC THERAPY (MST)

Service Definition

Multisystemic Therapy (MST) is an intensive family and community-based, evidence-based treatment which addresses the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST is provided using a home-based model of service delivery for youth and families, targeting youth between the ages of 12 - 17 who are at high risk of out-of-home placement or justice system involvement, or who may be returning home from a higher level of care. [Exceptions may be requested for youth ages 10, 11, or 18; admission of such youth must be approved by the MST team supervisor and MST consultant]. MST is delivered in the natural environment (e.g., home, school, community) with the treatment plan designed in collaboration with the youth, family, and all relevant child-serving systems (e.g., DJJ, DSS, DMH, and/or other SC child-serving agencies, Education, Faith-based organizations, etc.).

MST includes engagement with the youth's family, caregivers, and natural supports, as well as professionals delivering interventions in the recovery environment. MST is an intensive but short-term service, effecting change, on average, within **four months (120 days) of treatment** and **60 hours of intervention**. This culturally sensitive rehabilitative service may also serve as a step-down or diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and neighborhood/community.

Critical Components of the MST Model

Critical Components of MST include the following:

- Integration of evidence-based therapeutic interventions to address a comprehensive range of risk factors across family, peer, school, and community contexts;
- Promotion of behavioral change in the youth's natural environment, with the overriding goal of empowering caregivers with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school, and neighborhood problems;
- Rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change; and
- MST providers who are on call 24 hours/day, seven days/week to provide safety planning and crisis intervention.

MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when many of them have serious and multiple needs of their own. One primary goal of MST is to empower caregivers to effectively parent their children. MST reaches across all of the youth's life domains and is highly individualized for each case.

MST providers may deliver the therapeutic interventions involved in a range of community settings, such as the youth's home, school, homeless shelters, libraries, etc. MST includes therapeutic intervention and care coordination to assist the youth in meeting their specific goals.

Therapeutic interventions and collateral contacts may range from brief check-ins to more intensive sessions lasting up to two-hours or more. The required supervision, professional consultation, and monitoring provided through the evidence-based model work to uphold treatment fidelity expectations around service delivery intensity and frequency.

Frequency, Intensity, and Duration

MST providers deliver this service primarily face-to-face with the youth and their natural supports, in locations outside of a clinic or facility. MST sessions are tailored by an MST Service Plan. Service intensity varies with the needs of the youth and family/caregiving system. Early in treatment, the MST provider may meet with the family several times a week, but as treatment progresses, intensity typically tapers. The frequency of therapeutic interventions is flexible and based on clinical need, allowing the service to be responsive to periods of crisis or high risk and to decrease the intensity for families with lower levels of need. The MST model expects the MST provider to take the lead in coordinating care while youth are participating in MST services.

The frequency, intensity, and duration of MST services is dependent on the needs of the youth as described in the Service Plan:

- If not in conflict with the MST Service Plan for a particular youth, the MST model expects an average of 10-20 therapeutic interventions within the first month *but should ultimately be tailored to the needs of the youth*.
- These initial therapeutic interventions typically occur multiple times per week in frequency. For the second and third months of MST, an average of 8 to 12 therapeutic interventions typically occur each month, though *will vary based on the needs of the youth*.
- The MST model expects that service frequency typically will be tapered over the duration of the treatment period based on the youth's needs and the family's adaptation to the new skills in use. Close to treatment termination, the MST provider contacts the family as needed to ensure that treatment gains have been sustained by the family.

NOTE: *These numbers do not represent definitive guidelines for MST service provision; rather, they illustrate the standard course of an MST episode of care. These numbers are not to be used as quality assurance or productivity metrics.*

Service Components and Documentation

Service components of MST include:

- Assessment
- Service Planning
- Therapeutic interventions
- Crisis intervention, and
- Care coordination

Assessment

At the start of services, a Licensed Practitioner of the Healing Arts (as described in Chapter 3, *Eligible Providers*) shall conduct an initial assessment consistent with the components required in the Diagnostic Assessment (see page 53 for service description), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria.

Service Planning

MST Service Plans shall be required during the entire duration of services and must be current. The treatment planning process should be collaborative but must be authorized by the MST Supervisor. In cases where the MST provider is not independently licensed, the MST Supervisor directs and authorizes the treatment planning process as part of the MST model.

MST Service Plans must be reviewed as necessary at a minimum of every 30-calendar days or more frequently depending on the youth's needs. These 30 day reviews are consistent and comply with the routine activities required for fidelity in the MST model and include treatment team meetings, consultations with MST supervisors and consultants, meetings with youth and natural supports, and administration of fidelity measures.

MST Service Plan Development Requirements

MST therapists are required to create a Service Plan for each family. This plan will incorporate the desired outcomes of the key participants/stakeholders involved in the family's treatment (e.g., parents, probation, social services, school personnel, etc.). This plan shall be sent to the referring agency caseworker/case manager and a copy of the Plan will be placed in the youth's individual file.

The Service Plan will identify family/client strengths, help the family/client define specific goals, provide instruction in ways to prevent the recurrence of delinquent behavior and other family conflict, and set up resources and skills to maintain ongoing progress. Additionally, the Service Plan will:

- Identify the multiple determinants of anti-social behavior for each case.
- Identify and document the strengths and needs of the adolescent, family, and the extra-familial systems (e.g., peers, school, neighborhood, etc.).
- In collaboration with family members, identify and document problems throughout the family and extra-familial systems (e.g., peers, school, neighborhood, etc.) that explicitly need to be targeted for change.

The MST supervisor must review and approve all service plans.

Therapeutic Interventions

MST therapists provide a range of goal-directed services to each client/family that may include but shall not be limited to:

- a. Improving parenting practices;
- b. Increasing family affection;
- c. Decreasing association with deviant peers;
- d. Increasing association with pro-social peers;
- e. Improving school/vocational performance;
- f. Engaging youth/family in positive recreational activities;
- g. Improving family/community relations;
- h. Empowering family to solve future difficulties;
- i. Teaching appropriate parenting skills, such as:
 - Alternatives to corporal punishment
 - Appropriate supervision of children
 - Age appropriate expectations
 - Choices and consequences
 - Displays of greater parent/child affection and trust;
- j. Family and marital interventions consistent with MST principles;
- k. Individual interventions for parents and youth consistent with MST principles;

- l. Aiding the family in meeting concrete needs such as housing, medical care and legal assistance and assisting in making available follow-up support resources as needed;
- m. Teaching the family organizational skills needed to provide a positive environment (e.g. teaching budgeting skills, etc.);
- n. Referring and linking the family with follow-up services when necessary to ensure continued success meeting the family's MST treatment goals;
- o. Transporting youth/family when necessary and facilitating family plans to access transportation themselves on an ongoing basis;
- p. Providing services in the client's home, or, at the client's request, at a location mutually agreed upon by the therapist and client; and
- q. Assessing for and managing substance use issues and providing specialized interventions such as contingency management, as necessary.

Crisis Intervention

Crisis intervention services must be available to youth and families receiving MST on a 24 hours a day, seven days a week, 365 days a year basis and provided by a member of the MST team. Crises may be managed in person or telephonically, based on clinical need, by the assigned MST provider, an on-call MST provider, or the MST team supervisor (or MST supervisor on-call).

Crisis services should be billed using the MST procedure code, H2033.

Documentation

Documentation must relate to the goals of the MST Service Plan and should be completed for each therapeutic intervention or collateral contact; *however*, the bulk of ongoing clinical documentation for regularly scheduled MST sessions should be provided in the *MST Weekly Case Summary*. Service notes for planned MST sessions may be brief and utilize references to goals and interventions by goal/objective number (corresponding to the formatted list of goals/objectives on the Service Plan), **as long as** the MST Weekly Case Summary provides adequate clinical detail to summarize goals that were addressed in the week's sessions, interventions provided, response of the youth/family, and overall treatment progress/status of youth/family for each session.

In summary, a reviewer of the youth's file should be able to see that a service was provided for each date MST was delivered to the youth and/or family or collateral contact, in chronological order, with the clinical details and expansive narrative in the MST Weekly Case Summary.

NOTE: *This does not apply for crisis intervention services, which should be documented independently including identified risks, interventions provided, and safety planning.*

All documentation for services rendered, including that which is specific to the MST model, must be included in the youth's individual record. It is permissible to utilize any MST format or template for documentation and as long as there is evidence of ongoing clinical intervention adequately covered in each submission, this documentation will serve as the requirement for Healthy Connections Medicaid.

Medical Necessity

Admission Criteria -- Diagnosis, Symptoms, and Functional Impairment

Youth must meet **all** of the following criteria for **admission** to MST:

1. The youth must be between the ages of 12 and 17. [Exceptions may be requested for youth ages 10, 11, or 18; approval must be provided by the MST supervisor and/or MST consultant].
2. The Diagnostic Assessment completed by an LPHA demonstrates evidence of symptoms and functional impairment that the youth meets criteria for a primary diagnosis that falls within the categories of disruptive behavior disorders, mood, substance use, or trauma and stressor-related disorders, consistent with the most recent version of the Diagnostic and Statistical Manual (DSM). There may be additional primary behavioral health diagnoses that may benefit from the interventions of MST that may be considered on a case-by-case basis under EPSDT.
3. Within the past 30 calendar days, the youth has demonstrated at least **one** of the following that puts the youth at risk of out of home placement:
 - a. Persistent and deliberate attempts to intentionally inflict serious injury on another person;
 - b. Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of actions that are endangering to self or others, are difficult to control, cause distress to the youth or others, or negatively affect the youth's or others' health and well-being; this criterion may include a pattern of oppositional or defiant behavior, delinquency, or previous or current involvement with law enforcement or the juvenile justice system;
 - c. Increasing and persistent symptoms associated with depression (e.g., chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, etc.) or anxiety (e.g., rumination, panic attacks, hypervigilance, dissociation, etc.), **in combination with externalizing problems** (e.g., physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the home, school, and/or community;
 - d. Ongoing substance use or dependency that interferes with the youth's interpersonal relationships and functioning in the home, school, and/or community;
 - e. The youth is returning home from out-of-home placement or an institutional setting (such as DJJ); or
 - f. MST is needed as a step-down transition from an out-of-home placement or an institutional setting.

4. The youth's successful reintegration or maintenance in the home and community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the MST model. ***Participation in an alternative community-based service would not provide the same opportunities for effective intervention and rehabilitation of the youth's problem behaviors.***
5. There is a family member or other committed caregiver available to participate in this intensive service.
6. Arrangements for supervision at home/in the community are adequate to ensure a reasonable degree of safety, and a safety plan has been established (or will be quickly established) by the MST provider as clinically indicated.

Exclusion Criteria

Youth who meet any **one** of the criteria below are **not** eligible to receive MST:

1. The youth is currently experiencing active suicidal or homicidal behavior (i.e., not transient ideation), or psychotic processes that require continuous supervision that is NOT available through the provision of MST, and/or the youth's psychiatric problems are the primary reason leading to referral.
2. The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends, or other potential surrogate caregivers.
3. The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors.
4. The youth's functional impairment is solely a result of intellectual or developmental disability, or the youth has moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism or other disorder.

Continued Stay Criteria -- Diagnosis, Symptoms, and Functional Impairment

Within the past thirty (30) calendar days, MST continues to be the appropriate level of care for the youth as evidenced by at least **one** of the following:

1. The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria;
2. The youth has manifested new symptoms/behaviors that meet admission criteria and those have been documented in the MST Service Plan;
3. Progress toward identified goals is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goals have been achieved.

To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following:

- An MST Service Plan with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support objectives for community integration, including the development of the youth's network of personal, family, and community support. Treatment objectives are related to readiness for discharge and MST-specific expected outcomes;
- Progress toward objectives is being monitored with fidelity to the model as evidenced in the 30 calendar day Service Plan review documentation;
- The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement;
- The type, frequency, and intensity of interventions are consistent with the MST Service Plan and maintain fidelity to the model;
- The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care than that of the intensity and frequency of a service such as MST. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service practitioners, community partners, and natural supports that will meet the needs of the client;
- The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care but requires additional time to implement the plan.

If youth does not meet criteria for continued treatment, MST may still be authorized by SCDHHS Office of Behavioral Health for (up to) an additional 10 calendar days under any of the following circumstances:

- There is no less intensive level of care in which the objectives can be safely accomplished; or
- The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or
- The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.

High-fidelity implementation of MST requires that teams aim for average episodes of care from three to five months; nearly all families (with few exceptions) complete MST treatment in five months. Likewise, rarely are youth re-referred to MST after discharge from the program – although this is possible, it is generally only in circumstances where the youth's entire ecology has changed and problems have resurfaced in that new ecology (ex., a youth has changed schools and neighborhoods, and is now engaging in apparent gang activity). Therefore, while MST does not limit a youth from re-entering MST services, the case would be substantially reviewed by the MST supervisor and/or MST consultant prior to accepting the referral.

Documentation of the request for service extension must be provided on the "Request for Approval of Continued Services" form (*found in the RBHS provider manual "Forms" section*) and signed by

the MST Supervisor and MST consultant. Continued service requests are approved by the SCDHHS Office of Behavioral Health. The form should be attached to the first claim submitted after all initial (48) per diems are exhausted; the claim with attachment must be submitted via the Medicaid webtool. Questions or other inquiries may be submitted to behavioralhealth004@scdhhs.gov. [Additional documentation may be requested as necessary.](#)

Discharge Criteria

The youth meets discharge criteria if any of the following are met:

- The youth's documented MST Service Plan goals have been met and the discharge plan has been successfully implemented;
- The youth and family are not engaged in treatment despite documented efforts to engage them in services and there is no reasonable expectation of progress at this level of care;
- The youth is placed in an out-of-home placement, including, but not limited to, a hospital, skilled nursing facility, psychiatric residential treatment facility, institutional setting (such as DJJ), or therapeutic group home and will not be ready for discharge to a family home environment or a community setting with community-based support within 31 consecutive calendar days;
- Required consent for treatment is withdrawn; or
- There is a lapse in services greater than 31 consecutive calendar days.

Provider Qualifications, Staff Requirements, and Training Requirements

MST teams must be licensed through MST Services, Inc. and maintain active program certification. This means that all providers operating within an MST team must complete training as outlined and required by the model and maintain the standards of MST service provision with fidelity to the model. MST providers should not have split caseloads when working for an organization (i.e., they should be dedicated to provision of MST).

The MST team composition includes an MST supervisor and a minimum of two to a maximum of four MST therapists. Both team supervisor and team therapists participate in a rotating schedule of coverage so that an MST-trained team member is available 24-hours per day, seven days per week, year-round for crises.

MST supervisors must be LPHAs, which requires the following: A master's degree in psychology, social work, counseling, or a related field; independent licensure in their identified discipline (i.e., licensed psychologist, LISW-CP, LPC, LMFT, or LAC). MST supervisors must attend additional training on MST supervision before managing an MST team.

MST therapists must have a master's degree in psychology, social work, counseling, or a related field, or a bachelor's degree in psychology, social work, counseling, or a related field plus two years of experience working with families.

NOTE: *The term “therapist” is in keeping with the nomenclature of this evidenced-based practice. Where providers are intended to be LPHAs who provide counseling and psychotherapy under the respective scope of practice defined by their SC license, it is so designated.*

A full-time MST supervisor may supervise:

- A single MST Team; or
- Two MST teams in the same geographical area; or
- One MST team and provide MST services to one or two youth (exceptions may be made during times of staff transition within the team, which may require the supervisor to take on more than two cases; any additional cases assigned to the supervisor must be in accordance with the MST consultant's guidance and approval).

An MST therapist maintains an average caseload of four to six youth. MST therapists provide direct intervention and also arrange, coordinate, and monitor services on behalf of the youth.

The MST model requires that all MST team members participate in weekly MST-specific group supervision sessions facilitated by the MST supervisor per MST model standards. MST team members also must participate in weekly MST-specific telephone consultations provided by MST Services, Inc., or a licensed MST Network Partner training organization (which can be found on the MST Services, Inc website at <https://www.mstservices.com/>), with no more than six weeks per year without consultation (i.e., due to the occurrence of quarterly trainings and/or holidays, etc.).

MST therapists and MST supervisors must attend all required training. This training will include both pre-service and ongoing in-service training and consultation. Training and consultation for clinical staff shall be provided in three ways:

1. MST Orientation and Initial Training-- Intensive orientation training through MST Services, Inc. is required for all staff who will engage in treatment and/or clinical supervision of MST cases. This includes 20 hours of eLearning and two days of in-person training sessions.
2. All MST staff must attend one and one-half (1½) day booster sessions on a quarterly basis.

3. Treatment teams and their supervisors must participate in weekly telephone consultation provided by trained MST consultants. The objectives of MST orientation and initial training are to:

- Familiarize therapists with the theoretical, empirical, and clinical paradigms underlying the MST model and help them begin to incorporate those paradigms into their work.
- Familiarize therapists with the scope, correlates, and causes of serious behavior problems addressed by MST.
- Describe the theoretical and empirical basis for MST.
- Describe common family, peer, school, individual, and social support assessment and intervention strategies used in MST.
- Teach therapists to conceptualize cases and interventions in terms of the MST principles.
- Teach therapists to use the Do-Loop to conceptualize cases and design and implement interventions.
- Describe strategies MST teams use to build strong, collaborative relationships with stakeholder agencies in the community.
- Describe MST therapists' role in continuous quality improvement.
- Provide therapists with opportunities to practice using MST assessment strategies and interventions.

The multi-media approach to training includes didactic and experiential components. The participants are required to practice the MST approach through critical analysis, problem solving exercises, and role-plays. It is expected that participants will have read the MST treatment manual (textbook) prior to the initial training.

Fidelity Measures

Fidelity measures for MST are required components for all MST teams. Quality assurance support activities focus on monitoring and enhancing program outcomes through increasing therapist adherence to the MST treatment model. The ***MST Therapist Adherence Measure (TAM)*** and the ***MST Supervisor Adherence Measure (SAM)*** have been validated in the research on MST with antisocial and delinquent youth and are now being implemented by all licensed MST programs. Both measures are available through the MST Institute at:

<https://www.msti.org/mstinstitute/index.html>.

An overview of the MST Quality Assurance Program can be found at:

https://www.msti.org/mstinstitute/ga_program/

Required Quality Assurance Program components include the following:

- Register the program and all staff at the MST Institute (<https://www.msti.org>).
- Register each family engaged in MST at the MST Institute secure website using HIPPA approved procedures.
- Complete discharge summaries on all families and close out each discharged family on the MST Institute secure website.
- Complete yearly evaluations of team members to assess knowledge of and compliance with MST philosophy and intervention strategies. MST adherence data may be used as part of this team member evaluation.
- Monitor the adherence of program staff to the MST model by collecting the MST Therapist Adherence Measure-Revised (TAM-R) data as specified by MST Services. In addition, MST therapists are required to complete the MST Supervisory adherence Measure (SAM) at least every other month by logging on directly to the MST Institute website.

The ***Therapist Adherence Measure Revised (TAM-R)*** is a 28-item measure that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. The adherence scale was originally developed as part of a clinical trial on the effectiveness of MST. The measure proved to have significant value in measuring an MST therapist's adherence to MST and in predicting outcomes for families who received treatment. More information is available at:

https://www.msti.org/mstinstitute/qa_program/tam.html

The ***Supervisor Adherence Measure (SAM)*** is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists. The measure is based on the principles of MST and the model of supervision presented in the MST Supervisory Manual. More information is available at:

https://www.msti.org/mstinstitute/qa_program/sam.html

Billing Guidance

MST is provided under the CMS-approved procedure code for Multisystemic Therapy (H2033). MST includes a bundled service rate, which takes into account indirect costs such as meetings, travel time, training, supervision, documentation, fidelity reviews, etc., in the development of reimbursement. Based on what constitutes a therapeutic “dose” of MST and the expected course of treatment as per the MST model, service units are structured as a per diem, organized in the following way to offer flexibility in service provision:

- ***Providers are allowed 48 per diems over a period of 120 days (4 months);***

- These units may be used with any frequency to meet the intensity level required based on the youth/family's needs.
- Only one per diem per youth/family may be billed per day.
- The initial 48 per diems do not require prior authorization.
- Additional per diems may be approved if substantiated by the appropriate documentation (see *Continued Stay Criteria*, above).

Face-to-face or telephonic service time between the provider and youth or family may be billed when geared towards specific goals on the MST Service Plan; the youth is not required to be present, and in fact, most sessions will take place between the caregiver(s) and the provider.

Face-to-Face or telephonic service time between the provider and collateral contacts are billable to Medicaid using procedure code H2033 under the following conditions:

- Contacts involve other professionals (i.e., school personnel, probation officers, or other child-serving agencies) with a vested interest/relationship with the child receiving treatment.
- Contacts are based on goals from the youth's plan of care.
- The youth or family are present during or engaged in the contact.

Service Limitations and Exclusions

MST **may not** be authorized concurrently with the following services*:

- Group or Family Therapy
- Any other type of Intensive In-Home Services
- Outpatient or inpatient substance use disorder services, *except for opioid use disorders*
- Partial Hospitalization or Intensive Outpatient

*Other family members may be receiving one of the above services and still participate in MST as appropriate for the benefit of the youth receiving MST services.

No other RBHS services may be provided during the course of MST with the exception of the following:

- Psychological evaluation/testing
- Psychiatric evaluation and management

- Medication management
- Individual therapy (**ONLY** when indicated and medically necessary)+

+If the youth continues to meet with an existing outpatient therapy provider for specific treatment needs outside the scope of MST (for ex., is receiving Trauma-Focused Cognitive Behavioral Therapy or another EBP for trauma), the MST provider must coordinate the treatment plan with the outpatient provider. The MST Supervisor and/or MST Consultant must be aware of and approve the proposed split in services when additional therapeutic adjuncts are necessary and documentation describing this need should be included in the youth's individual file.