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REHABILITATIVE SERVICES OVERVIEW

Effective July 1, 2010, the South Carolina State Medicaid Plan was amended to allow an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d). Rehabilitative Services are medical or remedial services that have been recommended by a physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South Carolina State Law and as further determined by the 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.

The purpose of this manual is to provide pertinent information to Rehabilitative Behavioral Health Services (RBHS) providers for successful participation in the South Carolina Medicaid Program. This manual provides a comprehensive overview of the program, standards, policies and procedures for Medicaid compliance. This provider manual only addresses the policy for state agencies and private organizations as service providers. All providers, unless otherwise specified, are required to meet all requirements as set forth in this policy manual for the delivery of services and all other applicable state and federal laws. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of “evidence-based” practices and “emerging best practices” 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.

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REHABILITATIVE SERVICES OVERVIEW

Rehabilitative Services Overview (Cont'd.)

The National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/) and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

Rehabilitative Behavioral Health Services are available to all Medicaid beneficiaries diagnosed with mental health and/or substance use disorder(s), 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 Rehabilitative Behavioral Health Services 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.

REHABILITATIVE SERVICES

The following must be rendered in accordance with this policy:

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

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REHABILITATIVE SERVICES OVERVIEW

REHABILITATIVE SERVICES (CONT'D.)

- Family Support
- Therapeutic Child Care
- Community Integration Services
- Peer Support Services (DMH and DAODAS providers only)
- Substance Abuse Treatment Services (DAODAS providers only)

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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)

Effective November 1, 2015, all private RBHS providers must meet the following additional requirements to be considered fully accredited:

- Each 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.
- All locations owned and/or operated by private RBHS providers in South Carolina and/or the SC 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 payable and may result in termination.

Private RBHS providers enrolled prior to November 1, 2015 in the South Carolina Medicaid Program must maintain compliance with previous accreditation requirements and shall have until October 31, 2016 to provide evidence that the provider meets the above additional accreditation requirements. 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 shall submit evidence of meeting additional requirements to the Division of Behavioral Health on the *Accreditation for Rehabilitative Behavioral Health Services* form, located

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ACCREDITATION (CONT'D.)

in the Forms section of the manual. The form can be submitted via the following options:

Email: behavioralhealth002@scdhhs.gov
Fax: (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 negative change in accreditation status must be reported to Division of Behavioral Health in writing via the *Program Changes for Rehabilitative Behavioral Health Services* form (located in the Forms section of the manual) within five (5) 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 negative change in accreditation status;
- The steps and timeframes, if applicable, the accreditation organization is requiring from the providers to maintain accreditation.

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

If at any time a provider loses accreditation, an automatic termination of enrollment shall 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.

ENROLLMENT APPLICATION FOR ORGANIZATIONS

To participate in the South Carolina Medicaid Program, applicants must meet, and shall maintain compliance with during enrollment, all applicable federal and state requirements, all requirements outlined in the SCDHHS Provider Enrollment manual, and this RBHS policy:

- Complete the SCDHHS online Enrollment Application and pay the required fee, if applicable

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PROVIDER QUALIFICATIONS

ENROLLMENT APPLICATION FOR ORGANIZATIONS (CONT'D.)

- New applicants and all enrolled providers will be subject to pre-enrollment and post-enrollment site visits.

  At any time a provider changes locations within South Carolina or the SCMSA, a new site visit must be conducted before Medicaid services can commence at the new location.
- Evidence of current and valid accreditation must be submitted: A copy of the accreditation certificate, the accreditation letter identifying the specific services and sites that have been accredited, and the most recent accreditation survey report.
- LPHAs and/or medical staff must be licensed by the State where the service(s) is rendered to beneficiaries.
- 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.
- 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.

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ENROLLMENT APPLICATION FOR ORGANIZATIONS (CONT'D.)

- 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 land-line 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.

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.

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

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PROVIDER QUALIFICATIONS

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 continuously 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 SC border) and be in compliance with Federal and State requirements (*e.g.,* if applicable, be licensed by the SC Department of Social Services). 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 SC 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 USDHHS assume no responsibility with respect to accidents, illness or claims arising out of any activity performed by any State or private organization. The organization shall take necessary steps to insure or protect its recipient, itself and its personnel. The provider agrees to comply with all applicable local, staff, and federal occupational and safety acts, rules and regulations.
- Providers must have cost information available for review by SCDHHS upon request.
- All providers must demonstrate evidence of having the following required policies and procedures in place by January 1, 2016, and these shall be maintained during enrollment as a provider:

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PROVIDER QUALIFICATIONS

BUSINESS REQUIREMENTS (CONT'D.)

- Confidentiality and protection of health information
- Record security and maintenance
- Record retention
- Use of electronic signatures if provider uses an Electronic Health Record (EHR) or Electronic Medical Record (EMR)
- Release of information
- Consent for treatment
- 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 (DRA) of 2005, Employee Education about False Claims Recovery, and provide Federal False Claims Act education to its employees.

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PROVIDER QUALIFICATIONS

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.

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.

- Effective November 1, 2015 for private RBHS providers, all Clinical Directors must be South Carolina Licensed Practitioners of the Healing Arts. A master's level clinical professional who is serving as a Clinical Director without a South Carolina license on November 1, 2015, may continue to serve as Clinical Director until October 31, 2017, provided that he or she can demonstrate that he or she is making a bona fide effort to become a South Carolina LPHA. Minimum evidence of effort includes a copy of the supervision contract and application packet with the appropriate licensure board.

An organization must include, at minimum, an Administrator, a Clinical Director and two other professional or paraprofessional staff to provide direct services.

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PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

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 with official raised seal from the education institution; copies are not acceptable.

  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
- Letters or other documentation to verify previous employment or volunteer work that documents work experience with the population to be served as per the required Staff Qualifications later in this manual

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PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

- 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

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MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

- 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/bureau-compliance-and-performance-review
  - Office of the Inspector General (OIG) 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

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PROVIDER QUALIFICATIONS

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

- 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/FINALNurseAide Registries 2014 2015 MC 11.4.14.pdf.

LICENSED PROFESSIONALS

All providers who enroll with South Carolina Medicaid to provide services in a category that require a professional license **must be licensed to practice in the State of South Carolina** and must not exceed their licensed scope of practice under state law.

When licensure is required for any service and the service is rendered outside of South Carolina, but within the SCMSA, the professional must be licensed in the respective state where the professional renders services to Medicaid beneficiaries. Professionals rendering services outside of South Carolina must not exceed the licensed scope of practice granted under that state's laws.

Providers who enroll as a physician or LPHA must be able to 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.

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 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.

Specific training requirements are outlined later in this section.

Training records must indicate:

- The name of the training course;

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TRAINING (CONT'D.)

- 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.

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 Provider Service Center (PSC) within thirty (30) days of the change. This updated information m*ust 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 ten (10) days of receipt. Please refer to the SCDHHS Provider Enrollment 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 Rehabilitative Behavioral Health Services* form (located in the Forms section of the manual) within ten (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: behavioralhealth002@scdhhs.gov
Fax: (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

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

REPORTING PROGRAM CHANGES (CONT'D.)

- 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 Provider Service Center (PSC). Refer to the SCDHHS website for the Disclosure Form. Questions concerning the W-9 form should be directed to Provider Service Center.

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 South Carolina Department of Social Services (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.

PROVIDER TERMINATION

Providers may terminate enrollment upon providing SCDHHS with thirty (30) days written notice of termination. SCDHHS may terminate enrollment for good cause upon providing thirty (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 thirty (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

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PROVIDER QUALIFICATIONS

PROVIDER TERMINATION (CONT'D.)

Division of Behavioral Health via the *Voluntary Termination Notification for Rehabilitative Behavioral Health Services* form thirty (30) days prior to closing business or ending any discrete service. The form can be submitted via the following options:

Encrypted Email: behavioralhealth002@scdhhs.gov
Fax: (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.

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PROVIDER TERMINATION (CONT'D.)

- 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 (5) 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 (5) 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 (5) year period, whichever is later.

THIRD PARTY LIABILITY

Third-party Liability (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. For additional information, please refer to Third-party Liability Supplement.

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.

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MAINTENANCE OF FISCAL AND MEDICAL RECORDS (CONT'D.)

All fiscal and medical records shall be retained for a period of five (5) 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 (5) 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 (5) year period, whichever is later.

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.

MANAGED CARE ORGANIZATION

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

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MANAGED CARE ORGANIZATION (CONT'D.)

The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at https://msp.scdhhs.gov/managedcare/ for additional information regarding MCO coverage.

QUALITY IMPROVEMENT AGENT (QIO) AUTHORIZATION

This section applies to RBHS providers required to obtain approval through the SCDHHS designated Quality Improvement Organization (QIO) (KEPRO). Providers must follow the prior authorization (PA) guidelines as outlined by SCDHHS before billing Medicaid. All services must be determined medically necessary as approved by the QIO.

The PA request form can be found on the QIO web portal at http://scdhhs.kepro.com. 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.

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ELIGIBILITY FOR REHABILITATIVE SERVICES

The determination of eligibility for Rehabilitative Services should include a system-wide assessment and/or an intake process. This requires that specific information be gathered consistently regardless of the assessment tool being used. Medicaid-eligible beneficiaries may receive services when there is a confirmed psychiatric diagnosis from the current edition of the DSM or the ICD. This excludes irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders unless they co-occur with a serious behavioral health disorder that meets current edition DSM criteria. Developmental disabilities should not be confused with behavioral health disorders. Persons with a developmental disability should be carefully assessed to determine if there are co-occurring behavioral problems and if those problems could be addressed with Rehabilitative Services. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of services.

For dates of service on or after **September 30, 2015,** the use of V-codes is allowed under certain circumstances, but in general is considered temporary. Please see additional guidance regarding V-Codes and Medical Necessity for Child and Adolescent Community Support Services later in the manual.

For dates of service on or after **October 1, 2015,** the use of Z-codes is allowed but is considered temporary and may not be used for longer than six-month duration. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. Z-codes may not be used for ages 7 and up for longer than six-month duration. The use of Z-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

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ELIGIBILITY FOR REHABILITATIVE SERVICES

MEDICAL NECESSITY

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

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services. An LPHA must certify that the beneficiary meets the medical necessity criteria for each service. Please refer to the "Documenting Medical Necessity" table for additional information. LPHAs authorized to confirm medical necessity can be found under "Licensed Practitioners of the Healing Arts (LPHAs)."

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

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 a 12 or more months, the diagnosis should be confirmed immediately.)
- Made by an LPHA enrolled in the SC Medicaid Program

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ELIGIBILITY FOR REHABILITATIVE SERVICES

DOCUMENTING MEDICAL NECESSITY

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

The DA must be completed prior to any RBHS services being rendered. If a placement is necessary for Therapeutic Foster Care (TFC), the DA must be completed within 14 days of placement.

The diagnostic assessment must document the presence of a serious behavioral health disorder from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria. The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended.

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

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

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

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.

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.

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ELIGIBILITY FOR REHABILITATIVE SERVICES

Documenting Medical Necessity:

- Medical Necessity must be documented on a Diagnostic Assessment (DA) administered by an LPHA qualified to conduct this service in accordance with their respective licensing body. 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 rendering any RBHS services, unless a therapeutic foster care placement is required.
- The LPHA's name, credentials, signature, and date of signature must be listed on the document to confirm medical necessity.
- The DA must document a serious mental health and/or substance use disorder or serious emotional disturbance 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 the 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 Diagnostic Assessment Service description located later in this manual.
- Medical Necessity must be confirmed annually via a Diagnostic Assessment if there is clinical need for continued 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.

REFERRAL PROCESS FOR RBHS

Referrals may be made among and between private providers enrolled in the SC 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.

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

Licensed Practitioners of the Healing Arts (LPHAs) must be enrolled in the SC 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

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Who Can Confirm Medical Necessity-Licensed Practitioners of the Healing Arts (LPHAs) (Cont'd.)

- Licensed Advanced Practice Registered Nurse
- Licensed Independent Social Worker-Clinical Practice
- Licensed Physician Assistant
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

When medical necessity for services is required to be established and/or confirmed by an independently licensed LPHA, 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 SC Medicaid Service Area.

A Licensed Master Social Worker is considered a Licensed Practitioner of the Healing Arts (LPHA) in South Carolina, and can establish and/or confirm medical necessity under a State Agency.

For private providers, a Licensed Master Social Worker must have the DA co-signed by an independently Licensed Practitioner of the Healing Arts.

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 SC Medicaid Program. The professional must be licensed at the independent level in each respective state where the professional renders services within the SC Medicaid Service Area. The following professionals can establish and/or confirm medical necessity within the state listed:

North Carolina	Georgia
• Medical Doctor (MD) • Doctor of Osteopathic Medicine (DO) • Nurse Practitioner (NP) • Family Nurse Practitioner (FNP) • Psychologist • Physician's Assistant (PA) • Physician's Assistant- Certified (PA-C) • Licensed Professional Counselor (LPC)	• Medical Doctor (MD) • Doctor of Osteopathic Medicine (DO) • Advanced Practice Registered Nurse- Nurse Practitioner (APRN-NP) • Advanced Practice Registered Nurse- Clinical Nurse Specialist (APRN-CNS) • Advanced Practice Registered Nurse- Clinical Nurse Specialist/Psychiatric Mental Health

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• Licensed Marriage and Family Therapist (LMFT) • Licensed Clinical Social Worker (LCSW)	(APRN- CNS-PMH) • Psychologist • Physician's Assistant (PA) • Licensed Professional Counselor (LPC) • Licensed Marriage and Family Therapist (LMFT) • Licensed Clinical Social Worker (LCSW)

RETROACTIVE COVERAGE

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

UTILIZATION MANAGEMENT FOR PRIVATE PROVIDERS

The rendering of Rehabilitative Behavioral Health Services 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).

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 SC Medicaid Program policy requirements.

Prior authorization is required for all RBHS Community Support Services rendered by private providers.

Community Support Services 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 South Carolina Department of Social Services.

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 Rehabilitative Behavioral Health Services Referral Form, • the QIO prior authorization request form, and	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: • the most recent 90-day progress summary, • A current IPOC, • the QIO prior authorization request form,

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REFERRAL SOURCE: STATE AGENCY	
Initial Prior Authorization	**Continued Service Prior Authorization**
• supporting documentation, as applicable.	• Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form, and • supporting documentation, as applicable. • *Note, if beneficiary needs continued services after 365 days, an updated diagnostic assessment is required to be submitted to the QIO.
REFERRAL SOURCE: SELF OR OTHER ENTITY--DOCUMENTATION FOR PRIOR AUTHORIZATION	
Initial Prior Authorization	**Continued Service Authorization**
For the initial medical prior authorization 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: • the QIO prior authorization request form, • the Diagnostic Assessment (DA), • For beneficiaries 0-21, the age-appropriate assessment tool: o Parenting Stress Index (PSI) (birth to 1.5 years), or o The Child Behavior Check List (1.5 -5 years), or o CALOCUS administered by a qualified clinical professional with a CALOCUS-SCDHHS provider certification (ages 6-21) • For beneficiaries 15 years of age and under: Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form and • supporting documentation, as applicable.	For the continued service prior 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 QIO prior authorization request form • the most recent 90-day progress summary, • a current IPOC, • For beneficiaries 15 years of age and under: Parent/Caregiver/Guardian Agreement to Participate in Community Support Services form, and • supporting documentation, as applicable. • *Note, if beneficiary needs continued services after 365 days, an updated diagnostic assessment is required to be submitted to the QIO.

UTILIZATION MANAGEMENT FOR PRIVATE PROVIDERS

Requests for each continued service prior authorized period must be submitted to the QIO, ten (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 (5) business days of receipt, pending complete submission of all required information.

When Community Support Service(s) are added to a

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UTILIZATION MANAGEMENT FOR PRIVATE PROVIDERS (CONT'D.)

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 Diagnostic Assessment (DA),
- the age-appropriate assessment tool, administered and scored by a qualified clinician:
  - Parenting Stress Index (PSI) (birth to 1.5 years), or
  - The Child Behavior Check List (1.5 -5 years), or
  - CALOCUS administered by a qualified clinical professional with a CALOCUS-SCDHHS provider certification (ages 6-21),
- the QIO prior authorization request form,
- the Parent/Caregiver/Guardian Agreement to Participate in Community Support Services (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 Community Support Service, 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.

FEE-FOR-SERVICE SERVICE LIMIT EXCEPTION 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 South Carolina Department of Health and Human Services (SCDHHS) for approval. The table below identifies the required documentation for these requests.

Required Documentation for Requests
• Most recent Diagnostic Assessment • IPOC

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- The most recent Service Plan Development (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 Community Support Services form, as applicable
- QIO approval letter
- Fax Cover Sheet for RBHS Exceptions (if applicable)
- RBHS Exception Request Form

FEE-FOR-SERVICE SERVICE LIMIT EXCEPTION PROCESS (CONT'D.)

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 803-255-8204
  - A fax cover sheet must be included with the fax
- **Encrypted** email to behavioralhealth002@scdhhs.gov

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

STAFF QUALIFICATIONS

All providers of Rehabilitative Behavioral Health Services must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation. Professionals, who have received appropriate education, experience, have passed prerequisite examinations as required by the applicable state laws and licensing/certification board and additional requirements as may be further established by SCDHHS, may qualify to provide Rehabilitative Behavioral Health Services. **The presence of licensure/certification means the established licensing board in accordance with SC Code of Laws,**

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STAFF QUALIFICATIONS (CONT'D.)

or the state in which the individual is practicing, has granted the authorization to practice in the state. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State of South Carolina, or the state in which licensed clinical professionals render services, and must be operating within their scope of practice.

Medicaid Rehabilitative Staff Qualifications

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 or osteopathy and has completed a residency in psychiatry	Licensed by SC Board of Medical Examiners	40-47-5 et seq.	All Services, except PSS
Physician	Doctor of medicine or osteopathy	Licensed by SC Board of Medical Examiners	40-47-5 et seq.	All Services, except PSS, PT
Psychologist	Doctoral degree in psychology	Licensed by SC Board of Psychology Examiners	40-55-20 et seq.	All Services except PSS
Physician Assistant (PA)	Completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs	Licensed by SC Board of Medical Examiners	40-47-905 et seq.	All Services, except PSS, PT
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 (NABP)	Licensed by SC Board of Pharmacy	40-43-10 et seq.	MM
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 SC 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
Licensed Psycho-Educational Specialist	Master's degree plus 30 hours of psychopathology class, successfully complete the ETS School Psychology exam (PRAXIS), and be licensed	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-75-510 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC,ST, PTR, ADA, ADS,CIS, TCC

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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				
Licensed Independent Social Worker – Clinical Practice (LISW-CP)	Master's or doctoral degree from a Board-approved social work program	Licensed by SC Board of Social Work Examiners	40-63-5 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC,ST, PTR, ADA, ADS, CIS, TCC
Licensed Masters 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 SC Board of Social Work Examiners	40-63-5 et seq.	B-Mod, BHS, CM, DA**, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Licensed Marriage and Family Therapist (LMFT)	A minimum of 48 graduate semester hours or 72 quarter hours in marriage and family psychotherapy along with an earned master's degree, specialist's degree, or doctoral degree. Each course must be a minimum of at least a 3 semester hour graduate level course with a minimum of 45 classroom hours or 4.5 quarter hours; one course cannot be used to satisfy two different categories.	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-75-5 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
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, one of its transferring regional associations, 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 SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-75-5 et seq.	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC,ST, PTR, ADA, ADS, CIS, TCC

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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, PTR, ADA, ADS, CIS, TCC
Certified Substance Abuse Professional	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	SC 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, PTR, ADA, ADS, CIS, TCC
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, PTR, ADA, ADS, CIS, TCC
Qualified Mental Health Professional (QMHP)	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, working for a South Carolina State Agency		40-75-290	B-Mod, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SAC, ST, PTR, ADA, ADS, CIS, TCC
Mental Health Professional (MHP)	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, PTR, ADA, ADS, CIS, TCC

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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				
Substance Abuse Professional (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 SCAADAC credentialed or be certified by SCAADAC	SC Association of Alcoholism and Drug Abuse Counselors Certification Commission	40-75-300 et seq.	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), CIS, TCC
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 SC Board of Social Work Examiners	40-63-5 et seq.	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, SPD, CIS, TCC
Behavior Analyst	A board certified associate behavior analyst must have at least a bachelor's degree, have 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's degree in nursing from a Board- approved nursing education program and one year of experience working with the population to be served	Licensed by SC Board of Nursing	40-33-10 et seq.	B-Mod, FS, MM, PRS, MA, ST, ADA, ADS, VI,CIS, TCC
Licensed Practical Nurse (LPN)	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 SC Board of Nursing	40-33-10 et seq.	MM, MA, ADN, ADS, VI
PARAPROFESSIONALS				

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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				
Child Service Professional	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 filed and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment	None required	N/A	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD), TCC,CIS
PARAPROFESSIONALS (PRIVATE RBHS PROVIDERS DIRECTLY SERVING CHILDREN AND ADOLESCENTS IN THERAPEUTIC FOSTER CARE PLACEMENT)				
Child Service Professional	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 filed and has a minimum of 45 documented training hours related to child development and children's mental health issues and treatment	None required	N/A	B-Mod, BHS, CM, FS, PRS, SAC, ST, ADA, ADS, (Assist with developing the SPD),TCC, CIS
Mental Health Specialist	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 30 hour training and certification program		N/A	PRS, B-Mod, FS
PARAPROFESSIONALS (DAODAS ONLY)				
Substance Abuse Specialist	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		N/A	PRS, B-Mod, FS, ST
Peer Support Specialist	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.	Certification as a Peer Support Specialist	N/A	PSS

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

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ELIGIBILITY FOR REHABILITATIVE SERVICES

**As of April 1, 2016, private service providers must be licensed practitioners of the healing arts in order to conduct a Diagnostic Assessment. LMSWs must have DA's cosigned by independent LPHAs.

SERVICE KEY					
Service	**Abbr.**	**Service**	**Abbr.**	**Service**	**Abbr.**
Alcohol and Drug Assessment *	ADA	Family Psychotherapy	FP	Psychosocial Rehabilitation Service	PRS
Alcohol and Drug Nursing Assessment*	ADN	Group Psychotherapy	GP	Psychological Testing and Evaluation	PTE
Alcohol and Drug Screening *	ADS	Individual Psychotherapy	IP	Psychological Testing & Reporting *	PTR
Behavior Modification	B-Mod	Vivitrol Injection*	VI	Service Plan Development	SPD
Behavioral Health Screening	BHS	Medication Administration *	MA	Skills Training and Development *	ST
Crisis Management	CM	Medication Management	MM	Alcohol and Drug Substance Abuse Counseling *	SAC
Diagnostic Assessment	DA	Medical Evaluation and Management*	E&M	Multiple Family Group Psychotherapy	MFGP
Family Support	FS	Peer Support Service **	PSS	Community Integration Services	CIS
Therapeutic Child Care	TCC				

***Service provided by DAODAS only.**

****Services provided only by DMH and DAODAS providers.**

STAFF QUALIFICATIONS (CONT'D.)

Please refer to the Core and Community Support Services 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.

STAFF MONITORING/ SUPERVISION STAFF

Rehabilitative Behavioral Health Services 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.

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.

Substance Abuse professionals who are in the process of becoming credentialed must be supervised by a certified substance abuse professional or an LPHA.

Licensed and/or master's level clinical professionals have the responsibility of planning and guiding the delivery of

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

STAFF MONITORING/ SUPERVISION STAFF (CONT'D.)

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 expected to operate within current best practices to ensure competence and quality performance of staff. Training is essential to the development of a competent workforce capable of providing quality Rehabilitative Behavioral Health Services. Training provides the opportunity to respond to and strengthen the individual needs and skills of employees, subsequently strengthening and supporting the individual needs and skills of beneficiaries served. The following table outlines the training requirements for staff of RBHS:

Rehabilitative Behavioral Health Service Trainings			
Training:	**Orientation**	**Core Services**	**Community Support Services**
Timeframe to Complete:	Prior to rendering any services	Within first 60 days of hire	Within first 60 days of hire

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ELIGIBILITY FOR REHABILITATIVE SERVICES

Rehabilitative Behavioral Health Service Trainings			
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, and FS)
Minimum # of Hours Required	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**
Required Material to be Covered	• 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 *Additional information provided below	• Crisis Response and Intervention • IPOC Development • Person Centered Values, Principles, and Approaches • Assessments	• 8 hours minimum, covering the following topics: o Crisis Response and Intervention o IPOC Development o Person Centered Values, Principles, and Approaches o Childhood/Adolescent Development (if serving) • 3 hours minimum for each CSS Service Specific Training, covering the following topics: o Purpose and Service Description o Medical Necessity criteria for all populations served o Staff Qualifications o Staff-to-Beneficiary Ratio o Billing Frequency o Billable Place of Service o Non-Billable Medicaid Activities o Documentation Requirements
Minimum # of Hours Required	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**	**Topics/Areas that must be covered**
			o Modalities o Interventions Example: Staff A renders both FS and B-Mod to beneficiaries. Staff A must have 3 hours of FS training and 3 hours of B-Mod training Interventions

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)

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Rehabilitative Behavioral Health Service Trainings
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84) - The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36) - The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91) - Appeal - Freedom of Choice **Prohibition of Abuse, Neglect, & Exploitation** Focuses on mandated reporting, the provider's reporting policy, requirements for reporting abuse, neglect, exploitation, and disciplinary actions (internally and lawfully) which may be taken as a result of failure to report or follow policy and procedures. **Health & Safety/ Emergency Preparedness** Focuses on procedures detailing actions to be taken in the event or occurrence of a natural disaster (*e.g.*, tornado, hurricane, flood, earthquake, ice storm, snow storm, and etc.) and/or violent or other threatening situation (*e.g.*, explosion, gas leak, biochemical threats, acts of terrorism, and use of weapons, and etc.).

STAFF-TO-BENEFICIARY RATIO

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 subject to recoupment. **The ratio count applies to all participants receiving 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 a list of beneficiaries and individuals present in the group and the staff person(s) responsible for service delivery. This documentation must be available upon request.

EMERGENCY SAFETY INTERVENTION (ESI)

The Emergency Safety Intervention (ESI) policy applies to any community-based provider that has policies

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

EMERGENCY SAFETY INTERVENTION (ESI) (CONT'D.)

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, go to the *Project Rest Manual of Recommended Practice*, available at http://www.frcdsn.org/rest.html.
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion or restraints are being used that adheres to all state licensing laws and regulations (including all reporting requirements).

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

COORDINATION OF CARE

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

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

COORDINATION OF CARE

COORDINATION OF CARE (CONT'D.)

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.

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.

OUT-OF-HOME PLACEMENT

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

Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive a per diem payment that is considered all-inclusive. Rehabilitative Behavioral Health Services provided to beneficiaries in these settings are not Medicaid reimbursable.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

All Rehabilitative Behavioral Health Services (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. 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 Diagnostic Assessment(s) and other assessments, as applicable
- Assessment tool(s), administered and scored by a qualified clinician, as applicable
    - Parenting Stress Index (PSI) (birth to 1.5 years), or
    - The Child Behavior Check List (1.5 -5 years), or
    - CALOCUS administered by a qualified clinical professional with a CALOCUS-SCDHHS provider certification (ages 6-21)

      (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 Community Support Services form, as applicable

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

DOCUMENTATION REQUIREMENTS (CONT'D.)

- Signed, credentialed or functional titled, and dated IPOCs — initial, reviews, and reformulations
- Behavior Modification Plan (BMP), as applicable
- Signed, credentialed or functional titled, and dated 90-day Progress Summaries
- Signed, credentialed or functional titled, and dated Clinical Service Notes (CSNs)
- RBHS 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.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CONSENT TO EXAMINATIONS AND TREATMENT (CONT'D.)

Consent forms are not necessary to conduct court ordered examinations. However, a copy of the court order must be kept in the clinical record.

CLINICAL SERVICE NOTES (CSNS)

The purpose of the Clinical Service Note (CSN) is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions, and any changes in medical, behavioral or psychiatric status.

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
- 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)

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CLINICAL SERVICE NOTES (CSNS) (CONT'D.)

- Location where the service was rendered (Refer to the Billable Code/Location of Service section 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 participants 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 functional 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 the 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:

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CLINICAL SERVICE NOTES (CSNS) (CONT'D.)

- 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 Non-Billable Medicaid Activities section of the manual for additional information)
- 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).

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.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

SERVICE UNIT CONTACT TIME (CONT'D.)

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

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.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

BILLABLE CODE/LOCATION OF SERVICE

See the "Billable Place of Service" heading for each service under "Program Services" in this section. The following list provides the codes most commonly used:

03 — School

11 — Clinician or Doctor's Office

12 — Home

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)

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.

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.*, Child 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 Section 1 of this manual for the use of electronic signatures and/or exceptions.)

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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.

RECORD RETENTION

Clinical records shall be retained for a period of five years. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five-year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the five-year period, whichever is later. In the event of an entity's closure, providers must notify SCDHHS regarding medical records.

Clinical records must be arranged in a logical order to

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

RECORD RETENTION (CONT'D.)

facilitate the review, copy, and audit of the clinical information and course of treatment. Clinical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1 of this manual. Questions regarding access to protected information should be referred to the PSC. Provider can also submit an online inquiry at http://www.scdhhs.gov/contact-us to request additional information.

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

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES

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

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

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (*e.g.*, GED, Adult Development), or tutorial services in relation to a defined education course
- Education interventions that do not include individual process interactions
- Services provided to teach academic subjects or as a substitute for educational personnel (*e.g.*, a teacher, teacher's aide, an academic tutor, etc.)
- Shadowing beneficiary in the classroom
- Assisting beneficiary with homework or other educational assignments
- Any child care services or other services provided as a substitute for the parent or other primary care taker responsible for the beneficiary
- When prior authorization is required, dates of services not covered in the range of the QIO approval letter
- Services not identified on the IPOC (excluding those not required to be listed on the IPOC per policy)
- Services provided to children, spouse, parents or siblings of the beneficiary under treatment, or others in the beneficiary's life, to address problems not directly related to the beneficiary's issues and not listed on the beneficiary's IPOC
- Any art, movement, dance or drama therapies
- Filing, mailing, and faxing of any reports to other entities or individuals on behalf of the beneficiary
- Medicaid eligibility determinations and re-determinations
- Medicaid intake processing
- Completion of and monitoring of prior authorization requests for Medicaid services
- Required Medicaid utilization review
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) administration

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- 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
- **S**taffing 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

COMPONENTS OF THE INDIVIDUAL PLAN OF CARE (IPOC)

Definition

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

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Definition (Cont'd.)

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

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC Documentation (Cont'd.)

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.

IPOC Components

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,

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC Components (Cont'd.)

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, Family Support, etc.)

Frequency of Services: The frequency must be listed on the IPOC for each service. Each service should be listed by its name or approved abbreviation with 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).

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC Components (Cont'd.)

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. If the beneficiary does not sign the plan of care or if it is not considered appropriate for the beneficiary to sign the plan of care, the reason must be documented on the IPOC.

Authorized Signature(s): An LPHA, master's level 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 diagnostic assessment.

Services Not Required on the IPOC

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

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

IPOC – CORE TREATMENT AND COMMUNITY SUPPORT SERVICES
DURATION • The initial IPOC must be completed, signed, titled, and signature dated by the LPHA or master's level qualified clinical professional within 30 calendar days of the Diagnostic Assessment. • 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 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.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

IPOC – CORE TREATMENT AND COMMUNITY SUPPORT SERVICES

- 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 participants within 10 business days.

SERVICE PLAN DEVELOPMENT (SPD) OF THE IPOC

Purpose

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

Service Description

Service Plan Development is interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop a plan of care based on the assessed needs, physical health, personal strengths, weaknesses, social history, support systems of the beneficiary and to establish treatment goals and treatment services to reach those goals.

The planning process should focus on the identification of the beneficiary's and his/or her family's needs, desired

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Service Description (Cont'd.)

goals and objectives. The beneficiary and clinical professional(s) or interdisciplinary team should identify the skills and abilities of the beneficiary that can help achieve their goals, identify areas in which the beneficiary needs assistance, support, and decide how the team of professionals can help meet those needs.

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

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

When there are multiple agencies or providers involved in serving the beneficiary, Service Plan Development 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 cannot sign the IPOC, the reason must be documented on the IPOC.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

SPD-Interdisciplinary Team — Conference with Client/Family (Cont'd.)

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 cannot sign the IPOC, the reason must be documented on the IPOC. The physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

Service Plan Development 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 cannot sign the IPOC, the reason must be documented on the IPOC.

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

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Service Documentation

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 substance use disorder, 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.

Medical Necessity Criteria

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

Staff Qualifications

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

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.

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

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Billing Frequency

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.

SPD codes 99366, 99367, and H0032 cannot be billed on the same date of service. Assessment codes cannot be billed on the same date of service as 99366 and 99367. The assessment must be completed prior to the development of the IPOC.

DAODAS providers should continue to only utilize H0032 for IPOC development for Medicaid Fee for Service Providers and those members enrolled directly with a managed care organization. The LBSW is not authorized to sign the IPOC.

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 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:

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

90-DAY PROGRESS SUMMARIES (CONT'D.)

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

DISCHARGE/TRANSITION CRITERIA

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

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

DISCHARGE/TRANSITION CRITERIA (CONT'D.)

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

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SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

SCREENING SERVICES

Behavioral Health Screening (BHS)

Purpose

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

Service Description

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

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI— Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

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

Screenings should focus on patterns of behavior and associated factors such as legal problems, mental health status, educational functioning, and living situation.

The beneficiary's awareness of the problem, feelings about his or her behavior, mental health or substance use and motivation for changing behaviors may also be integral parts of the screen.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Description (Cont'd.)

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.

Medical Necessity Criteria

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

Staff Qualifications

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.

Service Documentation

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's 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 clinical service notes.

Documentation must:

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

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.

Billing Frequency

BHS is billed in 15-minute units for a maximum of two units per day. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Billable Place of Service

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

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 90791 and/or H2000.

Diagnostic Assessment (DA) Services

Purpose

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

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

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

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

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

Assessments include clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Purpose (Cont'd.)

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.

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

Service Description

Psychiatric Diagnostic Assessment without Medical Services (Comprehensive Diagnostic Assessment) identify the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. The assessment must include a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records to obtain information necessary to establish or support a diagnosis. It also serves to drive the development or revision of the treatment plan and development of discharge criteria.

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

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

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Description (Cont'd.)

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

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Description (Cont'd.)

Psychiatric Diagnostic Assessment with Medical Services includes the components listed above as well as the medical components listed below.

Additional components of a Psychiatric Diagnostic Assessment with Medical Services include:

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

Mental Health Comprehensive Assessment - Follow-up

A Mental Health Comprehensive Assessment – Follow-up occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any significant changes in behavior and/or condition, and to monitor and ensure appropriateness of treatment. Follow up assessments may also be rendered to assess the beneficiary's progress, response to treatment, the need for continued treatment and establish medical necessity 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 CSN and comply with the service documentation requirements. The course of treatment and documentation in the IPOC must reflect these changes.

Mental Health Comprehensive Assessments must be conducted face-to-face with the beneficiary.

Medical Necessity Criteria

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

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Staff Qualifications

Diagnostic Assessment 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.

Service Documentation

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.

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.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Billing Frequency

The initial and follow-up diagnostic assessments are billed as an encounter. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

The initial assessment may be rendered once every six months.

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

Billable Place of Service

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

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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 assessment with medical cannot be rendered or billed on the same day as the assessment without medical.

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

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

CALOCUS ASSESSMENT — PRTF AND COMMUNITY SUPPORT SERVICES

South Carolina Department of Health and Human Services requires the use of the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized pre-admission criteria for all beneficiaries being considered for placement in a psychiatric residential treatment facility (PRTF) and/or RBHS Community Support Services. **The assessment must be a face-to-face assessment with the beneficiary.**

The Child and Adolescent Level of Care Utilization System (CALOCUS) links a clinical assessment with

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

CALOCUS ASSESSMENT — PRTF AND COMMUNITY SUPPORT SERVICES (CONT'D.)

standardized criteria that describes the level of intensity of services needed for a beneficiary. The CALOCUS rating can be done for any beneficiary in any setting, regardless of the diagnosis or service agency with which the beneficiary is involved.

CALOCUS must be administered by a Licensed Practitioner of the Healing Arts that has successfully completed training on CALOCUS and passed a competency test with prior written approval from SCDHHS. Master's level clinical staff with three years of experience working with beneficiaries and families that have successfully completed training on CALOCUS and passed a competency test may be eligible to administer CALOCUS, with prior written approval from SCDHHS.

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

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

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

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

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

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

Treatment and/or services are recommended based on the composite score of the dimensions and the corresponding

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

CALOCUS ASSESSMENT — PRTF AND COMMUNITY SUPPORT SERVICES (CONT'D.)

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

When CALOCUS score indicates a Level 4, 5, or 6, PRTF placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered.

For more detailed information regarding the CALOCUS screening and process, refer to the Psychiatric Hospital Manual.

Staff-to-Beneficiary Ratio

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

Billing Frequency

The CALOCUS assessments are billed as an encounter. One encounter can be reimbursed every six months. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

CALOCUS assessments must be administered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Billable Place of Service (Cont'd.)

Excluded settings include Psychiatric Residential Treatment Facilities (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).

Service Documentation

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 clinical service notes.

PSYCHOLOGICAL TESTING AND EVALUATION (PTE)

Psychological Testing and Evaluation 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.*, MMPI, Rorschach, and WAIS). Testing and evaluation must involve face-to-face interaction between 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.

Psychological testing and evaluation may be used for the purpose of diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning.

Prior to administering a battery of tests it is important for the evaluating psychologist to review relevant clinical information from the most recent Diagnostic Assessment

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

PSYCHOLOGICAL TESTING AND EVALUATION (PTE) (CONT'D.)

and/or medical, psychiatric, and educational evaluations. The psychologist must consider historical clinical information, identify specific referral questions to be addressed by the evaluation, and determine that the clinical questions cannot be addressed through a Diagnostic Interview with a skilled clinician.

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

Medical Necessity Criteria

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a mental health and/or substance use disorder(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). Information should be provided in the documentation to explain why a Diagnostic Assessment was inconclusive and why testing is needed to clarify the diagnosis.

Staff Qualifications

Psychological Testing and Evaluation must be provided by qualified Clinical Psychologists 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.

Service Documentation

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 Psychological testing and evaluation and/or make reference to the completed test. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Service Documentation (Cont'd.)

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.,* Minnesota Multiphasic Personality Inventory [MMPI]).
- Test results and interpretation
- Identify any recommendations or referrals based on test results
- The diagnoses code and the diagnosis
- Documentation must support the number of units billed

Staff-to-Beneficiary Ratio

Psychological Testing and Evaluation Services require one professional for each beneficiary.

Billing Frequency

Psychological Testing and Evaluation is billed as a 60 minute unit with a limit of ten units billed within a week and a limit of 20 units billed per year. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

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

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Special Restrictions Related to Other Services (Cont'd.)

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 Diagnostic Assessment must be completed before the Psychological testing and evaluation has been conducted.

The Psychological Testing and Evaluation and Diagnostic Assessment can be billed on the same day. The assessments must be billed separately.

Code	Assessment	Description	Modifier	Frequency
90791	Psychiatric Diagnostic Assessment without medical services - Initial (Comprehensive Diagnostic Assessment)	Licensed Psychologist Master's level staff	AH HO	1 encounter per 6 months
90792	Psychiatric Diagnostic Assessment with medical services - Initial	Specialty physician (Psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN)	AF AM SA	1 encounter per 6 months
H2000	Child and Adolescent Level of Care Utilization System (CALOCUS)	Licensed Psychologist Master's level	AH HO	1 encounter per 6 months
96101	Psychological Testing and Evaluation	Licensed Psychologist	AH	1 unit = 60 minutes 10 units per week 20 units per year
H0031	Mental Health Comprehensive Assessment – Follow-up	Licensed Psychologist Master's level	AH HO	1 encounter per day 12 encounters per year

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

PSYCHOTHERAPY

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

As of April 1, 2016, 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.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

PSYCHOTHERAPY (CONT'D.)

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 (SCLLR).

Individual Psychotherapy (IP)

Purpose

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.

Service Description

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.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(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.

Staff Qualifications

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.

Service Documentation

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 clinical service notes.

Billing Frequency

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. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

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

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), institutions of more than 16 beds, and recreational settings (a place primarily used for play and

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service (Cont'd.)

leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

None.

Group Psychotherapy (GP)

Purpose

Group Psychotherapy (GP) is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician. The 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.

Service Description

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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- 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 experiences
- Beneficiaries need to demonstrate a level of competency to function in a group.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(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.

Staff Qualifications

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.

Service Documentation

GP 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 clinical service notes.

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.

Billing Frequency

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. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service

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

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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

None.

Multiple Family Group Psychotherapy (MFGP)

Purpose

Multiple Family Group Psychotherapy 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.

Service Description

MFGP involves a small therapeutic group that is designed to produce behavioral change. The beneficiary must be a part of an active treatment plan and the goals of 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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

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

Beneficiaries who meet the following criteria may benefit from MFGP:

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

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of mental health and/or substance use disorder(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.

Staff Qualifications

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.

Service Documentation

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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Documentation (Cont'd.)

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 clinical service notes.

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.

Billing Frequency

MFGP 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. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

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

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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

None.

Family Psychotherapy (FP)

Purpose

The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his or her family unit. The therapist assists family members in developing a greater understanding of

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Purpose (Cont'd.)

the beneficiary's psychiatric and/or behavioral disorder and the appropriate treatment for this disorder, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction.

Service Description

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

FP 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 family support to help facilitate the beneficiary's improvement. The goal of FP is to get family members to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include, 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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)	for the beneficiary from mental illness and/or co-occurring substance use disorders.
Medical Necessity Criteria	Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(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.
Staff Qualifications	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.
Service Documentation	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 clinical service notes.
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 family psychotherapy.
Billing Frequency	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. See Section 4 of this manual for additional information regarding procedure codes and frequencies.
Billable Place of Service	Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service (Cont'd.)

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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)

Purpose

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.

Service Description

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

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

Crisis Management (CM) should therefore be immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual. **CM is not a scheduled service**.

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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- 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.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental health and/or substance use disorder(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.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Medical Necessity Criteria (Cont'd.)

Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning.

Staff Qualifications

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

Service Documentation

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 clinical service notes. 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 participants during the service
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis
- Content of the session, including safety risk assessment and safety planning
- Active participation and intervention of the staff
- Response of the beneficiary to the treatment
- Beneficiary's status at the end of the session
- A plan for what will be worked on with the beneficiary
- Resolution of the crisis

Staff-to-Beneficiary Ratio

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

Billing Frequency

CM is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service

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

Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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

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

MEDICATION MANAGEMENT (MM)

Purpose

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.

Service Description

Medication Management (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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

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 regiment

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- Coordinate and integrate MM services within the broader health care management services being provided to the beneficiary

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or substance use disorder(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.

Staff Qualifications

MM services must be provided by qualified licensed clinical professionals operating within their scope of practice as allowed by state law.

Service Documentation

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 clinical service notes. 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

Staff-to-Beneficiary Ratio

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

Billing Frequency

MM is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

Billable Place of Service	Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality. Excluded settings include acute care hospitals, Inpatient Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (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	MM cannot be reimbursed with Individual Psychotherapy with the E&M codes when rendered to a beneficiary on the same day.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

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SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

PSYCHOSOCIAL REHABILITATION SERVICES (PRS)

Purpose

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

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 skills training that enhances the beneficiary's communication skills, ability to develop and maintain environmental supports, and ability to develop and maintain interpersonal relationships

Service Description

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.

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

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

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

Medical Necessity Criteria

Admission Criteria 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 diagnostic assessment, and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or substance use disorder (SUD).

B. The beneficiary has a serious and persistent mental illness (SPMI) and/or substance use disorder (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, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Admission Criteria for Adults (age 22 and older) (Cont'd.)

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is at risk of psychiatric hospitalization, homelessness, and/or isolation from social supports due to the beneficiary's SPMI and/or SUD
- Exhibits behaviors that require repeated interventions by the mental health, social services, and/or judicial system
- 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 Licensed Practitioner of the Healing Arts (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 participants in the creation of the treatment plan and discharge plan, and are actively participating in treatment. The

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Continued Service Criteria for Adults (age 22 and older) (Cont'd.)

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 Individual Plan of Care (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 diagnostic assessment, which includes a DSM diagnosis that requires and will respond to therapeutic interventions specific to the PRS service description.

B. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and the symptom-related problems interfere with the individual's functioning and living, working, and/or learning environment. (Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).

C. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

D. Beneficiary meets three or more of the following criteria as documented on the diagnostic assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age;
- Is deemed to be at risk of psychiatric hospitalization and/or out-of-home placement;
- In the last 90 days exhibited behavior that resulted in at least one intervention

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Admission Criteria for Children (age 0-21) (Cont'd.)

by crisis response, social services, or law enforcement;

- Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior.

E. The family/caregiver/guardian agrees to be an active participant, which involves participating in interventions to better understand and care for the beneficiary for the purpose of maintaining progress during and after treatment.

F. Traditional mental health services (e.g., individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.

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

H. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for PRS *

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI)
- 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)
- For beneficiaries 6-18 years, has been assigned a minimum CALOCUS composite score of 17

*Private Providers Only

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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 Individual Plan of Care (IPOC).

Staff Qualifications

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

A Bachelor's Degree or above or a certified Substance Abuse Specialist (SAS) currently affiliated with DAODAS is required to render PRS.

Exclusions: Provider staff directly serving children in Therapeutic Foster Care (TFC) placement must have, at a minimum, a high school diploma or GED.

Service Documentation

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

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Service Documentation (Cont'd.)

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

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

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

Staff-to-Beneficiary Ratio

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

PRS can be provided in small groups of no more than one staff to eight (1:8) adult participants and no more than one staff to eight (1:8) child and adolescent participants, regardless of the payer source of the participants 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.

Billing Frequency

PRS is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

Billable Place of Service

Services must be rendered in a setting that is convenient for the both the beneficiary and the professional that affords an

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Billable Place of Service (Cont'd.)

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, Psychiatric Residential Treatment Facilities (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

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Community Integration Services, Therapeutic Child Care, and Family Support Services

SCDHHS will only reimburse for one RBHS Community Support Service (CSS) per day. For example, FS-Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

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

Children in foster care, therapeutic foster care, 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 DHEC licensure requirements. This delineation must be clearly defined, documented, and accessible in the beneficiary record.

BEHAVIOR MODIFICATION (B-MOD)

Purpose

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. Behavior Modification (B-Mod) is intended to be time-limited and the intensity of

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Purpose (Cont'd.)

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.

Service Description

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 behavioral modification.

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Medical Necessity Criteria

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 diagnostic assessment, 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 serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and must be engaging in one or more of the following behaviors: physical aggression, verbal aggression, object aggression, and/or self-injurious behavior that presents risk of harm to self or others (Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).

D. The beneficiary's behaviors interfere with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is deemed to be at risk of psychiatric hospitalization or out-of-home placement
- In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
- Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior

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Admission Criteria for Children and Adolescents (ages 0-21) (Cont'd).

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 Licensed Practitioner of the Healing Arts (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*:

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI)
- 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)
- For beneficiaries 6-18 years, has been assigned a minimum CALOCUS composite score of 17

*Private providers only

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

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

in the beneficiary's IPOC. The progress summary must specifically capture progress on each goal listed on the IPOC.

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

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

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

Service Documentation

The beneficiary's IPOC and treatment process 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.

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

The qualified staff providing the service is responsible for completing and signing the clinical service notes. The notes 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 clinical service notes and other documentation must meet all SCDHHS requirements, outlined in Section 2 (Documentation Requirements) of this manual.

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

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Service Documentation (Cont'd.)

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

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

- For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by 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 B-Mod services must not be provided.
- In addition to general documentation requirements, service documentation for B-Mod must identify the presence of the inappropriate and/or undesirable and detail how the behavior was redirected by qualified staff.

Behavior Modification Plan (BMP)

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

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Behavior Modification Plan (BMP) (Cont'd.)

- 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 participants in the creation of the BMP
- Signatures of persons who participated in the development of the plan (beneficiary, family/caregiver, and B-Mod staff)

Staff Qualifications

The specific behavior plan must be developed by an independent LPHA and conform to prevailing standards of practice based on peer-reviewed literature. B-Mod must be provided by qualified clinical professionals and paraprofessionals as defined in the "Staff Qualifications"

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Staff Qualifications (Cont'd.)

section. B-Mod services rendered by paraprofessionals must be under the supervision of qualified clinical staff. A Bachelor's Degree or above or a certified Substance Abuse Specialist (SAS) currently affiliated with DAODAS is required to render B-Mod.

- Exclusion: Provider staff directly serving children in Therapeutic Foster Care (TFC) placement must have, at a minimum, a high school diploma or GED.

Staff-to-Beneficiary Ratio

B-Mod is a 1:1 service. B-Mod must not be provided in group settings.

Billing Frequency

B-Mod is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

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, Psychiatric Residential Treatment Facilities (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

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Family Support Services Community Integration Services, and Therapeutic Child Care.

SCDHHS will only reimburse for one RBHS Community Support Service (CSS) per day. For example, Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

Exceptions to any same day service restrictions are noted under the specific service.

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

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FAMILY SUPPORT (FS) (0-21)

Purpose

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

Service Description

FS is intended to:

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

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

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

Medical Necessity Criteria

Admission Criteria

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

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Admission Criteria (Cont'd.)

A. The beneficiary is under the age of 22.

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

C. The beneficiary has a serious and persistent mental illness (SPMI), serious emotional disturbance (SED) and/or substance use disorder (SUD), and the symptom-related problems interfere with the individual's functioning, living, working, and/or learning environment. Children under the age of 7 may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM.

D. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting.

E. Beneficiary meets three or more of the following criteria as documented on the Diagnostic Assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is deemed to be at risk of psychiatric hospitalization and/or out-of-home placement
- In the last 90 days exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement
- Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior

F. Family/caregiver agrees to be an active participant in treatment; FS services should provide opportunities for the family/caregiver to acquire

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Admission Criteria (Cont'd.)

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 Licensed Practitioner of the Healing Arts (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*:

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI)
- 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)
- For beneficiaries 6-18 years, has been assigned a minimum CALOCUS composite score of 17

*Private providers only

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 Individual Plan of Care (IPOC).

C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected

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Continued Service Criteria (Cont'd.)

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.

Service Documentation

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

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.

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Staff Qualifications

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 Substance Abuse Specialist (SAS) affiliated with DAODAS.

Exclusion: Provider staff directly serving children in Therapeutic Foster Care 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.

Billing Frequency

FS is billed in 15-minute units. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

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, Psychiatric Residential Treatment Facilities (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

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Family Support Services, Community Integration Services, and Therapeutic Child Care.

SCDHHS will only reimburse one RBHS Community Support Service (CSS) per day. For example, Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

Exceptions to any same day service restrictions are noted under the specific service.

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

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Same Day Service Restrictions (Cont'd.)

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

THERAPEUTIC CHILD CARE (TCC)

Purpose

The purpose of this face-to-face service is to assist children 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.

Provider Credentialing

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 DSS licensure or approval as a daycare facility
- At least one staff member must be credentialed in Trauma-Focused Cognitive Behavior Therapy (TF-CBT) or Parent-Child Interactive Therapy (PCIT)
- 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
    - BH Manual: Intensive Family Based Services, and/or Outpatient Programs
  - Council on Accreditation

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Provider Credentialing (Cont'd.)

- Child and Family Development and Support Services (CFD), Day Treatment Services (DTX), Family Preservation and Stabilization Services (FPS), Outpatient Mental Health Services (MH), or Services for Mental Health and/or Substance Use Disorders (MHSU)

- The Joint Commission
  - BHC Day Treatment- Child/Youth Category and/or Mental Health- Child/Youth Category

Service Description

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 Trauma Focused Cognitive-Behavioral Therapy (TF-CBT), or Parent-Child Interactive Therapy (PCIT). 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.

TCC provides a continuum of individual, family, and group services that meet the needs of children with severe emotional and/or behavioral disturbances. The service is family-focused, with the intention of keeping the child in his or her home and community. 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 are provided directly to the child through a combination of activities 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

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Service Description (Cont'd.)

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.

As a result of 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.

As a result of TCC, it is expected that there will be an increase in the child's ability to be present, interact, and participate in various tasks for longer periods of time. Further, the child will demonstrate an increased capability to interact with adults in therapeutic and educational tasks, resulting in increased educational and emotional functioning. The 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:

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- 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;
- Consistently and appropriately provide for the child's basic needs for health, safety, comfort, affection, and stimulation.

Medical Necessity Criteria

Admission Criteria

A-J must be met to satisfy criteria for admission into TCC Services.

A. The beneficiary must be under the age of 6.

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. Traditional mental health services (e.g., individual/family/group therapy, medication management, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating.

G. 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.

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Admission Criteria (Cont'd.)

H. The beneficiary has a history of exclusion from one or more daycare or preschool due to behavioral problems and/or is at risk for abuse or neglect.

I. 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.

J. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for TCC*:

- For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI).
- 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).

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 participants 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 individual plan of care (IPOC).

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Service Documentation

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 clinical service notes.

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. Additionally, there must be individual documentation completed for each encounter (e.g. group vs. individual).

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

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

A calendar of scheduled program activities and hours will be posted and available. A clinical summary of the child's participation and parent or caregiver's involvement in the scheduled activities shall be included in the documentation of services received.

Staff Qualifications

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 TF-CBT or PCIT. For the initial year of TCC provision, this requirement may be satisfied by a clinician receiving training and supervision in TF-CBT or PCIT as part of the rostering process.

Staff-To-Beneficiary Ratio

TCC can be provided individually, face-to-face with one participant at a time, or provided face-to-face with two to six participants in a small group.

TCC must be provided in small groups of no more than one staff to six (1:6) child participants (unless state daycare license requirements mandate a smaller ratio), regardless of the payer source of the participants in the group. Only staff who meet the staff qualification requirements for TCC are

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Staff-To-Beneficiary Ratio (Cont'd.)

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.

Billing Frequency

TCC is billed as a 15-minute unit. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

TCC Services must be rendered in a DSS 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 Exclusion

Only one RBHS Community Support Service (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, therapeutic foster care, and those served by the Continuum of Care are exempt from the same-day service restriction.

COMMUNITY INTEGRATION SERVICES (CIS)

Purpose

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

Provider Credentialing

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 or co-occurring substance use disorders 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

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COMMUNITY SUPPORT SERVICES

Provider Credentialing (Cont'd.)

- Are accredited in the following:
  - Commission on Accreditation for Rehabilitation Facilities
    - BH Manual: Community Integration
  - Council on Accreditation
    - Vocational Rehabilitation Services (VOC), Supported Community Living Services (SCL), Services for Substance Use Conditions (SA), Services for Mental Health and/or Substance Use Disorders (MHSU), Psychiatric Rehabilitation Services (PSR), Outpatient Mental Health Services (MH), Adult Day Services, Counseling, Support, and Education Services (CSE), and/or Day Treatment Services (DTX)
  - The Joint Commission
    - BHC Day Treatment- Adult, Mental Health-Adult, or Community Integration

Service Description

CIS programs are appropriate for adults with a serious and persistent mental illness or co-occurring serious and persistent mental illness and substance use disorders 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:

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- Community living competencies (e.g., self-care, cooking, money management, personal grooming, 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 University 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

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

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.

Medical Necessity

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 serious and persistent mental illness (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 substance use disorder (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, medication management, 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 Diagnostic Assessment:

- Is not functioning at a level that would be expected of typically developing individuals their age
- Is at risk of psychiatric hospitalization, homelessness or isolation from social supports due to the beneficiary's SPMI or co-occurring disorders

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Admission Service Criteria (Cont'd.)

- Exhibits behaviors that require repeated interventions by the mental health, social services, or judicial systems
- 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.

Service Documentation

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

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clinical service notes.

Service Documentation (Cont'd.)

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 clinical service notes. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of CIS addresses.

Staff-Qualifications

CIS must be provided by qualified clinical professionals and/or paraprofessionals as defined in the "Staff Qualifications" section. 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 bill Medicaid for the service.

Billing Frequency

CIS is billed as a 15-minute unit. See Section 4 of this manual for additional information regarding procedure codes and frequencies.

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

Community Support Services (CSS) are defined as the following five services: Psychosocial Rehabilitation, Behavioral Modification, Family Support Services Community Integration Services, and Therapeutic Child Care.

SCDHHS will only reimburse for one RBHS Community Support Service (CSS) per day. For example, -Behavioral Modification will not be reimbursed on the same day as Psychosocial Rehabilitation Services or Family Support.

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

PEER SUPPORT SERVICES (PSS)

Purpose

The purpose of this service is to assist beneficiaries' recovery from mental health and/or substance abuse

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disorders by sharing similar lived experience and recovery.

Purpose (Cont'd.)

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 Peer Support Services (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. The peer support specialist guides the beneficiary through self-help and self-improvement activities that cultivate the beneficiary's ability to make informed independent choices and facilitates specific, realistic activities that lead to increased self-worth and improved self-concepts.

Service Description

Services are multi-faceted and emphasize the following:

- Personal safety
- Self-worth
- Introspection
- Choice

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Service Description (Cont'd.)

- Confidence
- Growth
- Connection
- Boundary setting
- Planning
- Self-advocacy
- Personal fulfillment
- The Helper Principle
- Crisis management
- Education
- Meaningful activity and work
- Effective communications skills

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

The availability of services is a vital part of PSS to reinforce and enhance the beneficiary's ability to cope and function in the community and develop natural supports. Services must be rendered face to- face. The beneficiary must be willing to participate in the service delivery. Services are structured or 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.

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Service Description (Cont'd.)

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 includes 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 substance use disorders or mental illness and recovery.
- System advocacy assists beneficiaries in making telephone calls and composing letters about issues related to substance use disorders, 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

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learning how to change an inadequate housing situation.

Service Description (Cont'd.)

- 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).

Services Evaluation and Outcome Criteria

To the extent measurable, the service will be evaluated on the effectiveness of developing rehabilitative skills and diminishing the effects of mental illness, substance use, or co-occurring disorders. Particular attention will be given to measuring outcomes for individuals who identify as having concurrent mental illness and substance use disorders, as well as those who may have greater difficulties with access to the appropriate services.

PSS should be monitored and reviewed quarterly using the following measures:

- A client advisory group that consists of the peer support specialist, the clinical supervisor, and other clinical staff shall meet quarterly to discuss the services and provide guidance as needed.
- The focus group consists of the beneficiaries, clinical staff, and the peer support specialist. The group will meet to discuss comments from the suggestion box and any other issues.
- Service satisfaction surveys and system-wide surveys must provide outcome measures in the following areas for PSS:
  - **Satisfaction with Services** — Beneficiaries will rate their satisfaction of PSS as evidenced by a survey that measures their own perception of care. Service satisfaction surveys and system-wide surveys will be used to improve access to

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Services Evaluation and Outcome Criteria (Cont'd.)

treatment, and to improve the quality of treatment.

- **Access to Services** — Beneficiaries will rate the accessibility of the services and how much assistance the program provided. The survey should be given at the beginning of the service and at the end of the service. The survey will assist in providing a guide to help determine treatment intensity for mental health and/or substance use disorders.
- **Clinical Outcomes** — Beneficiaries receiving PSS will maintain or improve their functioning as evidenced by a combination of the beneficiary's self-report measure of outcome (*e.g.*, MHSIP); and a clinical measure, such as the Global Assessment of Functioning (GAF).

Medical Necessity Criteria

Admission Criteria

- Beneficiary has been diagnosed with a serious and persistent mental illness (SPMI), and/or a substance use disorder (SUD); AND
- 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;

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Admission Criteria (Cont'd.)

- 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; AND
- Beneficiary has demonstrated a need for assistance with community living and the service is recommended by a Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his/her professional licensure; AND
- The service, including frequency of the service, is recommended as a result of the Diagnostic Assessment; AND
- Beneficiary has an Individual Plan of Care (IPOC) that addresses mental health concerns and any co-occurring general medical condition; AND
- 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.

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Staff Qualifications

Peer Support Specialist

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.

The criteria for meeting the consumer of services qualification are:

- Have had a diagnosis of behavioral health or substance use disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and received treatment for the disorder
- Self-identify as having had a behavioral health and/or substance use disorder
- 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

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other authorized entity.

Supervision

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.

Service Documentation

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.

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Service Documentation (Cont'd.)

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

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.

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.

Billing Frequency

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 clinical service notes.

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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

PROGRAM DESCRIPTION

SCDHHS and the South Carolina Department of Alcohol and Other Drug Abuse Services (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 substance use disorder 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 Licensed Practitioner of the Healing Arts (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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

PROGRAM DESCRIPTION (CONT'D.)

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.

DADOAS 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" in Section 4 of this manual.

PROGRAM SERVICES

Services listed below are rendered only by DAODAS providers. See the criteria listed below for policy guidelines and Section 4 for frequency limitations and modifiers.

Alcohol and Drug Screening (ADS) and Brief Intervention Services

Purpose

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

Service Description

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

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI — Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

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 substance use disorder 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 substance use disorder 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.

Medical Necessity Criteria

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

Staff Qualifications

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 "Staff Qualifications" for a list of qualified clinical professionals authorized to render ADS.

Service Documentation

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

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SUBSTANCE USE DISORDER TREATMENT SERVICES

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.

Billing Frequency

ADS is billed as an encounter. Twelve (12) encounters are allowed in a year. Only one encounter code is allowed per day.

Billable Place of Service

The only exclude 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)

Purpose

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 substance use disorder.

Service Description

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

that has not been reviewed in a 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 individual plan of care 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.

Components of the diagnostic assessment service include:

- Beneficiary demographic information
- Presenting complaint or source of distress
- 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
- Functional assessment (with age-appropriate expectations)
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

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Service Description (Cont'd.)

- 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
- Identification of the beneficiary's problems

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.

Medical Necessity Criteria

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

Staff Qualifications

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.

Service Documentation

Services must be documented on the CSN with a start time and end time Additionally; the documentation must meet all SCDHHS requirements for clinical service notes. 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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

Documentation must include components of the assessment and the following:

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

Staff-to-Beneficiary Ratio

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

Billing Frequency

The initial and follow-up assessments are billed as an encounter. A session should last a minimum of 60 minutes. One encounter is allowed every six months and coordination 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 clinical service notes.

Billable Place of Service

The only exclude 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 diagnostic assessment has been conducted in the last 90 days and information should be updated as needed. If a diagnostic assessment has been conducted within the last 90 days, efforts should be made to access those records. Services are rendered by the staff listed in Section 4 of this manual.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Alcohol and Drug/Substance Abuse Counseling (SAC)

Purpose

The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. Alcohol and Drug/Substance Abuse Counseling (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.

Service Description

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 substance use disorders. 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,

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

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.

Medical Necessity Criteria

Beneficiaries eligible for this service must have a diagnosis of a substance use disorder 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.

Staff Qualifications

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.

Service Documentation

Documentation must indicate how the counseling session applies to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. 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 clinical service notes.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

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.

Billing Frequency

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 last longer than 60 minutes, this time is not billable. Only one encounter code is allowed per day.

Billable Place of Service

The only exclude 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

None.

Skills Training (ST) and Development Services for Children

Purpose

The purpose of this service is to provide Skills Training 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 substance use disorder, 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. Skills Training 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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description

Skills Training 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.

Skills Training 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 skills training designed for age-appropriate and normal development of the beneficiary to improve communication, problem solving, and self-management

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

Skills Training include services provided in a small group based on the assessed needs and level of functioning of the beneficiary.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria

Beneficiaries 0 to 6 years of age who have been identified as having or are at risk of a substance use disorder and/or co-occurring substance use disorder 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.

Staff Qualifications

Skills Training and Development services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the "Staff Qualifications" section. Effective July 1, 2015, staff providing the service must have a Bachelor's Degree or above, or be a certified Substance Abuse Specialist (SAS) affiliated with DAODAS.

Service Documentation

The CSN must document how Skills Training and Development applies to the beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. 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 physician, LPHA, or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behaviors.

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.

Staff-to-Beneficiary Ratio

Skills Training 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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Billing Frequency

Skills Training and Development is billed in a 15-minute unit.

Billable Place of Service

The only exclude 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.

Psychological Testing and Reporting (PTR)

Purpose

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

Testing and evaluation must involve face-to-face interaction between a master's level qualified health care professional and the beneficiary for evaluating the beneficiary's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics, as well as use of other non-experimental methods of evaluation.

Psychological Testing and Reporting may be used for the purpose of psycho-diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning.

All psychological assessment/testing by the assessor must include a specific referral question(s) that can be reasonably answered by the proposed psychological assessment/testing tools to be administered. All requests for psychological assessment/testing must clearly establish the benefits of the psychological assessment/testing,

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Purpose (Cont'd.)

including, but not limited to, how the psychological assessment/testing will inform treatment.

Service Description

When necessary or appropriate, a consultation shall only include telephone or face-to-face contact by a qualified clinical professional to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary.

The psychologist is expected to review the report and render the diagnoses. The psychologist must document the recommended course of action.

Medical Necessity Criteria

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

Staff Qualifications

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

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

Service Documentation

The documentation must include the purpose of the test; the results of Psychological test and/or refer to the completed test.

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

Documentation must include the following:

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

Documentation must support the number of units billed.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Staff-to-Beneficiary Ratio

Psychological Testing and Reporting requires one 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.

Billing Frequency

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

Billable Place of Service

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

Special Restrictions in Relationship to Other Services

Efforts should be made to determine whether another psychological testing has been conducted within the last 90 days and information should be updated as needed. If an assessment has been conducted within the last 90 days, efforts should be made to access those records. An assessment should be repeated only if a significant change in the behavior or functioning of the beneficiary has been noted.

This service cannot be utilized when a determination of the appropriateness of initiating or continuing the use of psychotropic medication is required.

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

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

Psychological Testing and Reporting and Diagnostic assessment may be billed on the same day. Assessments must be billed separately and provide different outcomes.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

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

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Physical Examination (Cont'd.)

- 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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria	All beneficiaries who have been identified as having or are at risk of a diagnosis of a substance use disorder or co-occurring substance use and mental health disorders.
Staff Qualifications	Services are provided by qualified professionals operating within their scope of practice, as allowed by state law. Qualified health care professionals include physicians, physician assistants (PA) and advanced practical registered nurse (APRN) practitioners. A physician must be available in the event of an emergency.
Service Documentation	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. Services must be documented on the CSN and signed by a qualified professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
Staff-to-Beneficiary Ratio	Services require at least one professional for each beneficiary.
Billing Frequency	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 (99203) and Established Patient (99213) services are allowed one per day per service. When a beneficiary receives a medical evaluation and management (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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services (Cont'd.)

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 Individual Psychotherapy codes (90833 and 90836) are used.

A nurse is responsible for assisting in monitoring the beneficiary's medical treatment and medication administration.

Alcohol and Drug Assessment Nursing Services (ADN)

Service Description

Alcohol and Drug Assessment Nursing Services (AND) 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 medication management
- 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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)	• Monitoring for interactions of psychiatric medications, prescribe medications, and substance abuse
Medical Necessity Criteria	All Medicaid-eligible beneficiaries who have been identified as having or at risk of a substance use disorder or co-occurring substance use and mental health disorders.
Staff Qualifications	Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.
Service Documentation	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 clinical service notes. A nursing discharge form must be completed when the beneficiary moves to another level of service.
Staff-to-Beneficiary Ratio	Services require at least one qualified nursing professional for each beneficiary.
Billing Frequency	When billed as a discrete service, Alcohol and Drug Nursing 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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Medication Administration (MA)

Purpose

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

Service Description

Medication Administration 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.

Medical Necessity Criteria

Beneficiaries eligible for this service must have a diagnosis of a substance use disorder 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.

Staff Qualifications

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

Service Documentation

Medication Administration 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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

- 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

Staff-to-Beneficiary Ratio

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

Billing Frequency

Medication Administration is billed as an encounter and must be billed with the injection code. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Billable Place of Service

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

Medication Administration is billed in conjunction with injection code J2315.

Vivitrol Injection (VI)

Purpose

This code is the specific Injectable Medication, provided by a qualified health care professional with a medical prescription or order. The purpose of the treatment is to restore, maintain, or improve a beneficiary's behavior or substance use disorder.

Service Description

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. The procedure code for the injection is billed in conjunction with procedure code 96372.

Medical Necessity Criteria

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Staff Qualifications

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

Service Documentation

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

Billing Frequency

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 health care professional must provide a prescription for the injection.

The medication administration code is billed in conjunction with the injection code. Both services are documented on the same CSN, but must be billed separately.

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Substance Abuse Outpatient Treatment Services (Cont'd.)

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.

Purpose

The purpose of this array of services is to provide intervention for the treatment and management of substance use disorders 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, family support and medication management 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 substance use disorder 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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Purpose (Cont'd.)

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.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder 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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description

The IOP service is comprised of the following services:

Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following services may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and Reporting, AOD Assessment, AOD Assessment Nursing Services, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

Staff providing services:

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

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.

Service Documentation

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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

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.

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.

Billing Frequency

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

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management 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

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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of substance use disorder 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.1 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.

Service Description

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

Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

<u>The following may be billed as discrete services:</u>

Psychiatric Diagnostic Evaluation, Psychological Testing and Reporting, AOD Assessment, AOD Assessment Nursing Services, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

<u>Staff providing services:</u>

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

Length of Stay Criteria / Continued Stay Criteria:

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

Service Documentation

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 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.

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.

Billing Frequency

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services

All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

RESIDENTIAL SUBSTANCE ABUSE TREATMENT (CONT'D.)

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:

1. room and board services, including custodial care;
2. educational, vocational and job training services;
3. habilitation services;
4. services to inmates in public institutions as defined in 42 CFR §435.1010;
5. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
6. recreational and social activities; and
7. 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 substance use disorder 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 staffs, 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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder 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.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

- Physical examination within 48 hours after admission for beneficiaries in 24-hour facilities (EXCEPTION: If a client is admitted after 5:00 P.M. on Friday, a 24-hour facility has until close-of business the next workday to obtain the admission physical examination.)

Staff providing services:

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

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.

Service Documentation

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

(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, clinical service notes, 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.

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.

Billing Frequency

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 Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

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.

A registered nurse, 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 medication administration on an hourly basis, if needed.

Medical Necessity Criteria

Adult beneficiaries eligible for these services must have a diagnosis of a substance use disorder 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.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing evaluation and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration

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

Staff providing services:

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

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 5 days may be exceeded by continued receipt of the service based on medical necessity, and/or transfer to a 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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation

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 – Clinical Institute Withdrawal Assessment of Alcohol (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, 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.

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.

Billing Frequency

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 Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services (Cont'd.)

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

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.

Medical Necessity Criteria

Adult beneficiaries eligible for these services must have a diagnosis of a substance use disorder 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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria (Cont'd.)

- 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.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol), and Medication Administration.

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

- Physical examination within 24 hours after admission
- The provision of priority admission for pregnant women, as needed

Staff providing services:

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

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.

Service Documentation

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, clinical service notes, and progress update or continued stay authorization form.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

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.

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.

Billing Frequency

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 Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management 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

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.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder 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:

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Medical Necessity Criteria (Cont'd.)

- 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's 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.

Service Description

The program is comprised of the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/ Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing Evaluation and Reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol) and Medication Administration

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

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)

- Physical examination within 24 hours after admission and provide face-to face evaluations at least once a week.
- A registered nurse will be responsible for overseeing the monitoring of the beneficiary's progress and medication administration.

Staff providing services:

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

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.

Service Documentation

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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Documentation (Cont'd.)

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.

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.

Billing Frequency

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 Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management 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

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,

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Behavioral Health Short Term Residential Treatment Program – Medically Monitored High-Intensity Residential Treatment Services: Level III.7-RA (Cont'd.)

- Promote successful involvement in regular productive daily activity,
- Enhance personal responsibility and developmental maturity,
- Promote successful reintegration into community living.

Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a substance use disorder 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 the 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.

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SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description

The program comprises the following services:

AOD Assessment Nursing Services, Individual Psychotherapy, Family Psychotherapy, Group Psychotherapy, AOD/ Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management.

The following may be billed as discrete services:

Psychiatric Diagnostic Evaluation, Psychological Testing and reporting, AOD Assessment, AOD Screening, SPD, Medical Evaluation and Management, Crisis Intervention, Injection (Vivitrol) and Medication Administration.

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 a registered nurse who is responsible for overseeing the monitoring of the beneficiary's progress and medication administration.

Staff providing services:

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

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.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Service Description (Cont'd.)	The beneficiary must be discharged from Level III.7. R A by the physician or reviewed by the physician before the beneficiary is transferred to a lesser level of care within the same treatment system.
Service Documentation	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
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.
Billing Frequency	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 Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

SECTION 2 POLICIES AND PROCEDURES

SUBSTANCE USE DISORDER TREATMENT SERVICES

Special Restrictions in Relationship to Other Services (Cont'd.)

Modifier HA will be used with this code to indicate services for children and adolescents.

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.