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**POLICIES AND PROCEDURES**

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## SECTION 2 POLICIES AND PROCEDURES

### SERVICE DESCRIPTION

#### OVERVIEW

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

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

Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of “evidence-based” practices, and “emerging best practices” in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis, and treatment planning; and fosters improvement in the delivery system of mental health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as preferential use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. The National Registry of Evidence-based Programs and Practices and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### OVERVIEW (CONT'D.)

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

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

All services must be authorized for a beneficiary prior to service delivery. RBHS services must be determined medically necessary to be eligible for Medicaid reimbursement.

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

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

## PROGRAM REQUIREMENTS

### PROVIDER QUALIFICATIONS

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

- **A Licensed Psychologist** with the following qualifications:
  - Ph.D. or Psy.D. from an accredited college or university
  - A valid and current professional license with a specialty in Clinical, Counseling, or School Psychology as approved by the South Carolina Board of Examiners in Psychology
- **A Licensed Independent Social Worker-Clinical Practice (LISW-CP)** with the following qualifications:
  - Master's or doctorate degree from a board-approved social work program
  - One year of experience working with the population to be served
  - A valid and current professional license as approved by the South Carolina Board of Social Work Examiners
- **A Licensed Marriage and Family Therapist (LMFT)** with the following qualifications:
  - Master's, specialist, or doctorate degree from a degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or a regionally accredited institution of higher learning
  - A minimum of 48 graduate semester hours or 72 quarter hours in Marriage and Family Therapy.
  - A minimum of three semester hour graduate level courses with a minimum of 45 classroom hours or 4.5 quarter hours for each course. One course can not be used to satisfy two different categories.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

- o A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists
- **A Licensed Professional Counselor (LPC)** with the following qualifications:
  - o All coursework, including any additional core coursework, must be taken at a college or university accredited by the Commission on the Colleges of the Southern Association of Colleges and Schools, or one of its transferring regional associations; or the Association of Theological Schools in the United States and Canada; or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education; or a regionally accredited institution of higher learning subsequent to receiving the graduate degree
  - o A minimum of 48 graduate semester hours during a master's degree or higher degree program and has been awarded a graduate degree as provided in the regulation
  - o A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists

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

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

The presence of licensure and/or certification means the established licensing board in accordance with South

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

Carolina Code of Laws has granted the authorization to practice in the state. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State of South Carolina and must be operating within their scope of practice.

#### Enrollment Requirements for Participation

To enroll as a LIP provider, applicants must complete the following forms: Medicaid Application, Disclosure of Ownership, Electronic Funds Transfer, and Provider Enrollment packet. A LIP must also submit requested information regarding their clinical specialty and population served. A LIP must have a physical location for conducting business and a policy in place for handling emergency situations.

LIP applicants must complete the following steps to become enrolled as a Medicaid provider:

1. Obtain a National Provider Identifier (NPI) number. An NPI number is required to enroll directly with the Medicaid program. Information about the NPI number is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <https://nppes.cms.hhs.gov>. Once the NPI is obtained, the LIP must complete an On-Line Pre-Enrollment Orientation.
2. Register for the Pre-Enrollment Orientation at <https://training.scdhhs.gov/academy/course/view.php?id=5>. The pre-enrollment orientation is available online 24 hours per day, seven days per week.

The orientation is designed to provide the LIP with knowledge about RBHS policy and procedures and prevent potential Medicaid recoupment as a result of a post payment review. Following the orientation, the LIP will be prompted to complete a questionnaire. Once the LIP has successfully completed the session, SCDHHS Provider Enrollment will forward the LIP a Medicaid Enrollment packet. The LIP applicant must complete all forms included in the packet and return to:

Medicaid Provider Enrollment  
Post Office Box 8809  
Columbia, SC 29202-8809

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Enrollment Requirements for Participation (Cont'd.)

Packets that are incomplete will be returned to the provider. Upon receipt of the enrollment packet, the Division of Family Services or its designee will review the items listed on the application. All data enrollment forms included with the packet must be completed and signed by the applicant or responsible party. Upon approval, the provider enrollment forms will be processed.

#### GROUP ENROLLMENT

LIPs who are incorporated sole practitioners or members of a multi-specialty group, psychological group, professional association, or other professional organization should enroll their employing entity with Medicaid as a group provider of RBHS and receive a Medicaid Group NPI number.

Each member of the group wishing to render Medicaid reimbursable services under this program must also be enrolled individually.

Entering the Medicaid Group NPI number on the Medicaid billing form (CMS-1500) will ensure that payments is made to the group rather than to the individual LIP. Please refer to Section 3 of this manual for instructions regarding billing procedures.

#### Billing Requirements

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

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

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

The following changes to the Provider Enrollment form must be reported in writing to the Division of Family Services within 60 days:

- Address, e-mail address, or telephone number of the business office
- Licensure

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Requirements for Participation in Rehabilitative Behavior Health Services (Cont'd.)

- Accreditation status (if applicable)
- Other changes which affect compliance with Medicaid policy requirements

#### Closure

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

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

#### ELIGIBILITY FOR SERVICES

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

Medicaid-eligible beneficiaries may receive RBHS when there is a primary psychiatric diagnosis from the current edition of the DSM and/or ICD, (excluding, irreversible dementias, intellectual disabilities or related disabilities, developmental disorders, unless they co-occur with a serious mental disorder that meets current edition DSM criteria).

Developmental disabilities should not be confused with mental disorders. Persons with a developmental disability should be carefully assessed to determine if there are co-

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

occurring behavioral problems and if those problems could be addressed with RBHS. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of RBHS.

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

#### MEDICAL NECESSITY

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

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for RBHS being authorized. There are two ways the LIP may receive a referral and confirmation of the beneficiary's medical necessity: a state agency as designated by SCDHHS or a Medicaid-enrolled physician may refer an eligible beneficiary to the LIP. A referring physician or other Licensed Practitioner of the Healing Arts (LPHA) must certify that the beneficiary meets the medical necessity criteria for services. If a physician is referring the beneficiary to a LIP, prior authorization will be determined by the SCDHHS Quality Improvement Organization (QIO). The determination of medically necessary treatment must be confirmed on a Medical Necessity Statement (MNS). The following guidelines shall be used to determine medical necessity:

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

- Medical necessity must be made within SCDHHS's standards for timeliness.
- Medical necessity must be determined by a physician/LPHA who is not the direct treatment provider.
- Medical necessity based on V-codes is allowed but is considered temporary and may not be used for longer than six-month duration. V-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, a new MNS with a psychiatric diagnosis must be completed if continuation of services is needed. V-codes may not be used for ages 7 and up for longer than six-month duration. The use of V-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.
- Medical necessity must be documented for additional treatments by the referring physician, other LPHA for a state agency, or the physician for LIP referrals. The MNS shall include the new information and must be signed, titled and dated by the appropriate referring providers. The signature and date on the MNS will establish the date to be used for all subsequent annual confirmations.

The referring physician or LPHA from a designated state agency, or the physician for the LIP shall:

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

**Note:** For a physician referral, the MNS must be completed using the guidelines under the QIO section. If a state agency is making the referral, the MNS must be completed using the

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

guidelines under “State Agency MNS Confirmation” in this section.

The Medical Necessity Statement must:

- Identify the beneficiary’s current problem areas
- Specify treatment goals that need to be addressed by the service provider
- Include a current diagnosis
- Be signed and dated by a licensed physician/LPHA for a state agency referral
- Be signed and dated by a physician for LIP referral
- Be maintained in the beneficiary’s clinical record

The MNS must include the following information to be valid:

- The beneficiary’s name, date of birth and Medicaid member number or social security number. If the Medicaid member number is not available at the time of the referral, the state agency or physician must furnish the Medicaid member number to the LIP provider or QIO. The Medicaid member number must be added to MNS.
- A psychiatric diagnosis from the current edition of the DSM or the ICD (excluding irreversible dementias, intellectual disabilities or related disabilities, developmental disorders, unless they co-occur with a serious mental disorder that meets current edition DSM criteria)
- The specific RBHS recommended
- Identification of the beneficiary’s problem areas, the referring physician or LPHA’s handwritten name, professional title, signature, and date

Medical necessity is valid for 12 months and must be confirmed annually if the beneficiary needs continuing rehabilitative service(s). The initial signature date on the MNS from the referral entity (state agency or physician) stands as the date to be used for all subsequent annual confirmations.

A sample of the MNS form is available in the Forms section of this manual.

If the beneficiary has not received RBHS for 45 **consecutive**

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

calendar days, the medical necessity must be re-established. The LIP must contact the authorized referral entity to obtain a new MNS.

**If the physician is making a referral to a LIP for assessment, the physician must use the LIPS Referral Form to authorize the Initial Diagnostic Assessment and/or other assessment services on the form. If the referral is approved, the QIO will then send the LIP the QIO approval letter authorizing necessary services. The completed assessment results must be forwarded to the physician within the time frame specified on the QIO approval letter.**

If the state agency is making a referral to a LIP for assessment, the only form required to authorize the Initial Diagnostic Assessment is DHHS Form 254. The completed assessment must be forwarded to the referring state agency within the time frame specified on the DHHS Form 254.

#### MNS Confirmation

If a physician is referring the beneficiary for treatment, the MNS must be submitted to KePRO using one of the following methods:

Fax:	1-855-300-0082
Web Portal:	<a href="http://scdhhs.kepro.com">http://scdhhs.kepro.com</a>

The physician or LIP must submit the LIP Referral Form to KePRO using the guidelines specified under "Physician Responsibilities" in this section.

For beneficiaries under the age of 21, the physician's completion of the MNS is adequate for the initial 12 visits.

For beneficiaries over the age of 21, the physician or the LIP must submit an MNS and the SCDHHS LIP Authorization Form along with a standardized behavioral health screening tool that validates the medical necessity prior to the beneficiary's 1<sup>st</sup> visit. All forms must be sent to the QIO for authorization.

Although, the LIP may submit the request to the QIO, the physician must sign all applicable forms prior to submission. The physician or LIP must follow the guidelines specified under "Physician Responsibilities" in this section.

If the initial number of visits authorized is deemed inadequate to address the identified goals, reauthorization of services will be required for both adults and children.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MNS Confirmation (Cont'd.)

Reauthorization requests must be submitted two weeks **prior** to the expiration of authorized visits. The reauthorization request should be completed on the 10<sup>th</sup> visit for children. Failure to obtain reauthorization **prior** to the provision of services will result in recoupment of payment.

The MNS is valid for 12 months. If within the 12 month time frame, RBHS is still needed and there are no changes to the MNS, the physician or LIP must update the SCDHHS LIP Authorization Form and any screenings or clinical documentation that validates medical necessity. The LIP authorization form **must be** updated prior to submitting a reauthorization request to the QIO. The LIP may complete the LIP authorization form and the physician must sign the form to verify agreement with the request for the additional services and treatment protocol recommended by the LIP for the beneficiary.

Refer to the Forms section of this manual for a copy of the SCDHHS LIP Authorization Form.

#### State Agency MNS Confirmation

If the state agency is referring the beneficiary for treatment, the MNS must be signed by the state agency LPHA. By signing, the professional assumes responsibility for all information on the MNS.

Authorized State Agency Referral Entities are:

- Continuum of Care for Emotionally Disturbed Children
- Department of Juvenile Justice
- Department of Mental Health
- Department of Social Services
- Department of Disabilities and Special Needs
- Department of Education/Local Education Agencies

The following professionals are considered LPHAs for the referring State Agency and may confirm the medical necessity by signing the MNS.

- SC Licensed Psychiatrist
- SC Licensed Physician
- SC Licensed Ph.D. Psychologist
- SC Licensed Registered Nurse with a master's degree

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### State Agency MNS Confirmation (Cont'd.)

- with specialty in Psychiatric Nursing
- SC Advanced Practice Registered Nurse
- SC Licensed Master Social Worker
- SC Licensed Physician's Assistant
- SC Licensed Professional Counselor
- SC Licensed Marriage and Family Therapist
- SC Licensed Independent Social Worker-Clinical Practice

**The LIP rendering the service cannot self refer.**

#### QUALITY IMPROVEMENT ORGANIZATION (QIO) — PHYSICIAN REFERRALS

##### Physician Responsibilities

The current Quality Improvement Organization is Keystone Peer Review Organization, Inc. (KePRO). The referring physician or the physician for the LIP is responsible for the determination of medically necessary treatment for the beneficiary. The policy regarding medical necessity is described later in this section.

Prior authorization requests are submitted to the QIO using one or more of the following documents:

- LIP Referral Form
- Medical Necessity Statement (MNS)
- SCDHHS LIP Authorization Form

To receive reimbursement from Medicaid, all prior authorization requests must be faxed to or submitted via the KePRO web portal for approval. A fax cover sheet must be included with the request along with supporting documentation such as SCDHHS forms or clinical documentation to the QIO.

The LIP will be notified via a QIO approval letter if the authorization request is approved by KePRO. The LIP must download the approved document(s) from the KePRO web portal or request a copy from the referring physician to be placed in the beneficiary's clinical record.

The referring physician or LIP provider may contact KePRO

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Physician Responsibilities (Cont'd.)

using one of the following methods:

Customer Service: 1-855-326-5219  
 Fax: 1-855-300-0082  
 Provider Issues Email: atrezzoissues@Kepro.com

The approved document(s) must be placed in the beneficiary's clinical record prior to or at the time of the appointment for treatment. A faxed copy is acceptable.

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

#### Physician Referred Services

The following services may be authorized by the QIO to the enrolled a LIP:

- Diagnostic Assessment (initial comprehensive only)
- Individual Therapy
- Group Therapy
- Family Therapy
- Crisis Management
- Behavioral Health Screening

To ensure appropriate billing, LIP providers must reference sections on the service authorization.

#### QIO Responsibilities

The QIO is responsible for the following:

- The QIO must include the following on the approval letter:
  - The beneficiary's Medicaid member number
  - The LIP's name
  - The LIP's NPI number
  - The Prior Authorization number assigned by the QIO which is mandatory for billing purposes
  - The authorization (beginning) date and the expiration (ending) date, which establishes the

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### QIO Responsibilities (Cont'd.)

- o treatment period
- o The specific service(s) authorized to be provided
- o The maximum authorized amount (number of units)

#### STATE AGENCY REFERRALS/PRIOR AUTHORIZATION (PA)

##### DHHS Form 254

Referrals must be authorized by a designated state agency **prior** to the delivery of services. Authorization for services is achieved through the proper completion of the Referral/Authorization for RBHS form (DHHS Form 254). The referring state agency must complete, sign, title and date the DHHS Form 254 and provide the original document to the qualified LIP prior to the provision of services or at the time services are initiated.

DHHS Form 254 must be maintained in the clinical record and be available to confirm services have met the authorization requirements prior to billing Medicaid.

For state agency referrals, DHHS Form 254 must accompany the SCDHHS MNS.

DHHS Form 254 serves to:

- Establish the service(s) the beneficiary requires
- Identify the treatment provider
- Authorize the service(s) and amount and duration of services to be provided
- Identify the level of staff that is authorized to render services

Refer to the Forms section of this manual for a copy of DHHS Form 254.

#### State Agency Prior Authorization

The designated state agency will authorize and be responsible for the following:

- The beneficiary's Medicaid member number
- The referring provider/entity's name/NPI number
- The Prior Authorization number assigned by the designated referring state agency which is

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### State Agency Prior Authorization (Cont'd.)

- mandatory** for billing purposes
- The name of the designated referring state agency
- The authorization (beginning) date and the expiration (ending) date, which establishes the period during which services are authorized to be provided. Authorizations periods **must not exceed 12 months**
- The specific service(s) authorized to be provided, *i.e.*, individual therapy, behavior modification
- The staff level or designated modifier authorized to provide each service
- The maximum authorized amount (number of units) for each service to be rendered from the referring state agency
- The clearly identified rehabilitative service(s) to be rendered and
- Signature, title and date of a qualified state agency representative

#### State Agency Referred Services

The following services may be authorized by a state agency to the enrolled a LIP:

- Diagnostic Assessment
- Individual Therapy
- Group Therapy
- Family Therapy
- Service Plan Development for Multi-agency Team
- Crisis Management
- Behavioral Health Screening

To ensure appropriate billing, LIP providers must reference sections on the service authorization.

#### Retroactive Coverage

When a beneficiary receives retroactive Medicaid coverage, DHHS Form 254 or the QIO approval letter must be provided to the LIP provider within 10 business days from the date of the Medicaid eligibility determination.

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### MAINTENANCE OF LIP CREDENTIALS

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

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

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

LIP(s) must comply with all other applicable state and federal requirements.

All providers must maintain a file substantiating each practitioner's qualifications and training. This shall include employer verification of the treatment staff's certification, licensure, and work experience.

The individual or group LIP must maintain a signature sheet that identifies all professionals providing services by name, signature, and initial.

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

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

neglect against the individual

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

- Verification must be updated annually from the state and national sex offender registries that there are no findings of sexual charges against the individual

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

#### EMERGENCY SAFETY INTERVENTION

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

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

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

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

#### Staff-to-Beneficiary Ratio

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

Staff should be in direct contact and be involved with the beneficiary during service delivery. Ratios must be

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

maintained in accordance with the requirements of each individual service description array.

#### Out of Home Placement

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

#### Transition/Discharge

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

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

### CLINICAL RECORDS AND DOCUMENTATION REQUIREMENTS

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

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

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

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

- A comprehensive, diagnostic assessment, if applicable
- Referral/Authorization for Services (DHHS Form 254), QIO approval letter and completed Medical

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

Necessity Statement(s)

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

- Signed/titled and dated Individual Plans of Care (IPOC) initial, progress summaries, and reformulations
- Signed releases, consents, and confidentiality assurances for treatment
- Signed/titled and dated clinical service notes (CSN)
- Court orders, if applicable
- Copies of any evaluations and or tests, if applicable
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered) if applicable
- Copies of all written reports, and any other documents relevant to the care and treatment of the beneficiary
- Other documents relevant to the care and treatment of the beneficiary

#### Consent for Treatment

A consent form and release of information (if applicable), dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor). Beneficiary or legal representative (in adult cases), must be obtained at the onset of treatment from all beneficiaries.

If the beneficiary, parent/guardian or legal representative cannot sign the Consent form due to a crisis, and the beneficiary 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" should be noted on the Consent form and must be signed by the physician or other LPHA and one other staff member. The beneficiary, parent/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 services after discharge. Consent forms are not necessary to conduct court ordered examinations by the court. However, a copy of the probate court order must be kept in the clinical record.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### Coordination of Care

There must be evidence in the record of coordination between the provider and the referring agency case manager or referring physician regarding treatment planning for the beneficiary, monitoring, and follow-up. Interim progress reports should be provided to the referring agency or referring physician as warranted supporting the ongoing medical necessity of the services rendered. At the expiration of the period of service authorized on DHHS Form 254 or the QIO approval letter, the LIP should provide the authorizing agency or the referring physician with a statement describing the services rendered, outcomes achieved, and any recommendation for continued or additional services. These reports are not separately reimbursable but considered part of the beneficiary's overall care.

#### CLINICAL SERVICE NOTES (CSNs)

All Rehabilitative Behavioral Health Services (RBHS) must be documented in clinical service notes (CSNs) upon the delivery of services and filed in the beneficiary's record. The purpose of the CSN is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status.

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

- The specific objective from the IPOC toward which the session is focused
- The structured activities of the beneficiary in the session. These activities shall be within the session content specified previously
- The beneficiary's response to the intervention/treatment
- The specific intervention used
- The beneficiary's progress or lack of progress made in treatment.
- Recommendation and future plans for working with the beneficiary

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

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

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

- Each referral form must contain authorization for a specific beneficiary, specific dates of service, and specific services to be rendered. If an incomplete referral is received, please contact the agency representative referenced on the referral form
- Each clinical service note should be individualized to the referred beneficiary
- For those beneficiary's receiving therapy services, a written and complete IPOC must be included in each individual beneficiary record
- The record should indicate whether the session occurred face-to-face with the referred beneficiary, or with a family member/significant other or group. If the session is not face-to-face with the beneficiary, documentation should support that the focus of the session remained relevant to the referred beneficiary(s), and should include the beneficiary's relation to any persons present during the session
- Therapy session notes should appropriately indicate whether the counseling was individual, family, or group
- Documentation for siblings should remain separate
- The starting and ending time for each service
- Documentation must be legible and abbreviations decipherable. If abbreviations are used, the provider must maintain a list of abbreviations and their meanings. This list must be made available to SCDHHS
- Be completed each time RBHS is provided and whenever information is obtained that has bearing on

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

the identified beneficiary's treatment

- Document that RBHS corresponds to billing by type of service, units of service, and dates of service (with month, day and year)
- Be typed or handwritten using only black or blue ink
- Be legible and kept in chronological order
- Reference individuals by full name, title and agency/provider affiliation at least once in each note
- Specify the place of service, as appropriate for the particular service provided
- Be signed, titled and signature dated (month/date/year) by the LIP responsible for the provision of services. The signature verifies that the services are provided in accordance with these standards
- Be completed and placed in the clinical record following service delivery but no later than 10 business days from the date of rendering the service
- The interventions and involvement of treatment staff in service provision to the beneficiary to include coordination of care
- The response of the beneficiary and family (as applicable) to the interventions/treatment
- The general progress of the beneficiary to include observations of their condition and/or mental status
- The plan for on-going treatment with the beneficiary

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

#### Billing Information/Location of Service

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

- 03 – School
- 11 – Doctor's Office
- 12 – Beneficiary's Home
- 22 – Outpatient Hospital
- 23 – Emergency Room

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### 99 – Other Unlisted

##### **Record Retention**

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

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

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

##### **Abbreviations and Symbols**

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

An abbreviation key must be maintained to support the use of abbreviations and symbols entered in the record. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

##### **Error Correction**

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

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

##### **Late Entries**

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

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### PROGRAM REQUIREMENTS

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

Late entries should be rarely used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

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

#### INDIVIDUALIZED PLAN OF CARE (IPOC)

The individualized plan of care is a comprehensive plan of care outlining the service delivery that will address the specific strengths and needs of the beneficiary. The IPOC must be individualized and specify problems to be addressed. Excluding assessment services, an IPOC should be developed prior to the delivery of a service with the full participation of the beneficiary and his or her family, if appropriate, unless in case of an emergency.

The IPOC must be finalized within 45 calendar days of the signature date of the physician or other LPHA on the MNS Form received from the referral entity.

If the IPOC is not developed within 45 calendar days, services rendered from the 46<sup>th</sup> day until the date of completion of the IPOC are not Medicaid reimbursable. The

LIPs signature is required to confirm the appropriateness of care.

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

Documentation of compliance with this requirement must be located in the beneficiary's record. If the family/legal guardian/representative/primary caregiver will not be

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

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

involved in the treatment planning process, the provider must provide justification. Evidence of this justification must be located in the beneficiary's clinical record. For adults, family/legal representative should be included as appropriate.

The long-term goal should match the long-term goal of the referring agency. **The IPOC must contain the signature, title and date of the LIP and the date signed.** The beneficiary must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC.

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

Multiple agency staff or members of an interdisciplinary team must participate in the process of developing, preparing and/or reviewing the IPOC in order for the LIP to provide the service. (See the Sample in the Forms Section of this manual)

The IPOC must address the following:

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

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

The IPOC must be reviewed and updated according to the beneficiary's progress but at a minimum every 90 days. If the provider determines during treatment that additional services are required, these services should be added to the treatment plan. The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and renewals.

Other forms that reference signature sheets do not meet the IPOC signature requirements.

#### IPOC Reformulation

A new IPOC must be developed every 12 months. If services are discontinued, the LIP must indicate the reason for discontinuing treatment on the IPOC. The IPOC must include

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

	<p>the date when it was reformulated, the signature, title and signature date of the LIP.</p>
<b>IPOC Reformulation (Cont'd.)</b>	<p>When the IPOC is developed at least two months prior to the expiration date, the new plan is effective with the anniversary date.</p> <p>Please refer to the documentation format example in the Forms section.</p>
<b>Services Not Listed on the IPOC</b>	<p>The following services are not required to be listed on the IPOC: Crisis Management, Service Plan Development, Behavioral Health Screening, Psychological Testing and Evaluation, and Diagnostic Assessment.</p> <p>These services may be rendered prior to the development of the IPOC provided they are prior authorized by an Authorized Referral Entity.</p> <p>For physician referrals, the LIPS referral form is required to authorize the Initial Diagnostic Assessment, Crisis Management, Psychological Testing and Evaluation and Behavioral Health Screening. The physician will complete the LIPS Referral Form indicating the service and requested units and fax it to the QIO and the LIP provider.</p> <p><b>Note:</b> A fax cover sheet must be submitted along with the LIPS referral form. Upon receipt of the fax from the referring physician, the LIP may render only the service indicated on the form. The LIP must receive the QIO approval letter prior to the provision of services or after a crisis service on that LIP's referral form have been rendered.</p>
<b>IPOC Changes</b>	<p>Services added or frequencies of services changed in an existing IPOC must be signed or initialed and dated by the reviewing LIP. Beneficiaries are not required to have face-to-face contact with the LIP for the addition of services or changes in service frequency. All additions to the IPOC should be listed in chronological order.</p> <p>If changes and updates are made to the original IPOC, an updated copy must be provided to the referring state agency within 10 calendar days. A copy of the updated IPOC must be made available to the beneficiary. A faxed copy is acceptable.</p>

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM REQUIREMENTS

#### PROGRESS SUMMARY

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

A review of the beneficiary's participation in RBHS will be conducted at least every 90 calendar days from the signature date on the IPOC and each 90 days thereafter.

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

At or around the time of the third 90-Day Review, if a state agency or physician anticipates that treatment services will be needed at the anniversary date, the LIP must contact the authorizing state agency or physician for a new MNS.

The LIP in coordination with the referring entity will review the following areas:

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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE BEHAVIORAL HEALTH SERVICE STANDARDS

#### BEHAVIORAL HEALTH SCREENING (BHS)

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

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

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

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

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

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

Documentation must :

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

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

The purpose of an Initial Comprehensive Assessment is to determine the need for RBHS, to establish and/or confirm a diagnosis, and to provide the basis for the development of an effective course of treatment.

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

Initial assessments include a clinical interview with the beneficiary and/or family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits and history.

Components of an assessment include:

- Beneficiary demographic information
- Presenting complaint, source of distress
- Medical History and medications
- Family History
- Psychological and/or psychiatric treatment history
- Substance use history
- Mental status
- Current edition DSM or ICD diagnosis
- Age-appropriate Functional assessment
- Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

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

All enrolled LIPs may complete diagnostic assessments that have been prior authorized. Efforts should be made to determine whether another comprehensive assessment (initial and follow-up) has been conducted in the last 90 days and information should be updated as needed.

**SECTION 2 POLICIES AND PROCEDURES****PROGRAM SERVICES****COMPREHENSIVE  
ASSESSMENT – INITIAL  
AND FOLLOW-UP  
(CONT'D.)**

If a recent comprehensive assessment (initial and follow-up) has been conducted within the last 90 days, efforts should be made to access those records. A comprehensive assessment should be repeated, only if a significant change in behavior or functioning has been noted. Delivery of this service may include contacts with family and/or guardians for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

**Staff-to-Beneficiary Ratio**

The staff-to-beneficiary ratio for the comprehensive assessment (initial and follow-up) requires one LIP 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.

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 LIP, regardless of whether or not the beneficiary is Medicaid eligible.

Assessments must be documented as such on a clinical service note (CSN). The CSN must document the nature and extent of the assessment.

**PSYCHOLOGICAL  
TESTING AND  
EVALUATION**

Psychological testing and evaluation services include assessment of personality, psychopathology, and intellectual abilities (*e.g.*, WAIS-R, Rorschach, and MMPI) and are only to be rendered by a licensed psychologist.

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, psychiatric and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, and personality characteristics, as well as use of other non-experimental methods of evaluation.

When necessary/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 or receive an opinion and/or advice. The psychologist must document the recommended course of action.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

**Staff-to-Beneficiary Ratio** The ratio for Psychological Testing and Evaluation requires one psychologist 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.

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

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

### **SERVICE PLAN DEVELOPMENT (SPD)**

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

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

For multiple agency staff or interdisciplinary team members, a minimum 3 human service agency staff or interdisciplinary team members constitute a team.

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

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

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

The provider representative must have the “letter of invite” in the beneficiary’s clinical record which clearly invites the provider representative to the SPD meeting. The “letter of invite” does not supplant the SCDHHS prior authorization DHHS Form 254.

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

State Agencies that refer services to qualified LIP providers may designate the development of the service plan (only when it involves multiagency staff or an interdisciplinary team). LIP(s) must ensure State Agencies receive a copy of the IPOC within 10 days of completion.

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

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

#### THERAPY SERVICES OVERVIEW

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

Therapy Services are based on an empirically valid body of knowledge about human behavior. Therapy 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.

Therapy services are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability, improve their physical and emotional health and help the beneficiary to

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### **THERAPY SERVICES OVERVIEW (CONT'D.)**

cope with or gain control over the symptoms of their illness(es) and effects of their disabilities.

Therapy should be used to help beneficiaries solve problems, achieve goals, and manage their lives by treating a variety of behavioral health issues. Therapy Services may be provided in an individual, group or family setting.

#### **Excluded Settings**

The only excluded settings for Therapy Services are hospitals, Inpatient Psychiatric Residential Treatment Facilities and freestanding inpatient psychiatric facilities.

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

#### **INDIVIDUAL THERAPY (IT)**

Individual therapy is used to manage, reduce, or resolve identified problems of the beneficiary. 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, more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.

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

IT 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

### PROGRAM SERVICES

**Staff-to-Beneficiary Ratio** The ratio for IT is one professional to one 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.

**Service Documentation** The CSN must document how the IT session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

**GROUP THERAPY (GT)** The purpose of this face-to-face intervention is to assist a group of beneficiaries, who are addressing similar issues, in improving their functioning. 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.

Group Therapy (GT) is a method of treatment in which several beneficiaries with similar problems meet regularly with a clinician to improve and manage their emotions and behaviors. The goal of Group Therapy is to help beneficiaries with solving emotional difficulties and to encourage the personal development of the beneficiaries in the group.

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

Beneficiaries who meet the following criteria may benefit from Group Therapy:

- 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 factors that impact the beneficiary's symptoms

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### GROUP THERAPY (GT) (CONT'D.)

- A number of beneficiaries with the same type of problem that may gain insight by being in a group with others
- Beneficiaries may benefit from interaction with others who have a similar experience and all beneficiaries demonstrate a level of competency to function in group therapy

#### Staff-to-Beneficiary Ratio

The ratio for GT requires one LIP and a group of up to 8 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.

#### Service Documentation

The CSN must document how the GT session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

#### FAMILY THERAPY (FT)

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

Family Therapy (FT) 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.

FT may be rendered to family members of the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

FT 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.

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### **FAMILY THERAPY (FT) (CONT'D.)**

The family's strengths should be used to help them handle their problems.

FT helps families or 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 family therapy is to get family member to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include the identification and 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 understanding of the beneficiary's mental disorder, its dynamics, and treatment.

Services may also include addressing ways in which the family can promote recovery for the beneficiary from mental illness and/or co-occurring substance use disorders.

#### **Staff-to-Beneficiary Ratio**

The ratio for FT requires one LIP for each family unit. 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.

#### **Service Documentation**

The CSN must document how the FT session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

#### **CRISIS MANAGEMENT (CM)**

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

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

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

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 include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual.

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

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

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

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

**SECTION 2 POLICIES AND PROCEDURES****PROGRAM SERVICES****CRISIS MANAGEMENT  
(CM) (CONT'D.)**

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 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 IPOC.

CM is not required to be listed on the IPOC.

**Service Location**

Crisis Management services may be provided in a beneficiary's home, nursing facility, emergency room, outpatient hospital, clinic setting, or other community locations in the beneficiary's natural environment. Services may not be provided to beneficiaries residing in a residential psychiatric or freestanding Inpatient Psychiatric Hospital.

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

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

**Staff-to-Beneficiary Ratio**

The ratio for CM requires at least one LIP 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

**Service Documentation**

Crisis Management is not required to be listed on the IPOC. A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and duration
- All participants during the service
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

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

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

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

Medicaid reimbursement may be sought for services rendered under the direct supervision of a psychologist licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the supervising psychologist must be present at the site of service and be immediately available or accessible when the services being billed are provided. The supervising psychologist is responsible for all services rendered, fees charged, and reimbursement received. The supervising psychologist must cosign all session notes to indicate that he or she accepts responsibility for the service rendered. No more than three full-time supervisees may be in the employ of any one supervising licensed psychologist.

The South Carolina Board of Examiners in Psychology or SCBEP maintains a set of Guidelines for Employment or Supervision of Unlicensed Persons Providing Psychological Services. The following requirements are cited directly from SCBEP guidelines. According to these regulations, every unlicensed service provider must be under the direct and continuing administrative and professional supervision of a psychologist licensed by SCBEP.

The supervising psychologist shall be licensed for the practice of psychology and have adequate training knowledge, and skill to render competently any psychological service which his or her supervisee undertakes. The supervising psychologist shall supervise the provision of psychological services only in the specialty area(s) in which he/she is licensed by SCBEP.

The unlicensed service provider must have background, training, and experience appropriate to the functions performed.

The licensed supervising psychologist is responsible, subject to SCBEP review, for determining the adequacy of preparation of the unlicensed service provider and the designation of his or her title in accordance with the Code of Laws of South Carolina.

The supervising licensed psychologist must register all information deemed necessary by SCBEP with SCBEP at the

**SECTION 2 POLICIES AND PROCEDURES****PROGRAM SERVICES****SERVICES RENDERED  
UNDER THE SUPERVISION  
OF A LICENSED  
PSYCHOLOGIST  
(CONT'D.)**

time of initiation of supervision, prior to service delivery, and at the time of annual license review. It is recognized that the variability in the preparation for practice of all personnel will require individually tailored supervision. The range and content of supervision will have to be arranged between the individual supervising psychologist and the unlicensed person.

A detailed job description in which functions are designated at varying levels of difficulty, requiring increased levels of training, skill and experience should be available. The job description shall be made available to SCBEP and to beneficiaries upon request.

To obtain copies of the SCBEP requirements or to ask questions regarding supervision, call (803) 896-4664, write, or e-mail:

South Carolina Board of Examiners in Psychology  
Post Office Box 11329  
Columbia, SC 29211-1329  
<http://www.llr.state.sc.us/pol/psychology>

**SERVICES RENDERED  
UNDER LICENSED  
PROFESSIONAL  
COUNSELORS AND  
MARRIAGE AND FAMILY  
THERAPISTS**

Medicaid reimbursement may be sought for services rendered under the direct supervision of a professional counselor or a marriage and family therapist licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the supervising professional counselor or a marriage and family therapist supervisor must be present at the site of service and be immediately available or accessible when the services being billed are provided.

The licensed supervising professional counselor or a marriage and family therapist is responsible for all services rendered, fees charged, and reimbursement received. Acceptable modes of supervision of direct clinical individual contact are no more than two supervisees present for a period of at least one hour and for direct clinical group contact no more than four supervisees present for a period of at least one-half hour(s).

The licensed supervising professional counselor or a marriage and family therapist must co-sign all session notes to indicate that he or she accepts responsibility for the service rendered and have no more than six full-time supervisees in the employ of any one supervising professional counselor or a marriage and family therapist.

The South Carolina Board of Examiners for Licensed Professional Counselors and Marriage and Family Therapists maintain a set of Guidelines for Supervision of an Intern or other

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### **SERVICES RENDERED UNDER LICENSED PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS (CONT'D.)**

person requiring supervision providing clinical services. The following requirements are cited directly from the South Carolina Board of Examiners for Licensed Professional Counselors and Marriage and Family Therapists guidelines.

According to these regulations, every service provider intern or other person requiring supervision must be under the direct and continuing administrative and professional supervision of a professional counselor or a marriage and family therapist licensed by the South Carolina Board of Examiners for Licensed Professional Counselors and Marriage and Family Therapists.

The service provider intern or other person requiring supervision must have background, training, and experience appropriate to the functions performed.

The licensed supervising professional counselor and marriage and family therapist is responsible, subject to the South Carolina Board of Examiners for Licensed Professional Counselors and Marriage and Family Therapists guidelines review, for determining the adequacy of preparation of the service provider intern or other person requiring supervision and the designation of his and/or her title in accordance with the Code of Laws of South Carolina.

The supervising licensed professional counselor and marriage and family therapist must submit the plan for supervision and all information deemed necessary by and to the South Carolina Board of Examiners for Licensed Professional Counselors and Marriage and Family Therapist at the time of initiation of supervision and prior to service delivery. The confirmation of clinical supervision should be submitted to the South Carolina Board of Examiners for Licensed Professional Counselors and Marriage and Family Therapists following completion of supervision.

#### **LICENSED INDEPENDENT SOCIAL WORK-CLINICAL PRACTICE SUPERVISION**

Medicaid reimbursement may be sought for services rendered under the direct supervision of a licensed Independent Social Work–Clinical Practice Supervisor (LISW-CP-S) to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the supervising social worker-clinical practice must be present at the site of service and be immediately available or accessible when the services being billed are provided to the beneficiary.

The supervision must include face-to-face meetings between the approved clinical supervisor and supervisee for a minimum of

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

#### LICENSED INDEPENDENT SOCIAL WORK-CLINICAL PRACTICE SUPERVISION (CONT'D.)

100 hours equitably distributed. The LISW-CP supervision cannot begin until the LISW-CP's contract has been approved by the board.

The supervisor will be expected to keep notes and documentation of the supervision that occurs and the issues discussed. Upon completion of the supervision, the LISW-CP supervisor will be asked to comment on the performance assessment of the supervisee.

If the supervisory relationship is terminated or changed, LISW-CP supervisor will immediately notify the board.

The Supervisor is responsible for all services rendered, fees charged, and reimbursement received. For direct clinical group contact, no more than six supervisees can be present for a period of or at 50 percent of the time. The supervising LISW-CP Supervisor must co-sign all session notes to indicate that he or she accepts responsibility for the service rendered and has no more than six full-time supervisees in the employ of any one supervising LISW-CP Supervisor.

The requirements noted above are cited directly from LLR guidelines. According to these regulations, every unlicensed service provider must be under the direct and continuing administrative and professional supervision of a LIP supervisor or psychologist licensed by LLR.

#### Non-Covered Services

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

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

## SECTION 2 POLICIES AND PROCEDURES

### PROGRAM SERVICES

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

- Services provided to Medicaid-eligible beneficiaries who do not fall within the population served by Rehabilitative Services, with the exception of services provided to Medicaid eligibles who are also Qualified Medicare Beneficiaries (QMBs)

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

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

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