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POLICIES AND PROCEDURES

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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 Behavioral Health Services (RBHS) are medical or remedial services that have 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 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 RBHS policy for state agencies and private organizations as service providers. All providers are required to meet all requirements as set forth in this policy manual for the delivery of Rehabilitative Behavioral Health Services and all 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 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

SECTION 2 POLICIES AND PROCEDURES

REHABILITATIVE SERVICES OVERVIEW

REHABILITATIVE SERVICES OVERVIEW (CONT'D.)

Practices 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 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 *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.

Eligible beneficiaries may receive Rehabilitative Behavioral Health Services from a variety of qualified Medicaid providers. Public agencies that contract with the South Carolina Medicaid Program as qualified service providers may render Rehabilitative Behavioral Health Services directly to an eligible beneficiary. Private organizations may also render RBHS provided services have been prior authorized by a state referring agency.

LICENSED INDEPENDENT PRACTITIONERS (LIPs)

If it is determined that a beneficiary needs services rendered by an enrolled licensed independent practitioner, please refer to the Medicaid Licensed Independent Practitioners Rehabilitative Services Manual. This manual can be located at the SCDHHS Web site: www.scdhhs.gov.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

RBHS ENROLLMENT APPLICATION

To enroll as a RBHS Medicaid provider, please contact SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or you may submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

Updates and changes will continue to be posted on the SCDHHS Web site at <http://www.scdhhs.gov/>.

Providers are encouraged to subscribe to SCDHHS Medicaid Bulletins located on our Web site under Providers, to receive bulletins and newsletters via email. You may review the RBHS manual for policy and procedures at the SCDHHS Web site at www.scdhhs.gov.

Potential applicants may access the online Medicaid enrollment application on the SCDHHS website. Once enrolled, providers are required to revalidate every five years.

To participate in the South Carolina Medicaid Program, applicants must meet appropriate federal and state licensure, and all requirements outlined in the SCDHHS provider enrollment policy and this section including, but not limited to the following:

- Complete the SCDHHS online Enrollment Application for RBHS and fee requirements
- Complete an online orientation before enrollment and revalidation
- New applicants will be subject to a pre and post site visit Accreditation by CARF, or COA or the Joint Commission in Behavioral Health Services
- Staff must be licensed or registered with the State where the business is located
- Have a business license from the state and/or municipality or county where the services will be provided
- Physical business site must be located in the SC Medicaid Service Area (SCMSA)
- Proof of General Liability insurance coverage worth at a minimum of \$600,000
- Proof of Worker's Compensation insurance, if five or more personnel staff
- Accept the reimbursement rates established by Medicaid for RBHS

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

RBHS ENROLLMENT APPLICATION

Enrollment in the South Carolina 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.

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

ADDITIONAL REQUIREMENTS

Once enrolled, these additional requirements must be met:

- SCDHHS and USDHHS assume no responsibility with respect to accidents, illness or claims arising out of any activity performed by any State or private organization. The organization shall take necessary steps to insure or protect its recipient, itself and its personnel. The provider agrees to comply with all applicable local, staff, and federal occupational and safety acts, rules and regulations.
- Providers must have cost information available for review by SCDHHS upon request.
- Providers must have a policy on file for the definition of confidentiality issues, record security and maintenance, consent for treatment, release of information, beneficiary's rights and responsibilities, retention procedures, and code of ethics.
- 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.
- Providers must submit an attestation statement annually due July 1st of every year. The attestation letter must be submitted to the Division of Family Services. (See Sample Attestation Statement in the Forms section of this manual.)

SC Department of Health and Human Services
Division of Family Services
Post Office Box 8206
Columbia, SC 29202-8206
Fax (803) 255-8402

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

Personnel Files

The provider must maintain a documentation of licensure and personnel files for each employee at the primary business location. The personnel file must contain at a minimum the following:

- Copies of the staff's current licenses and documentation of training
- Copies of the staff's diploma filed at the primary business location
- Copies of the staff's degree filed at the primary business location
- Copies of all facility licenses

The provider must identify a CEO or director responsible for the business operation of the entity. The provider must also identify a clinical director responsible for supervision of the RBHS program. The clinical director must be a licensed and/or master's level clinical professional. An organization must include a clinical director and two other professional or paraprofessional staff that provide RBHS. **It is the provider's responsibility to ensure staff operates within the scope of practice as required by South Carolina State law.**

Reporting Changes

Changes affecting business operations must be reported in writing to the Medicaid Provider Service Center as soon as possible. Certain changes may impact your status as a Medicaid provider.

The following changes must be reported on company letterhead by the director/Chief Executive Officer(CEO):

- Physical address, e-mail addresses, or telephone numbers of the business office
- Change of location or adding a location
- Director or CEO
- Clinical Director
- Staff Licensure
- Business Licenses
- Accreditation status
- Change in ownership
- DHEC Residential Facility licensure
- DSS licensure
- New hires
- Other changes which affect compliance with Medicaid requirements

Exceptional circumstances may require that a new Enrollment Application for RBHS be completed prior to approval.

SECTION 2 POLICIES AND PROCEDURES

PROVIDER QUALIFICATIONS

Reporting Changes (Cont'd.)

Providers wishing to expand their RBHS must obtain approval from the Division of Family Services program representative prior to expansion. Expansion is defined as adding a new population to be served, and adding an additional service.

Closure of a RBHS Provider

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

1. If the provider voluntarily terminates his or her agreement with Medicaid, a written notification must be received by SCDHHS and other appropriate agencies within 30 days of closing the facility. The notification shall include the location where the beneficiary and administrative records will be stored.
2. If the provider is terminated involuntarily by Medicaid, the provider is responsible for all beneficiary and administrative records in the event of a post-payment review.

The owner(s) of the RBHS business entity provider is responsible for retaining administrative and beneficiary records for five years.

RBHS Services

The following services are in accordance with this policy manual:

- Behavioral Health Screening
- Diagnostic Assessment
- Individual Therapy
- Group Therapy
- Family Therapy
- Service Plan Development
- Crisis Management
- Medication Management
- Rehabilitation Psychosocial
- Behavior Modification (children only)
- Family Support

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

The determination of eligibility for Rehabilitative Behavioral Health Services (RBHS) should include a system-wide assessment and/or an intake process. This requires that specific information be gathered consistently regardless of the assessment tool being used. Medicaid-eligible beneficiaries may receive RBHS when there is a confirmed psychiatric diagnosis from the current edition of the DSM or the ICD. This excludes irreversible dementias, intellectual disabilities and related disabilities, and 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-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.

The use of V-codes is allowed under certain circumstances, but in general is considered temporary. V-codes may not be used for longer than a six-month duration for beneficiaries ages 7 and older. V-codes do not replace a psychiatric diagnosis from the current edition of the DSM or the ICD. After six months, if continued services are necessary, the treating clinician is expected to assess the beneficiary to determine an appropriate diagnosis code. 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

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

All Medicaid beneficiaries must meet specific medical

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

MEDICAL NECESSITY (CONT'D.)

necessity criteria to be eligible for RBHS. A physician or other LPHA must certify that the beneficiary meets the medical necessity criteria for services. LPHAs authorized to render services can be found under Licensed Practitioners of the Healing Arts (LPHAs).

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 within SCDHHS standards for timeliness
- Made by a physician or other LPHA employed by the state referring agency. LPHAs employed by private organizations are not authorized to determine medical necessity.

Contents of the SCDHHS Medical Necessity Statement

If Medical Necessity is confirmed using the SCDHHS Medical Necessity Statement (MNS), it must include the following information to be valid:

- The beneficiary's name, date of birth, and Medicaid number or social security number. If the Medicaid number is not available at the time of the referral, the state agency must furnish the Medicaid number to the service provider when it becomes available. The Medicaid number must be added to the SCDHHS MNS.
- A psychiatric diagnosis from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities and 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 problem areas
- The physician's or LPHA's name, professional title, signature, and date (of the professional

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Contents of the SCDHHS
Medical Necessity Statement
(MNS) (Cont'd.)

LPHA employed by the state referring agency)

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

Duration of the SCDHHS
Medical Necessity Statement

Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative service(s). The signature date from the DHHS MNS stands as the date to be used for all subsequent annual confirmations.

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

If SCDHHS or its designee determines that services were reimbursed when there was no valid medical necessity statement in the beneficiary's file, the provider payments will be subject to recoupment.

SERVICES DIRECTLY
PROVIDED BY STATE
AGENCIES

State agencies are designated by State law as the authority to meet the physical and mental health needs of an identified population.

State agencies may either provide RBHS directly to South Carolina Medicaid beneficiaries or they may refer beneficiaries to qualified Medicaid-enrolled private providers. When state agencies refer beneficiaries to other qualified Medicaid-enrolled providers, agencies are responsible for ensuring that services are medically necessary and are provided in accordance with acceptable medical standards.

When services are provided directly by a state agency, the record must clearly document the date the beneficiary was determined to meet the eligibility requirements for RBHS. The beneficiary's eligibility for services must be documented on a diagnostic assessment, IPOC, or SCDHHS MNS. This must be completed prior to the delivery of services and be maintained in the beneficiary's clinical record.

Please refer to the IPOC section. Some RBHS are not required to be listed on the IPOC and may be rendered prior to completion of the IPOC.

The physician or other LPHA must:

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

SERVICES DIRECTLY PROVIDED BY STATE AGENCIES (CONT'D.)

- Establish one or more diagnoses, including co-occurring substance abuse or dependence if present in accordance with the current edition of the DSM or ICD
- Determine the scope and appropriateness of treatment services — including the need for integrated treatment of co-occurring disorders
- Confirm medical and/or psychiatric necessity of treatment

The physician's or other LPHA's signature on the diagnostic assessment, IPOC, or SCDHHS MNS serves as documentation of the medical necessity. Medical necessity must be confirmed within 365 calendar days if the beneficiary continues in treatment.

Services must be initiated within 45 days of the physician's or other LPHA's signature on the document used to confirm medical necessity.

REFERRALS TO PRIVATE ORGANIZATIONS

State agencies may also refer beneficiaries to “private organizations” enrolled with the Medicaid Program to render RBHS.

Private organizations will be offered the opportunity to render an array of services designed to provide the necessary treatment and support to beneficiaries. All services must be authorized by a state referring entity as designated by SCDHHS prior to service delivery and must be determined medically necessary to be eligible for Medicaid reimbursement. The private organization does not determine medical necessity.

The referring state agency is responsible for establishing the medical necessity for each service. The state referring agency's LPHA must sign the medical necessity.

State Agency Referrals

The following agencies are identified as a designated state referring agency and may refer Medicaid beneficiaries to Medicaid-enrolled RBHS providers for treatment:

- Division of the Continuum of Care for Emotionally Disturbed Children
- Department of Disabilities and Special Needs
- Department of Education and Local Education Agencies

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

State Agency Referrals (Cont'd.)

- Department of Juvenile Justice
- Department of Mental Health
- Department of Social Services

Medical Necessity

Medical necessity must be confirmed and documented through the use of the SCDHHS MNS or the IPOC provided by the referring agency and made available to the treatment provider. This function is the responsibility of the state referring agency. Employees acting on behalf of enrolled private organizations shall not perform this function.

A properly completed SCDHHS MNS or IPOC should arrive with the beneficiary prior to or at the time of appointment. A faxed copy is acceptable. A copy of the SCDHHS MNS can be found in the Forms section of this manual.

The referring physician or other LPHA assumes professional responsibility for all information contained in the SCDHHS MNS.

Diagnostic Assessment Services

A state agency may authorize a private provider to render Diagnostic Assessment Services in order to confirm and/or substantiate the medical necessity. A MNS is not required for a Diagnostic Assessment. The only form required to authorize the Initial Diagnostic Assessment is the prior authorization form (DHHS Form 254). Once completed, the Diagnostic Assessment must be provided to the referring agency and should be used to develop the beneficiary's IPOC.

If the state agency provides the IPOC to an enrolled provider rather than a MNS, the IPOC must establish medical necessity and must be signed, titled and dated by a physician or other LPHA. (The enrolled private organization may not determine medical necessity.)

Licensed Practitioners of the Healing Arts (LPHAs)

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

- SC Licensed Psychiatrist
- SC Licensed Physician
- SC Licensed Ph.D. Psychologist

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Licensed Practitioners of the Healing Arts (LPHAs) (Cont'd.)

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

REFERRAL PROCESS/ PRIOR AUTHORIZATION (PA) — DHHS FORM 254

All Rehabilitative Behavioral Health Services provided by an enrolled private provider must be authorized by a designated state agency **prior** to the delivery of services.

When it is necessary to refer a beneficiary for services, the designated state agency will provide the qualified RBHS provider with a completed SCDHHS Referral/Authorization for Rehabilitative Services form (DHHS Form 254) prior to the provision of services, or at the time the services are rendered. A faxed copy is acceptable. The form will provide all of the information necessary for service delivery and billing. DHHS Form 254 should accompany the MNS and/or IPOC. (DHHS Form 254 can be found in the Forms section of this manual.)

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

If SCDHHS or its designee determines that services were reimbursed when there was no valid DHHS Form 254 in the beneficiary's file, the provider payments will be subject to recoupment.

The DHHS Form 254 serves to:

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

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

REFERRAL PROCESS/ PRIOR AUTHORIZATION (PA) — DHHS FORM 254 (CONT'D.)

The DHHS Form 254 must be completed prior to the delivery of services and placed in the beneficiary's clinical record within 10 business days of the signature date on the form. Faxed copies are acceptable.

The DHHS Form 254 must include the following:

- The beneficiary's Medicaid ID number
- The referred provider or entity's name and NPI number
- The Prior Authorization number assigned by the designated referring agency, which is 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. Authorization periods must not exceed 12 months duration.
- The specific service(s) authorized to be provided (*i.e.*, Individual Therapy, Behavior Modification, etc.)
- The designated modifier of the staff level authorized to provide each service
- The maximum authorized amount number of units and frequency for RBHS
- Signature, title and date of a qualified state agency representative and phone or contact number

The DHHS Form 254 must be signed, titled and dated by a state agency representative authorized to make treatment referrals. A list of authorized state agency representatives must be provided to SCDHHS annually and updated as needed.

When a beneficiary receives retroactive Medicaid coverage, DHHS Form 254 should be provided to the RBHS 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 retroactively covered periods.

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

UTILIZATION MANAGEMENT

Referral and prior authorization by a state agency is required for all services provided by private organizations.

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

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

MAINTENANCE OF STAFF CREDENTIALS

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

All RBHS providers must maintain and make available upon request, appropriate records and documentation of such qualifications, trainings and investigations. If these records are kept in a central “corporate office,” the provider will be given five business days to retrieve the records for the agency that is requesting them.

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

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. Providers rendering services outside of the South Carolina border must not exceed the licensed scope of practice granted under that state’s laws. Providers who enroll as a physician or other LPHA must be able to document experience working with the population to be served. Any services that are provided by staff who do not meet SCDHHS staff qualification requirements are subject to recoupment.

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

MAINTENANCE OF STAFF CREDENTIALS (CONT'D.)

The following general training requirements apply:

- All providers must ensure treatment staff receives adequate orientation to RBHS.
- The content of the training must be directly related to the duties of the individual receiving the training.
- Individuals who are qualified to conduct such training shall carry out the instruction.
- Documentation of the training received and successfully completed shall be kept in the individual's training record.
- Documentation of the training shall consist of an outline of the training provided and the trainer's credentials.
- When required, document the completion of certification criteria.

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

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

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

STAFF QUALIFICATIONS

The following professionals possessing the required education and experience are considered clinical professionals or paraprofessionals and may provide Medicaid Rehabilitative Behavioral Health Services in accordance with South Carolina State Law and the requirements set forth in this manual.

Medicaid RBHS 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	All Services, except PSS
Psychologist	Doctoral degree in psychology	Licensed by SC Board of Psychology Examiners	40-55-20 Et seq.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
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	All Services, except PSS
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
Licensed Registered Nurse	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.	BHS, DA, SPD, MM, CM, RPS, BMod, FS, SAE
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	Licensed by SC Board of Nursing	40-33-10 Et seq.	RPS, BMod, FS, SAE, MM

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

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.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
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.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Licensed Marriage and Family Therapist (LMFT)	A minimum of 48 graduate semester hours or 72 quarter hours in marriage and family therapy 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.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
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.	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Certified Substance Abuse Professional	Master’s degree in counseling, social work, family therapy, nursing, psychology, or other human services field, plus 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	BHS, DA, SPD, IT, GT, FT, SAC, CM, RPS, BMod, FS
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	Licensed by SC Board of Social Work Examiners	40-63-5 Et seq.	BHS, SPD, CM, RPS, BMod, FS

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PROFESSIONALS				
	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.)			
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	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
Mental Health Professional (MHP)	Master's or doctoral degree from a program that is primarily psychological in nature (<i>e.g.</i> , counseling, guidance, or social science equivalent) from an accredited university or college and one year of experience working with the population to be served	DHHS-approved credentialing program	40-75-290	BHS, DA, SPD, IT, GT, FT, CM, RPS, BMod, FS
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	BHS, DA, SAC, SPD, CM, RPS, BMod, FS
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 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. *Master's level only	Behavior Analyst Certification Board	N/A	RPS, BMod, FS BHS, DA*, SPD
PARAPROFESSIONALS				
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 field 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	BHS, RPS, BMod, FS
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	DHHS-approved Certification program	N/A	RPS, BMod, FS

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
PARAPROFESSIONALS				
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	DHHS-approved Certification program	N/A	RPS, BMod, FS
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, 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

Service Key

Service	Abbr.	Service	Abbr.	Service	Abbr.
Behavior Modification	BMod	Family Therapy	FT	Rehabilitative Psychosocial Services	RPS
Behavioral Health Screening	BHS	Group Therapy	GT	Service Plan Development	SPD
Crisis Management	CM	Individual Therapy	IT	Substance Abuse Counseling	SAC
Diagnostic Assessment	DA	Medication Management	MM	Substance Abuse Examination	SAE
Family Support	FS	Peer Support Service	PSS		

Please refer to the Core and Community Support Services section for specific service requirements.

**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 for each respective profession. Rehabilitative Behavioral Health Services provided by any unlicensed/uncertified professional must be supervised by a master’s level clinical professional or licensed practitioner of the healing arts (LPHA). Substance Abuse professionals who are in process of becoming credentialed must be supervised by a certified substance abuse professional or LPHA.

Licensed or master’s level clinical professionals have the responsibility of planning and guiding the delivery of services provided by unlicensed or uncertified professionals. These clinical professionals will evaluate and assess the beneficiary as needed.

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

STAFF MONITORING/ SUPERVISION STAFF (CONT'D.)

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(s) and the individual beneficiary's progress. Issues relevant to an individual beneficiary will be documented in a service note in the clinical record.
- Case supervision and consultation does not supplant training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

STAFF-TO-BENEFICIARY RATIO

Staff-to-beneficiary ratios are established for safety and therapeutic efficacy concerns. Ratios must be met and maintained at all times during hours of operation. Ratios must be maintained in accordance with the requirements of each individual service standard. Staff involved in the treatment delivery must have direct contact with beneficiaries. Staff present, but not involved in the treatment delivery, cannot be included in the ratio. Staff shall be in direct contact and involved with the beneficiary's activities during service delivery.

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

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

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

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

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

EMERGENCY SAFETY INTERVENTION (ESI)

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

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.

SECTION 2 POLICIES AND PROCEDURES

ELIGIBILITY FOR REHABILITATIVE SERVICES

COORDINATION OF CARE

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

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

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 be deemed as an Institution for Mental Diseases based on its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive 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 providers shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid participation, and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. The absence of appropriate and complete records, as described below, may result in recoupment of payments by SCDHHS. An index as to how the clinical record is organized must be maintained and made available to Medicaid reviewers or auditors upon request.

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

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

- A comprehensive, diagnostic assessment, if applicable
- Referral Form/Authorization for Rehabilitative Services form (DHHS Form 254), if applicable
- Completed Medical Necessity Statement (MNS), if applicable
- Signed, titled and dated individual plan of care (IPOC) — initial, reviews, and reformulations
- Signed, titled and dated Clinical Service Notes (CSNs)
- 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)

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

DOCUMENTATION REQUIREMENTS (CONT'D.)

- 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 for 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 physician or other LPHA and one other staff member. The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit. A new consent form should be signed and dated each time a beneficiary is readmitted to the system after discharge. Consent forms are not necessary to conduct court ordered examinations. However, a copy of the court order must be kept in the clinical record.

CLINICAL SERVICE NOTES (CSNs)

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

The CSN must:

- Be completed each time a rehabilitative service is provided and/or whenever information is obtained that has bearing on the identified beneficiary's treatment
- Be individualized
- Document that the rehabilitative service

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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

corresponds to billing by type of service, units of service, and dates of service (with month, day and year)

- Be typed or legibly handwritten using only black or blue ink
- Be kept in chronological order
- List the specific service that was rendered or its approved abbreviation
- Document the start and end time(s) for each rehabilitative service delivered (except Rehabilitative Psychosocial Services and Behavior Modification). Please refer to each individual service description in this section for specific documentation requirements.
- Reference individuals by full name, title and agency or provider affiliation at least once in each note
- Specify the place of service, as appropriate for the particular service provided
- Be signed, titled and signature dated (month/date/year) by the person responsible for the provision of services. The signature verifies that the services are provided in accordance with these standards.
- Be placed in the beneficiary's record as soon as possible but no later than 10 business days from the date of rendering the service

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

- The focus and/or reason for the session or interventions which should be related to a treatment objective or goal listed in the IPOC, unless there is an unexpected event that needs to be addressed
- The interventions and involvement of clinician and/or treatment staff in service provision

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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

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

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
- 21 — Inpatient 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

AVAILABILITY OF CLINICAL DOCUMENTATION

A CSN or other service documentation should be completed and placed in the clinical record immediately following the delivery of a service. If this is impossible due to the nature of the service, the documentation must be placed in the clinical record no later than 10 business days from the date of service.

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

ABBREVIATIONS AND SYMBOLS

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

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

ABBREVIATIONS AND SYMBOLS (CONT'D.)

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

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

ERROR CORRECTION

Clinical 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. 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

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

LATE ENTRIES (CONT'D.)

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, document as soon as possible.

RECORD RETENTION

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

Clinical records must be arranged in a logical order to facilitate the review, copy, and audit of the clinical information and course of treatment. Clinical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1 of this manual.

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 developed in collaboration with a beneficiary; significant other(s); parent, guardian, or primary caregiver ; and/or other state agencies, staff, or service providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Definition (Cont'd.)

While there may be certain treatment methodologies commonly utilized within a particular service, providers must ensure that services are tailored to the individual needs of each beneficiary and that service delivery reflects knowledge of the particular treatment issues involved.

An assessment of each beneficiary to identify problems and needs, develop goals and objectives, and determine appropriate Rehabilitative Behavioral Health Services and methods of intervention should be completed to develop the IPOC. The IPOC confirms the appropriateness of services for the beneficiary, and outlines the service delivery needed to meet the identified needs and improve overall functioning.

The IPOC incorporates information gathered during the screening and assessment process. The IPOC is beneficiary and family centered. 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 REFORMULATION

The maximum duration of the IPOC is 365 calendar days from the date of the signature of the physician, other LPHA, or other qualified clinical professional on the IPOC. Prior to termination or expiration of the treatment period, the physician, other LPHA, or other qualified level clinical professional must review the IPOC, preferably with the beneficiary, and evaluate the beneficiary's progress in reference to each of the

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

IPOC REFORMULATION (CONT'D.)

treatment objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The signature of the physician, other LPHA, or other qualified level clinical professional responsible for the treatment is required. The professional should also assess the need for continued services and specify services needed based on the progress of the beneficiary.

The IPOC must include the date when the reformulation was completed, the signature and title of the physician, other LPHA, or other qualified level clinical professional authorizing services, and the signature date. When the IPOC is developed months prior to the expiration date, the new plan is effective with the anniversary date.

There should be evidence in the clinical record regarding the involvement of the beneficiary in the reformulation of the IPOC. Copies of the reformulated IPOC must be distributed to all involved participants within 10 business days.

IPOC Components

The IPOC must include the following components:

Beneficiary Identification: Name and Medicaid ID number

Presenting Problem(s): Statements that outline the specific needs that require treatment (validate the need for and appropriateness of treatment).

Justification for Treatment: The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the DSM or the ICD.

For individuals who have more than one diagnosis regarding mental health, substance use, and/or medical conditions, all diagnoses should be recorded.

Goals and Objectives: A list of specific short- and long-term goals and objectives addressing the expected outcome of treatment. Goals should include input from the beneficiary and

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

IPOC Components (Cont'd.)

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

Specific interventions: A list of therapeutic interventions used to meet the stated goals and objectives must be included.

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

Criteria for Achievement: Outline how success for each goal and objective will be demonstrated. 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 that is individualized to the beneficiary and their goals and objectives.

Beneficiary Signature: 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 plan of care or if it is not considered appropriate for the beneficiary to sign the plan of care, the reason must be documented in the clinical record.

Authorized Signature(s): A qualified clinical professional must sign, title and date the IPOC. The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and reformulations. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The dated signature of the qualified staff responsible for the IPOC is required to confirm the appropriateness of care. Each page of the IPOC must be signed, titled and signature dated by the physician, other LPHA, or other qualified clinical professional. Other forms that reference signature sheets do not meet the IPOC signature requirements. The IPOC must be

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

IPOC Components (Cont'd.)

filed in the beneficiary's clinical record with any supporting documentation such as the diagnostic assessment.

IPOC — State Agencies Directly Providing Services

When services are provided directly by the state agency, the following requirements apply:

- The IPOC should be developed prior to service delivery with the full participation of the beneficiary and his or her family, if appropriate, unless it is an emergency situation. The service plan captures all goals and objectives and outlines each team member's responsibilities within the treatment process.
- The IPOC should be based upon an assessment of the beneficiary's current problems and needs in the areas of emotional, behavioral, and functional development.

If the IPOC confirms the medical necessity for services, it must be completed prior to service initiation and must be signed **by the physician or other LPHA**. The IPOC provides the overall direction for the treatment of the beneficiary.

IPOC Due Date

The initial IPOC must be finalized, signed, titled and signature dated by the physician, other LPHA, or other qualified clinical professional within 45 calendar days from the signature date of the document used to confirm medical necessity. If the IPOC is used as the sole document to confirm medical necessity, it must be signed **by the physician or other LPHA**. If the IPOC is not developed within 45 days, services rendered from the 46th day until the date of completion of the IPOC are not Medicaid reimbursable. Each page of the IPOC must be signed, titled and signature dated by the physician, other LPHA or other qualified clinical professional. Other forms that reference signature sheets do not meet the IPOC signature requirements.

Services added or frequencies of services changed in an existing IPOC must be signed or initialed and dated by the reviewing physician, other LPHA, or other qualified level clinical professional. Beneficiaries are not required to have face-to-face contact with the

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

IPOC Additions or Changes IPOC Additions or Changes (Cont'd.)

physician, other LPHA, or other qualified level clinical professional for the addition of services or changes in service frequency. All additions to the IPOC should be listed in chronological order.

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 calendar days.

Services Not Required on the IPOC

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

- Crisis Management
- Service Plan Development
- Behavioral Health Screening
- Diagnostic Assessment
- Substance Abuse Examination

Addendum IPOC

An addendum IPOC is used in conjunction with an existing IPOC when the space is unavailable on the current IPOC. Providers must label additional IPOC entries as “Addendum IPOC” and the addendum must accompany the existing IPOC.

The addendum must include the signature and title of the physician, other LPHA, or other qualified clinical professional who formulated the addendum(s), and the date it was formulated. The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews, and reformulations.

IPOC AUTHORIZATIONS — STATE AGENCIES REFERRING PRIVATE ORGANIZATIONS

An IPOC must be developed and maintained for each beneficiary.

State agencies may authorize a private organization to develop the IPOC for the beneficiary, or they may furnish the completed IPOC to the RBHS provider.

If the RBHS provider is authorized to develop the IPOC, the provider is responsible for ensuring the required components listed in the above section are documented in the IPOC, except for establishing medical necessity. Once the provider receives the DHHS MNS and the DHHS Form 254 authorization, the Service Plan Development should be initiated.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

IPOC Additions or Changes

Additions or changes to the IPOC must be coordinated between the RBHS provider and the referring state agency. Any changes and/or additions to services needed must be authorized to the RBHS provider via the prior authorization form (DHHS Form 254).

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

PROGRESS SUMMARIES

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

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

The review must be summarized in the IPOC by the physician, other LPHA, or other qualified clinical professional. The 90-day progress summary must be clearly documented on the IPOC.

The physician, other LPHA, or other qualified clinical professional will review the following areas:

- 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

Private Organizations

If a state agency or private RBHS provider anticipates that treatment services will be needed at the anniversary date, the provider must contact the authorizing state agency for a new MNS following the 90-day progress summary and in enough time to allow the agency to complete an authorization.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

DISCHARGE/TRANSITION CRITERIA

State agencies are 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 any of the following criteria:

- Level of functioning has significantly improved or has made limited or no progress with respect to the goals outlined in the IPOC
- Achieved the goals as outlined in the IPOC
- 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 (*i.e.*, inpatient hospitalization or PRTF)

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICE STANDARDS

Core Rehabilitative Services may be provided by a qualified state agency or services may be authorized to enrolled private organizations.

ASSESSMENT SERVICES

Behavioral Health Screening (BHS)

Purpose

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

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)

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

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 90 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

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

Eligibility

All Medicaid-eligible beneficiaries are eligible for this service.

Staff Qualifications

BHS may be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual, who have been specifically trained to review the screening tool and make a clinically appropriate referral.

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.

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 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.

SECTION 2 POLICIES AND PROCEDURES**CORE REHABILITATIVE SERVICES STANDARDS**

<i>Billing/Frequency Limits</i>	BHS is billed in unit increments of 15 minutes for a maximum of two units per day.
<i>Billable Place of Service</i>	Services can be delivered in any 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.
<i>Relationship to Other Services</i>	No restrictions.
Diagnostic Assessment (DA) Services	
<i>Purpose</i>	<p>The purpose of this face-to-face assessment is to determine the need for rehabilitative services, to establish or confirm a diagnosis, to provide the basis for development of an effective, comprehensive individual plan of care based upon the beneficiary's strengths and deficits, or to assess progress in and the need for continued treatment. This assessment includes a comprehensive biopsychosocial interview and review of relevant psychological, medical, and education records.</p> <p>Information obtained during the assessment must lead to a diagnosis that identifies the beneficiary's current symptoms or disorder by using the current edition of the DSM or the ICD.</p> <p>Information gathered during the assessment process may be obtained from diagnostic interviews with the beneficiary and/or others familiar with the beneficiary's functioning, psychological testing, interpretation, and questionnaires, review of written reports or medical records and observation of the beneficiary.</p> <p>Only diagnostic codes that are clearly and consistently supported by the documentation should be reported in the record. Diagnoses should be updated as the condition of the beneficiary changes. Information relating to a diagnosis that has not been reviewed in a 12-month or more periods should be confirmed immediately.</p>
<i>Service Description</i>	Psychiatric Diagnostic Assessment without medical services identifies the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. Patient condition, characteristics, or situational factors may

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CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)

require services described as being with interactive complexity. A bio-psychosocial assessment should be carried out to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of a Diagnostic Assessment Service include:

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

Psychiatric Diagnostic Assessment with medical services includes those same components listed in the assessment, but will include the medical components.

Components of a Diagnostic Assessment Service 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.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)

Comprehensive Diagnostic Assessment Services identifies the beneficiary's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment. A bio-psychosocial assessment should be carried out to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of a Diagnostic Assessment Service include:

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

Initial Assessment

Use of a standardized diagnostic tool is strongly recommended. Initial assessments must be completed within the first three non-emergency visits to the provider.

The initial assessment evaluates the beneficiary for the presence of a behavioral health disorder and is conducted face-to-face. The initial assessment is used to determine the beneficiary's mental status and social functioning and to identify any physical or medical conditions. Each beneficiary considered for initial entry into Rehabilitative Behavioral Health Services should receive an individualized, comprehensive assessment that includes a diagnosis, prior to the development of the individual plan of care.

Initial assessments may include a clinical face-to-face interview with the beneficiary and/or family members or guardians as appropriate, review of the presenting

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

Initial Assessment (Cont'd.)

problems, symptoms and functional deficits and history. This may include contact with service providers to gather beneficiary data. The initial assessment process leads to the development of the individual plan of care (provided the beneficiary meets medical necessity).

Follow-up Assessment

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.

The beneficiary's progress must be reassessed before the review of the IPOC, response to treatment, and need for continued participation in treatment. When changes occur, changes in behavior and/or conditions or when a reassessment is done, it must be documented separately on the CSN and comply with the service documentation requirements.

Psychological Testing and Evaluation

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

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. 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.

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

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

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

Staff Qualifications Diagnostic Assessment Services are provided by qualified clinical professionals as defined in the “Staff Qualifications” section of this manual.

When a determination of the appropriateness of initiating or continuing the use of psychotropic medication is required, a diagnostic assessment must be carried out by a physician, psychiatrist, or advanced practice registered nurse with prescriptive authority.

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 perform the diagnostic assessment.

Service Documentation Minimum standards require a CSN in the beneficiary’s record that includes the purpose of the assessment, the results of diagnostic assessment, or make reference to the completed assessment tool.

Staff-to-Beneficiary Ratio Diagnostic Assessment Services require 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 Limits Diagnostic Assessment Services are billed using the following frequency limits, procedure codes, and modifier combinations:

Code	Assessment	Description	Modifier	Frequency
90791	Psychiatric Diagnostic Assessment without medical services - Initial	Clinical Psychologist Master’ level staff	AH HO	1 encounter per 6 months
90792	Psychiatric Diagnostic Assessment with medical services - Initial	Specialty physician (psychiatrist) Doctoral level (MD) Physician team member svc (PA) Nurse practitioner (APRN)	AF HP AM SA	1 encounter per 6 months

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CORE REHABILITATIVE SERVICES STANDARDS

Code	Assessment	Description	Modifier	Frequency
H2000	Comprehensive Diagnostic Assessment - Initial	Clinical psychologist Master's level Bachelor's level* Registered nurse (RN)	AH HO HN TD	1 encounter per 6 months
96101	Psychological Testing (hour)	Clinical psychologist	AH	6 per day; 20 units per year
99213	Psychiatric Diagnostic Assessment - Follow-Up	Specialty physician (psychiatrist) Doctoral level (MD) Physician team member svc (PA) Nurse practitioner (APRN)	AF HP AM SA	12 encounters per year
H0031	Mental Health Comprehensive Assessment - Follow-up	Clinical psychologist Master's level Registered nurse (RN)	AH HO TD	12 encounters per year
H0001	Alcohol and/or Drug Assessment- follow-up	Clinical psychologist Master's level Registered Nurse (RN) Certified bachelor's level	AH HO TD HN	12 per year

Billable Place of Service

Diagnostic Assessment Services may be offered in all settings in the community.

Special Restrictions

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. A diagnostic assessment should be repeated only if a significant change in behavior or functioning has been noted. A repeated diagnostic assessment must be added to the clinical records.

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.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

Substance Abuse Examination (SAE) — AOD Only

Purpose

The purpose of this examination is to assess the extent of withdrawal symptoms and medical problems to determine the method for substance abuse treatment. These services are provided to beneficiaries who have received a diagnostic assessment, have been determined to have a substance abuse disorder, and are in need of substance abuse treatment.

Service Description

Delivery of this service involves a face-to-face interaction between a qualified professional and the beneficiary to assess the beneficiary's status and provide diagnostic evaluation and screening as a mechanism to provide referral for substance abuse treatment services.

The Substance Abuse Examination (SAE) is a face-to-face interaction between a qualified professional and the beneficiary to assess the beneficiary's physical and/or behavioral health status and provide diagnostic evaluation and screening. The SAE is one mechanism to provide referral for Alcohol and Other Drug Rehabilitative services. The SAE may include a tuberculosis test, as deemed necessary by the physician. The SAE must meet all applicable DHEC requirements. The SAE form must be completed and signed by a qualified professional within the appropriate time frame for the beneficiary's level of care.

Substance Abuse Examinations are performed to:

- Determine the medical necessity for initiating Alcohol and Other Drug Rehabilitation services
- Provide a specialized medical assessment
- Assess the need for referral to other health care providers

Substance Abuse Examinations must include the following:

- A brief medical history to include hospital admissions, surgeries, allergies, present medication information about shared needles, sexual activity and/or orientation, and history of hepatitis, cirrhosis, and liver diseases

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)

- A history of the beneficiary's and his or her family's involvement with alcohol and/or other drugs
- An assessment of the beneficiary's nutritional status
- An examination including, but not limited to, vital signs, inspection of the ears, nose, mouth, teeth and gums, inspection of the skin for recent or old needle marks and tracking, and abscesses or scarring from healed abscesses
- A general assessment of the beneficiary's cardiovascular system, respiratory system, gastrointestinal system, and neurological status
- A screening for anemia (hematocrit or hemoglobin may be used when the physician has access to equipment)

The SAE is a component of the process that establishes the medical necessity for the provision of residential treatment services.

Eligibility

Medicaid-eligible beneficiaries who meet the patient placement criteria for residential treatment services are eligible for this service.

Staff Qualifications

SAEs are provided by qualified professionals, such as physicians, physician assistants (PAs), advanced practice registered nurse (APRN), who are authorized by the South Carolina Board of Nursing to function in the extended role with prescriptive authority. Other professionals on a treatment team under supervision of the above listed qualified professionals may perform some SAE functions.

Staff-to-Beneficiary Ratio

SAEs require 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 Limits

SAE is billed in 15-minute units.

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CORE REHABILITATIVE SERVICES STANDARDS

Special Restrictions

SAEs must be completed within the time frame specified by DHEC licensing requirements.

Limited nursing services may be rendered as part of the physical assessment of the beneficiary following the SAE.

SERVICE PLAN DEVELOPMENT (SPD)

Purpose

The purpose of this service is the development of a plan of care for the beneficiary. The plan of care, which may be developed by an interdisciplinary team, establishes the beneficiary's needs, goals, and objectives and identifies 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 a face-to-face or telephonic 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, 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 and his/or her family's needs and desired goals and objectives. The beneficiary and clinical professional(s) or interdisciplinary team should identify the skills and abilities of the beneficiary that can help achieve their goals, identify areas in which the beneficiary needs assistance and support, and decide how the team of professionals can help meet those needs.

State Agency Interdisciplinary Team — Service Plan Development

Effective service planning should include representation from all systems of support in which the beneficiary is engaged. 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 two other health and human service agencies or providers to develop an individualized, multi-agency service plan that describes corresponding needs of the beneficiary and identifies the primary or lead provider for accessing and/or coordinating needed service provision.

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

State Agency Interdisciplinary Team — Service Plan Development (Cont'd.)

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.

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.

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.

Eligibility

All beneficiaries who are determined to need behavioral health treatment are eligible for this service.

Staff Qualifications

SPD services are provided by qualified clinical professionals as defined in the “Staff Qualifications” section of this manual.

Service Documentation

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

- The development, staffing, review and monitoring of the plan of care
- Discharge criteria and/or achievement of goals
- Confirmation of medical necessity for state agencies providing services
- Establishment of one or more diagnoses, including co-occurring substance abuse or dependence, if present (“N/A” for private organizations when documented on MNS)
- Recommended treatment

SECTION 2 POLICIES AND PROCEDURES

CORE REHABILITATIVE SERVICES STANDARDS

Staff-to-Beneficiary Ratio	SPD requires at least one professional for each beneficiary. An interdisciplinary team requires participation from at least three health and human services agency providers. Participants are actively involved in the development, revision, coordination, and implementation of the RBHS needed by the beneficiary.
Billable Place of Service	SPD may be offered in all settings in the community that allow for privacy and confidentiality.
Special Restrictions	State agencies that refer treatment services to qualified RBHS providers may designate and authorize the provider to develop the plan of care. Providers must ensure state agencies receive a copy of the IPOC within 10 days of completion.

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CORE REHABILITATIVE SERVICES STANDARDS

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SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

THERAPY

Therapy Services are provided within the context of the goals identified in the beneficiary's plan of care. Assessments, plans of care, and progress notes in the beneficiary's records must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality. The nature of the beneficiary's needs and diagnosis including substance abuse, strengths, and resources, determine the extent of the issues addressed in treatment, the psychotherapeutic modalities used by the clinical professional and its duration.

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, mental, and emotional health; and cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities. Therapy Service should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues. Therapy Services may be provided in an individual, group, or family setting.

Individual Therapy (IT)

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.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Description

Individual Therapy (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.

Eligibility

Beneficiaries that meet the medical necessity as defined by the current edition DSM or ICD diagnosis and would benefit from receiving this service.

Staff Qualifications

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

Staff-to-Beneficiary Ratio

IT is one professional to one beneficiary.

Documentation

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

Allowable Place of Service

The only **excluded** settings are hospitals. 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.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Group Therapy (GT)

Purpose

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.

Service Description

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

GT 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 GT must match the overall treatment plan for the individual beneficiary. GT 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 GT:

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

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CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

beneficiaries demonstrate a level of competency to function in GT

Caregiver Groups are direct services provided to persons serving in primary caregiver roles for beneficiaries. Caregiver groups are intended to promote effective support from the caregivers to facilitate the improvement and/or recovery of the beneficiary. These groups are psychoeducational in nature. They provide information and education to the participants about the nature of the severe mental illness, serious emotional disturbance, or substance abuse that the beneficiary experience. They allow and promote the participants to process the information and share feelings and experiences in caring for the beneficiary, and receive support from the group.

Multiple Family Group Therapy is directed toward the restoration, enhancement, or prevention of the deterioration of role performance of families. Multiple Family Group Therapy allows the therapist to address the needs of several families at the same time and mobilizes group support between families. The Multiple Family Group Therapy process provides commonality of the FT experience, including experiences with 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.

Eligibility

Beneficiaries that meet the medical necessity as defined by the current edition DSM or ICD diagnosis and would benefit from receiving this service.

Staff Qualifications

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

Staff-to-Beneficiary Ratio

GT requires one professional and no more than eight beneficiaries, or groups of up to six family units, but no more than 12 members per group.

Beneficiaries in excess of the allowed ratio should not be

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

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

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.

Documentation

The CSN must document how the group and/or family therapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Allowable Place of Service

The only **excluded** settings are hospitals. 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.

Family Therapy (FT)

Purpose

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

Service Description

Family 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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

changing the family dynamics and attempting to reduce and manage conflict. The family's strengths should be used to help them handle their problems.

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

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

Eligibility

Beneficiaries that meet the medical necessity as defined by the current edition DSM or ICD diagnosis and would benefit from receiving this service.

Staff Qualifications

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

Staff-to-Beneficiary Ratio

FT is one professional for each family unit.

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 clinical service notes.

Allowable Place of Service

The only **excluded** settings are hospitals. 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.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

SUBSTANCE ABUSE COUNSELING (SAC)

Purpose

The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. Substance Abuse Counseling (SAC) is focused on acknowledging 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 mechanisms, understanding related psychological problems that trigger addictive behavior, and encouraging the beneficiary to recognize opportunities and how to achieve them.

Service Description

SAC requires face-to-face goal-oriented interactions between a beneficiary and a clinical professional to help the beneficiary obtain the needed skills and supports to reduce use of substances, obtain abstinence, and/or manage his or her illness better. This service supports the beneficiary in achieving and maintaining substance-free stability, and helps the beneficiary to cope with or gain control over the symptoms of their illness and effects of their substance use or abuse.

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 abstinence, such as those needed to manage anger or cope with urges to use substances by altering thoughts and actions that lead to substance abuse. Interventions should focus on helping the beneficiary to develop 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 his or her physical, emotional and/or cognitive problems and helps

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

them to develop the skills and supports needed to live a satisfying life without substances. 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, anger management, etc.).

Groups serve as a forum to share information about maintaining abstinence and managing day-to-day, substance-free life and may address major developmental issues that contribute to addiction, interfere with recovery, or prevent relapse.

SAC may involve meeting 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 identified 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.

Eligibility

Beneficiaries who meet all of the following criteria:

- Requires treatment to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired
- Exhibits deficits in peer relations, dealing with authority, poor impulse control or other dysfunctional symptoms that have an adverse impact on concentration and the ability to learn or participate in daily living or social activities
- Is at risk for developing or requires treatment for maladaptive coping strategies
- Presents a reduction in adaptive behaviors and demonstrates extreme increase in personal distress

Staff Qualifications

SAC services are provided by, or under the supervision of, qualified clinical professionals as defined in the "Staff Qualifications" section.

Service Documentation

Documentation must indicate how the counseling session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

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CORE TREATMENT — THERAPY AND COUNSELING 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.

Billable Place of Service The only **excluded** settings are hospitals. 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.

Special Restrictions None.

CRISIS MANAGEMENT (CM)

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

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

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

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

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CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

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

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

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

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

Eligibility

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

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Eligibility (Cont'd.)	knowledge of the beneficiary's capabilities and functioning.
Staff Qualifications	<p>CM must be provided by qualified clinical professionals as defined in the "Staff Qualifications" section of this manual.</p> <p>Bachelor's level staff providing this service must have documented intensive training in Crisis Management.</p>
Documentation	<p>CM is not required to be listed on the plan of care. A CSN must be completed upon contact with the beneficiary and should include the following:</p> <ul style="list-style-type: none">• Start time and duration• All participants during the service• Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis• Content of the session• 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 <p>Resolution of the crisis must be clearly documented in the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>
Staff-to-Beneficiary Ratio	CM requires at least one professional for each beneficiary.
Billable Place of Service	<p>CM 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.</p> <p>Services may not be provided to a beneficiary residing in a Psychiatric Residential Treatment Facility or an Inpatient Hospital.</p>
Special Restrictions	Services provided to children must include coordination with family or guardians and other systems of care as appropriate.

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CORE TREATMENT — THERAPY AND COUNSELING SERVICES

MEDICATION MANAGEMENT (MM)

Purpose

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

Service Description

Education is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication.

Medication Management (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 one or more of the following services:

- Management, which involves prescribing and then reviewing medications for their side effects
- Monitoring, which involves observing and encouraging people to take their medications as prescribed (frequently used with people with a poor compliance history)
- Administration, which is the actual giving of an oral or injectable 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

MM is provided to do any or all of the following:

- Assess the need for beneficiaries to see the physician
- Determine the overt physiological effects related to any medication(s)
- Determine psychological effects of medications
- Monitor beneficiaries' compliance to prescription directions

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CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Description (Cont'd.)

- 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

During assessments, attempts should be made to obtain necessary information regarding the beneficiary's health status and use of medications.

MM interventions may include:

- Monitoring and evaluating the beneficiary's response to medication(s)
- Performing a medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Documenting the care delivered and communicating 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.
- Providing verbal education and training designed to enhance the beneficiary understanding and appropriate use of the medications
- Providing information, support services, and resources designed to enhance beneficiary's adherence to medication regimen
- Coordinating and integrating MM services within the broader health care management services being provided to the beneficiary

Eligibility

All Medicaid-eligible beneficiaries who meet the medical necessity criteria would benefit from this service.

Staff Qualifications

MM services are provided by, or under the supervision of, qualified clinical professionals as defined in the "Staff Qualifications" section of this manual.

A physician must be available in the event of an emergency.

SECTION 2 POLICIES AND PROCEDURES

CORE TREATMENT — THERAPY AND COUNSELING SERVICES

Service Documentation	<p>MM must be listed in the plan of care. Medication Monitoring requires that the following items be documented in the CSN:</p> <ul style="list-style-type: none">• 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• Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
Staff-to-Beneficiary Ratio	MM requires at least one professional for each beneficiary.
Billable Place of Service	The only excluded settings are hospitals. 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.
Special Restrictions	None.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

COMMUNITY SUPPORT SERVICES

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

REHABILITATIVE PSYCHOSOCIAL SERVICES (RPS)

Purpose

The purpose of the face-to-face service is to assist beneficiaries in the restoration or strengthening of skills needed to promote and sustain independence and stability in their living, learning, social, and working environments. Rehabilitative Psychosocial Services are a form of skill building support, not a form of therapy or counseling. This service includes activities that are necessary to achieve goals in the plan of care in the following areas:

- Skills development related to life in the community and to increasing the beneficiary's ability to manage their illness, to improve their quality of life and to live as actively and independently in the community as possible
- Basic living skills development in understanding and practice of daily and healthy living habits and self-care skills
- Interpersonal skills training that enhances the beneficiary's self-management and communication skills, cognitive functioning, and ability to develop and maintain environmental supports
- Consumer empowerment that improves the beneficiary's basic decision making and problem solving skills

Service Description

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

RPS should be provided in a supportive community environment. Each beneficiary should be offered RPS in a

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

manner that maximizes the beneficiary's responsibility, control, and feelings of self-worth, and encourages ownership in the rehabilitation process.

The goals of RPS are to:

- Effectively manage the illness
- Reduce problem areas that prevent successful independent living
- Develop or increase basic life skills that contribute to successful independent living

RPS includes services provided individually or in small groups based on the assessed needs and level of functioning of the beneficiary and includes activities that foster growth in the following areas:

- Basic Living Skills Development — Coaching and encouraging the beneficiary to participate in activities that enhance their basic living skills
- Interpersonal Skills Training — Directing and promoting the beneficiary's self-management, socialization, communication skills, and cognitive functioning
- Therapeutic Socialization — Teaching the beneficiary the necessary skills to appropriately perform activities that sustain independence
- Consumer Empowerment — Promoting and enhancing the beneficiary's development of basic decision-making and problem-solving skills

RPS activities that are directed to promote recovery, restore skills, and develop adaptive behaviors may include the following:

- Promoting the understanding and the practice of healthy living habits
- Promoting the enhancement of self-care, personal hygiene, selection of nutritional food, and appropriate eating habits
- Assisting with maintaining adequate relationships with others
- Promoting the expression of his or her needs, feelings, and thoughts in a supportive and safe environment

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- Promoting the safe use of community resources
- Assisting with issues of personal safety
- Promoting hope through understanding of his or her illness, its effect on their lives, social adaptation, and alternatives to improve their quality of life
- Assisting to restore basic functional abilities he or she may have lost because of the illness
- Assisting to develop abilities to maintain his or her personal belonging and living space
- Identifying and managing symptoms, attitudes, and behaviors that interfere with seeking a job or obtaining an education
- Improving concentration and attention, problem-solving skills, ethics development, and time management
- Directing interventions to identify and reduce stressors, develop coping skills and prevent decompensation
- Enabling to verbalize thoughts, feelings, and ideas in a supportive environment
- Helping to reduce distraction or preoccupation with disturbing thoughts and withdrawal

Eligibility

Beneficiaries with behaviors that interfere with the ability to function in primary aspects of daily living, such as personal relations, living arrangements, work, school and recreation would benefit from this service

Staff Qualifications

RPS is provided by qualified staff under the supervision of qualified clinical professionals as specified under the “Staff Qualifications” section.

Service Documentation

RPS must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary.

The person providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goal from the IPOC for which the delivery of this service addresses.

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COMMUNITY SUPPORT SERVICES

Service Documentation (Cont'd.)

The professional providing the service should record the specific deficit of the beneficiary and the therapeutic intervention that was used to address the deficit when the service is provided.

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

Special Restrictions

For services rendered to beneficiaries that are residing in a Community Residential Care 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.

Staff-to-Beneficiary Ratio

RPS may be provided individually, face-to-face with the beneficiary or in small groups of one staff to 12 beneficiaries, as determined appropriate based on the needs of the beneficiary. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether the beneficiary is Medicaid eligible or non-Medicaid.

Allowable Place of Service

The only **excluded** settings are hospitals. 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.

BEHAVIOR MODIFICATION (BMod)

Purpose

The purpose of this service is provided to children ages 0 to 21. The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his or her functioning within their home or community. The beneficiary's plan of care should determine the focus of this service.

Service Description

The goal of Behavior Modification (BMod) is to alter behavior that is inappropriate or undesirable of the child or the adolescent. Behavior Modification involves regularly scheduled interventions designed to optimize emotional

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

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.

BMod 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.

Inappropriate and/or undesirable behaviors are identified, targeted, stopped and/or redirected. BMod involves the observation of client behaviors and events that occur before an inappropriate and/or undesirable behavior is exhibited by the client and 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 should be used to develop, shape, model, reinforce and strengthen the new behaviors.

BMod 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 BMod should result in the display of certain desirable behavior that has been infrequently or never displayed by the beneficiary.

Eligibility

Beneficiaries ages 0 to 21 exhibiting behavior that interferes with their ability to function in primary aspects of daily living, such as personal relations, living arrangements, work, school and recreation and/or beneficiaries with behaviors that present risk of harm to self or others are eligible for this service.

Staff Qualifications

BMod services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the "Staff Qualifications" section.

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COMMUNITY SUPPORT SERVICES

Service Documentation	<p>BMod must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary.</p> <p>The physician, or other LPHA or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behavior.</p> <p>The person providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goal from the IPOC for which the delivery of this service addresses.</p> <p>In addition to general documentation requirements, the documentation of this service must include the inappropriate/undesirable behavior of the beneficiary and how the behavior was redirected.</p> <p>Billable service time must be documented in units on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>
Staff-to-Beneficiary Ratio	<p>BMod is provided individually, face-to-face with the beneficiary and a qualified professional or paraprofessional.</p>
Billable Place of Service	<p>BMod may be offered in all settings in the community.</p>
Special Restrictions	<p>Services cannot be billed for group activities.</p>
FAMILY SUPPORT (FS)	
Purpose	<p>The purpose of this face-to-face or telephonic service is to enable the family or caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as a knowledgeable member of the beneficiary's treatment team and to develop and/or improve the ability of families or caregivers to appropriately care for the beneficiary.</p>
Service Description	<p>Family Support (FS) is a medical supportive service with the primary purpose of treatment of the beneficiary's condition. The intent of this service is face-to-face contact, but services may also include telephonic contact with the identified beneficiary and collateral contact with persons who assist the beneficiary in meeting their goal as specified in the Individual Plan of Care. The documentation must</p>

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

support the circumstances that warrant services provided by telephone. FS is the process of family participation with the services provider in the treatment process of the Medicaid beneficiary. FS should result in an intervention that changes or modifies the structure, dynamics and interactions that act on the beneficiary's emotions and behavior.

FS does not treat the family or family members other than the identified beneficiary. FS is not for the purpose of history taking or coordination of care. This service includes the following discrete services when they are relevant to the goal in the individual plan of care: providing guidance to the family or caregiver on navigating systems that support individuals with behavioral health needs, such as behavioral health advocacy groups and support networks; fostering empowerment of family or caregiver by offering supportive guidance for families with behavioral health needs and encouraging participation in peer or parent support and self-help groups; and modeling these skills for parents, guardians, or caregivers. Family Support does not include respite care or child care services.

Instruction will be provided to the family or caregiver for the purpose of enabling the family or caregiver to better understand and care for the needs of the beneficiary and participate in the treatment process by coaching and redirecting activities that support therapy interventions.

Services may only be provided to the family or caregiver and directed exclusively to the effective treatment of the beneficiary.

FS is intended to:

- Equip families with coping skills to counteract the stress of dealing with the beneficiary's behavioral health needs
- Alleviate the burden of stigma that families carry
- Teach families to deal with the crisis and to coordinate effectively with service provider
- Reduce families isolation by connecting them with behavioral health advocacy and support network
- Teach families to advocate effectively for their relatives
- Provide families with knowledge and skills

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)	necessary to allow them to be an integral and active part of the beneficiary's treatment team
Eligibility	Beneficiaries with severe oppositional behaviors that unreasonably interfere with the ability to function in primary aspects of daily living, such as personal relations, living arrangements, work, school and recreation and/or beneficiaries with behaviors that present harm to self or others are eligible for this service.
Staff Qualifications	FS is provided by, or under the supervision of, qualified professionals or paraprofessionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law.
Service Documentation	<p>FS must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary.</p> <p>The physician or other LPHA or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behavior.</p> <p>The person providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goal from the IPOC for which the delivery of this service addresses.</p>
Staff-to-Beneficiary Ratio	FS requires one professional for each family unit.
Allowable Place of Service	Services may be offered in all settings in the community.
Special Restrictions	None.

PEER SUPPORT SERVICES (PSS)

Purpose	The purpose of this service is to allow people adult Medicaid beneficiaries with similar life experiences to share their understanding with other beneficiaries to assist in their recovery from mental illness and/or substance use disorders. The 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
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SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Purpose (Cont'd.)

beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of Peer Support Services (PSS).

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 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
- Confidence
- Growth
- Connection
- Boundary setting
- Planning

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- 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 illness 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.

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.

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COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- 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 learning how to change an inadequate housing situation.
- Social network interventions assist beneficiaries with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Service Description (Cont'd.)

- 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 board that consists of beneficiaries and agency staff members shall meet to discuss the services and provide reports.
- Focus groups consist of the beneficiary and the peer support specialist. Focus groups meet to discuss specific issues of the group.
- Comments from the suggestion boxes are reviewed by the client advisory board and responded to accordingly.
- Services satisfaction surveys and system-wide surveys will produce 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 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Services Evaluation and Outcome Criteria (Cont'd.)

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.

- o **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).

Eligibility

Adult beneficiaries diagnosed with severe mental illness and/or substance use disorders are eligible. Eligible services are those necessary to provide support and encouragement to beneficiaries and their families when beneficiaries first begin to receive services. Intake and assessment, adjusting to new medications, relapse, and discharge planning are examples of beginning services.

Staff Qualifications

PSS are provided under the supervision of a qualified mental health professional (MHP) or master's level substance abuse professional specified in the "Clinical Supervision" section of this manual and in accordance with South Carolina State Law. The degree of direct supervision will be contingent upon the qualifications, competencies and experience of the peer support provider specialist.

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/she must be a current or former beneficiary of services as defined by SCDHHS.

The criteria for meeting the consumer of services qualification are:

- Have had a diagnosis of mental illness 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 mental illness and/or substance use disorder
- Be in a recovery program

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Peer Support Specialist (Cont'd.)

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. 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. All trainings must be approved by SCDHHS or other authorized entity.

Note: For beneficiaries in dual recovery, experience with recovery self-help programs for individuals with mental illnesses, substance use disorders, or with co-occurring disorders is particularly valuable.

Clinical Supervision

Clinical supervision must be provided by an individual who holds at least a master's degree in a health or a human services field, is SCAADAC credentialed, or holds any of the following credentials/licensures: CSAP, LPHA, or MHP.

The clinical 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 clinical supervisor is required to chair regularly scheduled staff meetings with the peer support specialists

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Clinical Supervision (Cont'd.)

to discuss administrative and individual treatment issues. At a minimum, staff meetings shall occur every two weeks. Staff meetings are not separately billable under another clinical service, unless the staffing includes a physician consultation. The clinical 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 clinical 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. The evaluation may be billed separately as an assessment.

Service Documentation

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. PSS are required to be listed on the POC and may be listed with PRN frequency. PSS must be documented daily in the beneficiary's record.

Staff-to-Beneficiary Ratio

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

Allowable Place of Service

PSS may be provided in the beneficiary's home or natural environment, community mental health center, substance abuse facility, or other approved community mental health facility. 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' are in operation. PSS do not operate in isolation from the rest of the programs in the facility.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY SUPPORT SERVICES

Relationship to Other Services

PSS cannot be billed for Medicaid beneficiaries that are residents of an inpatient facility. PSS may only be billed to Medicaid when the beneficiary begins to receive outpatient treatment services and within 14 days of discharge from the residential facility.

Special Restrictions

None.