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## SECTION 2 POLICIES AND PROCEDURES

### REHABILITATIVE SERVICES OVERVIEW

Effective July 1, 2010, the South Carolina State Medicaid Plan was amended to allow an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d). Rehabilitative Services are medical or remedial services that have 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 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 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 Services and all other applicable state and federal laws. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of “evidence-based” practices and “emerging best practices” that ensure thorough and appropriate screening, evaluation, diagnosis, and treatment planning, and fosters improvement in the delivery of 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.

## SECTION 2 POLICIES AND PROCEDURES

### REHABILITATIVE SERVICES OVERVIEW

#### REHABILITATIVE SERVICES OVERVIEW (CONT'D.)

The National Registry of Evidence-based Programs and Practices and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

Rehabilitative Services are available to all Medicaid beneficiaries with a Behavioral health and/or Substance use 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 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 Services directly to an eligible beneficiary. Private organizations may also render Rehabilitative Services that have been prior authorized as further defined in this policy manual. **If the provider bills without authorization, the claim will not pay.**

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### ENROLLMENT APPLICATION FOR ORGANIZATIONS

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 and fee requirements
- New applicants and providers seeking revalidation shall be subject to a pre and post site visit.
- Providers must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Joint Commission in Behavioral Health Services
- LPHA or medical staff must be licensed or registered with the State where the business is located
- The applicant must have a business license from the state and/or municipality or county where the service 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.

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

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### ENROLLMENT APPLICATION FOR ORGANIZATIONS (CONT'D.)

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

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

FIELD	OPTION
Enrollment Type	Organization
Provider Type	Behavioral Health Services
Primary Specialty	Private Rehabilitative Health Services

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

**Enrollment 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.**

#### FACILITY REQUIREMENTS

Facilities must be one of the following types:

- Free Standing Building
- Office Suite – Mall
- Office Suite – Office Building Complex

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### BUSINESS REQUIREMENTS

Once enrolled, these requirements must be met:

- SCDHHS and USDHHS assume no responsibility with respect to accidents, illness or claims arising out of any activity performed by any State or private organization. The organization shall take necessary steps to insure or protect its recipient, itself and its personnel. The provider agrees to comply with all applicable local, staff, and federal occupational and safety acts, rules and regulations.
- Providers must have cost information available for review by SCDHHS upon request.
- Providers must have a policy on file for the definition of confidentiality issues, record security and maintenance, consent for treatment, release of information, beneficiary's rights and responsibilities, retention procedures, and code of ethics.
- 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. Providers are subject to termination, if the attestation is not received by the annual due date. The attestation letter must be submitted to the Division of Behavioral Health Services. (See Sample Attestation Statement in the Forms section of this manual.)

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

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### MAINTENANCE OF STAFF CREDENTIALS

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

The provider must 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 Rehabilitative 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 services. **It is the provider's responsibility to ensure staff operates within the scope of practice as required by South Carolina State law.**

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

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

All providers shall maintain a file substantiating that each treatment 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

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

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

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

The following general training requirements apply:

- All providers must ensure treatment staff receives adequate orientation to RS.
- 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 personnel file.
- 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 for existing and new employees:

- 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.

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

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

- Verification from the state and national sex offender registries that there are no findings of criminal charges against the individual. Sex offender and child abuse registries should be checked annually.
- 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 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 services. **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 using the Rehabilitative Services provider update form and submit to the Behavioral Health Division as soon as possible. Certain changes may impact your status as a Medicaid provider. The Rehabilitative provider form can be found in the Form section of the manual.

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

- Email addresses or telephone numbers of the business office
- Clinical Director
- Staff Licensure
- Business License
- Accreditation status
- DHEC licensure
- Other changes which affect compliance with Medicaid requirements

Exceptional circumstances may require that a new enrollment application be completed prior to approval. Providers must use the online application process on our Web site, <http://provider.scdhhs.gov>, to add or change a location and business ownership to an existing enrollment.

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### Reporting Changes (Cont'd.)

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

#### Business Termination Guidelines

In the event the 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 Rehabilitative services business entity is responsible for retaining administrative and beneficiary records for five years.

#### Rehabilitative Services

The following services may be rendered in accordance with this policy:

- Behavioral Health Screening
- Diagnostic Assessment
- Psychological and Evaluation and Testing
- Individual Psychotherapy
- Group Psychotherapy
- Family Psychotherapy
- Service Plan Development
- Crisis Management
- AOD Counseling Services
- Medication Management

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

#### Rehabilitative Services (Cont'd.)

- Psychosocial Rehabilitation Services (formally Rehabilitative Psychosocial)
- Family Support
- Behavior Modification (children only)
- Peer Support Services (DMH and AOD providers only)

#### Managed Care Organization

Some behavioral health services are covered for beneficiaries enrolled in Medicaid Managed Care Organizations (MCO). If the service is covered by the MCO, the provider must get authorization and claim reimbursement from the MCO directly. The policy herein does not cover services under the MCO. Providers are encouraged to visit the SCDHHS Web site at <https://msp.scdhhs.gov/managedcare/> for additional information regarding MCO coverage.

#### Quality Improvement Agent (QIO) Authorization

This section is only for Rehabilitative Service providers authorized to obtain approval through the DHHS designated Quality Improvement Organization (QIO) (KePRO). Providers must follow the prior authorization guidelines as outlined by SCDHHS before billing Medicaid. All services must be determined medically necessary as approved by the QIO.

The referring physician or state agency is responsible for the determination of medical necessity for the beneficiary. The prior authorization request form can be found on the QIO web portal at <http://scdhhs.kepro.com>. The PA form must be submitted to the QIO with the required documentation. To receive reimbursement from Medicaid, all prior authorization requests must be faxed to or submitted to the QIO via the web portal for approval. A fax cover sheet must be included with the request along with supporting documentation such as SCDHHS forms and/or clinical documentation to the QIO.

The provider will be notified via a QIO approval letter if the authorization request is approved. The provider must download the approved document(s) from the web portal or request a copy from the referring physician or state agency to be placed in the beneficiary's clinical record. The referring physician or provider may contact the QIO for additional information as follows:

## SECTION 2 POLICIES AND PROCEDURES

### PROVIDER QUALIFICATIONS

Quality Improvement  
Agent (QIO) Authorization  
(Cont'd.)

Customer Service: 1-855-326-5219  
Fax: 1-855-300-0082  
Provider Issues Email: [atrezzoissues@Kepto.com](mailto:atrezzoissues@Kepto.com)

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

## **SECTION 2 POLICIES AND PROCEDURES**

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## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

#### ELIGIBILITY FOR REHABILITATIVE SERVICES

The determination of eligibility for Rehabilitative Services should include a system-wide assessment and/or an intake process. This requires that specific information be gathered consistently regardless of the assessment tool being used. Medicaid-eligible beneficiaries may receive services when there is a confirmed psychiatric diagnosis from the current edition of the DSM or the ICD. This excludes irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders unless they co-occur with a serious 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 Rehabilitative Services. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of services.

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 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 0 to 6 years of age. Clinical documentation justifying the need for continued services 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.

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services. A physician or LPHA must certify that the beneficiary meets the medical necessity criteria for each service. 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 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 or related disabilities, and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria
- The specific rehabilitative service(s) recommended
- Identification of the beneficiary’s problem areas

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

- The physician's or LPHA's name, professional title, signature, and date (of the professional 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 services. The signature date from the SCDHHS MNS stands as the date to be used for all subsequent annual confirmations.

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

The assessment and IPOC must be completed before some services are rendered. See IPOC section for these exceptions.

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 services 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 RS. 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.

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

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

The physician or LPHA must:

- 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 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 listed on the IPOC and initiated within 45 days of the physician's or 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 SC Medicaid Program.

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 (excluding providers who receive approval through the QIO).

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 (excluding providers who receive approval through the QIO).

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

#### REFERRALS TO PRIVATE ORGANIZATIONS (CONT'D.)

Please refer to the IPOC section for services that can be rendered prior to the completion of the IPOC and are not required to be listed on the IPOC. Services not listed Cannot be rendered prior to the completion of the assessment and IPOC. Services must be listed on the IPOC and initiated within 45 days of the physician's or LPHA's signature on the document used to confirm medical necessity.

#### State Agency Referrals

The following agencies are identified as a designated state referring agency and may refer Medicaid beneficiaries to Medicaid-enrolled 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
- 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 LPHA assumes professional responsibility for all information contained in the SCDHHS MNS.

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

#### 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 LPHA from the referring state agency. **(The enrolled private organization shall 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:

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

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

All Rehabilitative Services provided by an enrolled private provider must be authorized by a designated state agency or the SCDHHS designated QIO (as authorized by SCDHHS) **prior** to the delivery of services.

When it is necessary to refer a beneficiary for services, the designated state agency will provide the qualified RS provider with a completed SCDHHS Referral/Authorization for Rehabilitative Services form (DHHS

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

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

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 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 **six months** duration.

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

- The specific service(s) authorized to be provided (*i.e.*, Individual Psychotherapy, Behavior Modification, etc.)
- The designated modifier of the staff level authorized to provide each service
- The maximum authorized amount or number of units and frequency for each service
- Signature, title and date of a qualified state agency representative and telephone 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 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.

#### UTILIZATION MANAGEMENT

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

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

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

#### STAFF QUALIFICATIONS

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

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

#### Medicaid Rehabilitative Staff Qualifications

Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
<b>PROFESSIONALS</b>				
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, PT
Psychologist	Doctoral degree in psychology	Licensed by SC Board of Psychology Examiners	40-55-20 Et seq.	All Services except PSS
Physician Assistant (PA)	Completion of an educational program for physician assistants approved by the Commission on Accredited Allied Health Education Programs	Licensed by SC Board of Medical Examiners	40-47-905	All Services, except PSS, PT
Pharmacist	Doctor of Pharmacy degree from an accredited school, college, or department of pharmacy as determined by the Board, or has received the Foreign Pharmacy Graduate Equivalency Certification issued by the National Association of Boards of Pharmacy (NABP)	Licensed by SC Board of Pharmacy	40-43-10 Et seq.	MM
Advanced Practice Registered Nurse (APRN)	Doctoral, post-nursing master's certificate, or a minimum of a master's degree that includes advanced education composed of didactic and supervised clinical practice in a specific area of advanced practice registered nursing	Licensed by SC Board of Nursing; must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty	40-33-10 Et seq.	All Services, except PSS, PT
Psycho-Educational Specialist	Master's degree plus 30 hours of psychopathology class, successfully complete the ETS School Psychology exam (PRAXIS), and be licensed	Licensed by SC Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists	40-63-5 Et seq.	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC,ST, PTR, ADA, ADS
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.	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC,ST, PTR, ADA, ADS
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.	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS

## 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
<b>PROFESSIONALS</b>				
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.	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS
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.	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS
Behavior Analyst	Must possess at least a master's degree, have 225 classroom hours of specific graduate-level coursework, meet experience requirements, and pass the Behavior Analysis Certification Examination	Behavior Analyst Certification Board	N/A	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS
Certified Substance Abuse Professional	Master's degree in counseling, social work, family therapy, nursing, psychology, or other human services field, and 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	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS
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	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS

## 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
<b>PROFESSIONALS</b>				
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	BMod, BHS, CM, DA, FS, FT, GT, IT, RPS, SPD, SAC, ST, PTR, ADA, ADS
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	BMod, BHS, CM, FS, RPS, SAC, ST, ADA, ADS
Licensed Bachelor of Social Work (LBSW)	Bachelor's degree in social work. (The practice of baccalaureate social work is a basic generalist practice that includes assessment, planning, intervention, evaluation, mediation, case management, information and referral, counseling, advocacy, supervision of employees, consultation, client education, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Baccalaureate social workers are not qualified to diagnose and treat mental illness nor provide psychotherapy services. Baccalaureate social work is practiced only in organized settings such as social, medical, or governmental agencies and may not be practiced independently or privately.)	Licensed by SC Board of Social Work Examiners	40-63-5 Et seq.	BMod, BHS, CM, FS, RPS, SAC, ST, ADA, ADS
Behavior Analyst	A board certified associate behavior analyst must have at least a bachelor's degree, have 135 classroom hours of specific coursework, meet experience requirements, and pass the Associate Behavior Analyst Certification Examination.	Behavior Analyst Certification Board	N/A	BMod, BHS, CM, FS, RPS, SAC, ST, ADA, ADS
Licensed Registered Nurse (RN)	At a minimum, an associate's degree in nursing from a Board- approved nursing education program and one year of experience working with the population to be served	Licensed by SC Board of Nursing	40-33-10 Et seq.	BMod, FS, MM, RPS, MA, ST, ADA, ADS
Licensed Practical Nurse (LPN)	Completion of an accredited program of nursing approved by the Board of Nursing and one year of experience working with the population to be served, a high school diploma or GED equivalent	Licensed by SC Board of Nursing	40-33-10 Et seq.	BMod, FS, MM, RPS, MA, ADN, ADS
<b>PARAPROFESSIONALS</b>				
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	BMod, BHS, FS, PRS, SAC, ST, ADA, ADS

## 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
<b>PROFESSIONALS</b>				
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, ST
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, ST

Title of Professional	Level of Education/Degree/or Experience Required	License or Certification Required	State or Licensure Law	Services Able to Provide
<b>PARAPROFESSIONALS</b>				
Peer Support Specialist	High school diploma or GED equivalent peer support providers must successfully complete a pre-certification program that consists of 40 hours of training. The curriculum must include the following topics: recovery goal setting; wellness recovery plans and problem solving; person centered services; and advocacy. Additionally, peer support providers must complete a minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training.	Certification as a Peer Support Specialist	N/A	PSS

#### Service Key

Service	Abbr.	Service	Abbr.	Service	Abbr.
Alcohol and Drug Assessment *	ADA	Family Psychotherapy	FT	Psychosocial rehabilitative Service formally Rehabilitative Psychosocial Services	PRS
Alcohol and Drug Nursing Assessment*	ADN	Group Psychotherapy	GT	Psychological Testing and Evaluation	PT
Alcohol and Drug Screening *	ADS	Individual Psychotherapy	IT	Psychological Testing & reporting *	PTR
Behavior Modification	BMod	Injection Medication *	IJ	Service Plan Development	SPD
Behavioral Health Screening	BHS	Medication Administration *	MA	Skills Training and Development *	ST
Crisis Management	CM	Medication Management	MM	Alcohol and Drug Substance Abuse Counseling *	SAC
Diagnostic Assessment	DA	Medical Evaluation and Management	EM		
Family Support	FS	Peer Support Service **	PSS		

\*Service provided by DAODAS only.

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

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

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

#### STAFF MONITORING/ SUPERVISION STAFF

Rehabilitative Services provided by licensed or certified professionals must follow supervision requirements as required by South Carolina State Law for each respective profession. Rehabilitative Services provided by any unlicensed/uncertified professional must be supervised by a master's level clinical professional or LPHA.

Substance Abuse professionals who are in the 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.

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

- The qualified licensed or master's level clinical professional who monitors the performance of the unlicensed professional must provide documented consultation, guidance, and education with respect to the clinical skills, competencies, and treatment provided, at least every 30 days.
- The supervising licensed or master's level clinical professional must maintain a log documenting supervision of the services provided by the unlicensed or uncertified professional to each beneficiary.
- Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care and the individual beneficiary's progress. Issues relevant to an individual beneficiary will be documented in a service note in the clinical record.

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

#### STAFF MONITORING/ SUPERVISION STAFF (CONT'D.)

- 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.

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:

## SECTION 2 POLICIES AND PROCEDURES

### ELIGIBILITY FOR REHABILITATIVE SERVICES

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

- 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.

#### 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 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 Services provided to beneficiaries in these settings are not Medicaid reimbursable.

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## **SECTION 2 POLICIES AND PROCEDURES**

### **ELIGIBILITY FOR REHABILITATIVE SERVICES**

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## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

All Rehabilitative 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 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 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

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

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

- Document that the rehabilitative service 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 services delivered. **Please refer to each individual service description in this section for specific documentation requirements.**
- Reference individuals by full name, title and agency or provider affiliation at least once in each 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 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
- 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.

Services 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 documentation. An abbreviation key must be maintained to support the use of abbreviations and symbols in entries. Providers must furnish the list and

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### ABBREVIATIONS AND SYMBOLS (CONT'D.)

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 to add new information that was not discovered until a later time. When late entries are made, adhere to the following guidelines:

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### LATE ENTRIES (CONT'D.)

- 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.

#### COMPONENTS OF THE INDIVIDUAL PLAN OF CARE (IPOC)

##### Definition

The individual plan of care (IPOC) is an individualized comprehensive plan of care to improve the beneficiary's condition. The IPOC is developed in collaboration with a beneficiary, which may include an interdisciplinary team of the following: significant other(s), parent, guardian, primary caregiver, other state agencies and staff, or service providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. While there may be certain

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Definition (Cont'd.)

treatment methodologies commonly utilized within a particular service, providers must ensure that services are tailored to the beneficiary's individual needs and the service delivery reflects knowledge of the particular treatment issues involved.

The assessment of the beneficiary is used to identify problems and needs, develop goals and objectives, and determine appropriate Rehabilitative Services and methods of intervention 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 utilizes information gathered during the evaluation, screening and assessment process. The IPOC must be written to provide a beneficiary and family-centered plan. The beneficiary must be given the opportunity to determine the direction of his or her IPOC. If family reunification or avoiding removal of the child from the home is a goal for the beneficiary, the family, legal guardian, legal representative, or primary caregiver must be encouraged to participate in the treatment planning process. Documentation of compliance with this requirement must be located in the beneficiary's record. If the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the beneficiary's clinical record. For adults, the family or a legal representative should be included as appropriate.

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

#### IPOC Documentation

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

**Beneficiary Identification:** Name and Medicaid ID number.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

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

**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 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 for completion that is individualized to the beneficiary and their goals and objectives.

**Medical or Health History:** A brief summary of medical history to include present medication, medical issues, any safety services and supports systems (a safety net).

**Family or Social Support:** A brief family or psycho social summary of the beneficiary to identify support systems available to aid the beneficiary in achieving goals

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

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

**Contact Information:** A list of all emergency contacts must be listed.

**Beneficiary Signature:** The beneficiary or their guardian must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC. If the beneficiary does not sign the plan of care or if it is not considered appropriate for the beneficiary to sign the plan of care, the reason must be documented on the IPOC.

**Authorized Signature(s):** An LPHA or master's level staff, the beneficiary, the clinician and/or interdisciplinary team which may include: significant other(s), parent, guardian, or primary caregiver, other state agencies, staff, or service providers must sign and date a signature sheet or the IPOC which identifies who is present during the IPOC meeting. If a separate signature sheet is completed, it must be kept with the IPOC.

The dated signature of the physician, LPHA or master's level clinical professional is required to confirm the appropriateness of care. Each page of the IPOC must be signed, titled and signature dated by the physician, LPHA, or master's level qualified clinical professional. The IPOC must be filed in the beneficiary's clinical record with any supporting documentation such as the diagnostic assessment.

#### Services Not Required on the IPOC

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

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

#### Duration of the IPOC

The initial IPOC must be finalized, signed, titled and signature dated by the physician, LPHA, or master's level qualified clinical professional within 45 calendar days from the signature date of the document used to confirm medical necessity. If the IPOC is not developed within 45 days, services rendered from the 46<sup>th</sup> day until the date of completion of the IPOC are not Medicaid reimbursable.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Addendum to the IPOC

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

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

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

#### IPOC REFORMULATION

The maximum duration of the IPOC is 365 calendar days from the date of the signature of the physician, LPHA, or master's level qualified clinical professional on the IPOC. Prior to termination or expiration of the treatment period, the physician, LPHA, or master's level qualified clinical professional must review the IPOC, preferably with the beneficiary and evaluate the beneficiary's progress in reference to each of the treatment objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The signature of the physician, LPHA, or master's level qualified 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.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### IPOC REFORMULATION (CONT'D.)

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

#### IPOC DEVELOPMENT – PRIVATE PROVIDERS

A state agency may authorize a private organization to develop the IPOC. The state agency must have a completed assessment to determine medical necessity.

When the private provider is authorized to develop the IPOC, the state agency must furnish the private provider the assessment, all related clinical documentation on the beneficiary, the DHHS MNS and DHHS 254 Form.

Once these steps are completed the private provider may develop the IPOC. The private provider must submit the IPOC to the state agency within 30 working days from the initial authorization date.

The state agency is responsible for ensuring the required components listed in the above section are documented in the IPOC.

After an assessment is completed, the IPOC must be developed within 45 days. If the IPOC is not completed, services rendered on or after the 46<sup>th</sup> day are not Medicaid reimbursable.

#### IPOC Additions or Changes — Private Providers

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

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

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### SERVICE PLAN DEVELOPMENT (SPD) OF THE IPOC

##### Purpose

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

##### Service Description

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

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

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

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

When there are multiple agencies or providers involved in serving the beneficiary, Service Plan Development should be conducted as a team process with the beneficiary. This treatment planning process requires meeting with at least two other health and human service agencies or providers to develop an

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

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

individualized, multi-agency service plan that describes corresponding needs of the beneficiary and identifies the primary or lead provider for accessing and/or coordinating needed service provision.

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

#### SPD-Interdisciplinary Team — Conference with Client/Family -

The purpose of this service is to allow the Physician, LPHA or master's level staff to review with other entities or support teams and the opportunity to discuss issues that are relevant to the needs of the beneficiary with the beneficiary or family member being present. Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

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

#### SPD-Interdisciplinary Team — Conference without Client/Family

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

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

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

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### Service Plan Development by Non-Physicians

The purpose of this service is to allow a non-physician to review, with or without other entities or support teams, the issues that are relevant to the needs of the beneficiary with the beneficiary or family member.

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

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

#### 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 use or dependence, if present (“N/A” for private organizations when documented on MNS)
- Recommended treatment
- Copy of the Assessment summary

The IPOC must include the date it was completed, the signature and title of the physician, LPHA, or master’s level qualified clinical professional signing the IPOC to authorize services.

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.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

Medical Necessity Criteria	Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders. The results of the assessment and/or screening tool must support the need for services.
Staff Qualifications	SPD is provided by, or under the supervision of, qualified professionals as specified under the “Staff Qualifications” section and in accordance with the South Carolina State Law. A physician, LPHA or master’s level qualified clinical professional staff must sign the finalized IPOC.
Staff-to-Beneficiary Ratio	<p>SPD requires at least one professional for each beneficiary. An interdisciplinary team requires participation from at least two qualified health professionals from any agency that have involvement with the beneficiary.</p> <p>Participants are actively involved in the development, revision, coordination and implementation of the SPD.</p>
Billing Frequency	<p>SPD-Interdisciplinary Team Conference with and without client/family present is billed as an encounter.</p> <p>SPD by a non-physician is billed in a 15 minute unit.</p>
Special Restrictions Related to Other Services	<p>State agencies that refer SPD to qualified providers may designate and authorize the provider to develop the plan of care. Providers must ensure state agencies receive a copy of the IPOC within 30 days of the authorization date. The state agency must approve the IPOC and ensure all of the components of the IPOC are completed.</p> <p>SPD codes 99366, 99367, and H0032 cannot be billed on the same date of service. Assessment codes cannot be billed on the same date of service as 99366 and 99367. The assessment must be completed prior to the development of the IPOC.</p>
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.

## SECTION 2 POLICIES AND PROCEDURES

### DOCUMENTATION REQUIREMENTS

#### PROGRESS SUMMARIES (CONT'D.)

The review of the beneficiary's participation in Rehabilitative Services 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, LPHA, or other qualified clinical professional. The 90-day progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.

The physician, 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

#### 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 or transferred to another level when they meet any of the following criteria:

- Level of functioning has significantly improved
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC
- Achieved the goals as outlined in the IPOC or reached maximum benefit
- Developed the skills and resources needed to transition to a lower level of care
- The beneficiary 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**

#### **DISCHARGE/TRANSITION CRITERIA (CONT'D.)**

- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals
- The beneficiary should be re-evaluated for services before discharge from that particular service or level of care

## **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.

#### SCREENING 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.

#### *Medical Necessity Criteria*

All Medicaid-eligible beneficiaries who have been identified as having or at risk of a substance abuse and/or mental health disorder 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***Billing Frequency*

BHS is billed in 15-minute units for a maximum of two units per day. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

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

*Special Restrictions Related to Other Services*

No restrictions

**Diagnostic Assessment (DA) Services***Purpose*

The purpose of this initial 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 bio-psychosocial interview and review of relevant psychological, medical, and education records.

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.

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.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### *Purpose (Cont'd.)*

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.

#### *Service Description*

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

Components of 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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### *Service Description (Cont'd.)*

- 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.

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. The assessment includes a bio-psychosocial assessment to gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Components of a Diagnostic Assessment Service include:

- Beneficiary 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.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### *Initial Assessment (Cont'd.)*

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 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 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).

#### *Mental Health - Comprehensive Assessment - Follow-up*

A follow-up assessment occurs after an initial assessment to re-evaluate the status of the beneficiary, identify any significant changes in behavior and/or condition, and to monitor and ensure appropriateness of treatment. .

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

#### **Medical Necessity Criteria**

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

#### **Staff Qualifications**

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

#### **Service Documentation**

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

Documentation must:

- Include the outcome of the assessment
- Identify any referrals resulting from the assessment

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

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

- Support the number of units billed

#### Staff-to-Beneficiary Ratio

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

#### Billing Frequency

DA is billed as an encounter. The initial session should last at least an hour. One encounter can be done every six months and coordination care should occur between providers. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Comprehensive Diagnostic Assessment follow-up is billed as an encounter. Services must be documented on the CSN with a start time and end time

#### Billable Place of Service

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

#### Special Restrictions Related to Other Services

The Diagnostic Assessment and Comprehensive Assessment can only be rendered every six months per beneficiary. These assessments cannot be rendered or billed on the same day.

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

#### PSYCHOLOGICAL TESTING AND EVALUATION

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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

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

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.

#### Medical Necessity Criteria

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

#### Staff Qualifications

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

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

#### Service Documentation

The CSN must include the purpose of the assessment, the results of diagnostic assessment, or make reference to the completed assessment tool.

#### Staff-to-Beneficiary Ratio

Psychological Testing and Evaluation 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.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### Billing Frequency

Psychological Testing and Evaluation is billed as a 60 minute unit. . The session should last, at a minimum, one hour. The provider can bill up to six units per day, but only 20 units are allowed in a year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

#### Billable Place of Service

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

#### Special Restrictions Related to Other Services

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

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

The Psychological Testing and Evaluation, Diagnostic and Comprehensive assessment can be billed on the same day. The assessments must be billed separately and provide different outcomes.

Code	Assessment	Description	Modifier	Frequency
90791	Psychiatric Diagnostic Assessment without medical services-Initial	Clinical Psychologist Master's level staff	AH HO	1 encounter per 6 months
90792	Psychiatric Diagnostic Assessment with medical services - Initial	Specialty physician (Psychiatrist) Physician team member svc (PA) Nurse practitioner (APRN)	AF AM SA	1 encounter per 6 months
H2000	Comprehensive Diagnostic Assessment - Initial	Clinical Psychologist Master's level	AH HO	1 encounter per 6 months

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

<b>Code</b>	<b>Assessment</b>	<b>Description</b>	<b>Modifier</b>	<b>Frequency</b>
96101	Psychological Testing (hour)	Clinical Psychologist	AH	6 per day; 20 units per year
H0031	Mental Health Comprehensive Assessment –Follow-up	Clinical Psychologist Master’s level	AH HO	1 encounter per day 12 encounters per year

## SECTION 2 POLICIES AND PROCEDURES

### CORE TREATMENT — PSYCHOTHERAPY AND COUNSELING SERVICES

#### THERAPY

Psychotherapy Services are provided within the context of the goals identified in the beneficiary's plan of care. An Assessment must be completed to determine the need for psychotherapy services. The nature of the beneficiary's needs and diagnosis including substance abuse, strengths, and resources, determine the extent of the issues addressed in treatment, the psychotherapeutic modalities used by the clinical professional and its duration.

Psychotherapy Services are based on an empirically valid body of knowledge about human behavior. Psychotherapy Services do not include educational interventions without therapeutic process interaction or any experimental therapy not generally recognized by the profession. These services do not include drug therapy or other physiological treatment methods.

Psychotherapy Services are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability; improve their physical, mental, and emotional health; and cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities. Psychotherapy Service should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues. Psychotherapy Services may be provided in an individual, group, or family setting. The assessments, plans of care, and progress notes in the beneficiary's records must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### Individual Psychotherapy (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.

##### *Service Description*

Individual Psychotherapy (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.

##### *Medical Necessity Criteria*

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

##### *Staff Qualifications*

Psychotherapy 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.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

<i>Service Documentation</i>	The CSN must document how the therapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. Services must be documented on the CSN with a start time and end time.
<i>Billing Frequency</i>	IT is billed as an encounter. Each encounter has a set time limit. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions Related to Other Service</i>	IT encounter sessions can only be rendered one time daily. Services can be rendered in a variety of combinations, but only eight sessions per month are billable. Only one Individual Psychotherapy session can be billed per day.
<b>Group Psychotherapy (GT)</b>	
<i>Purpose</i>	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.
<i>Service Description</i>	Group Psychotherapy (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.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### *Service Description (Cont'd.)*

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 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 psycho-educational 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 Psychotherapy** is directed toward the restoration, enhancement, or prevention of the deterioration of role performance of families. Multiple Family/Group Psychotherapy allows the therapist to

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

<i>Service Description (Cont'd.)</i>	address the needs of several families at the same time and mobilizes group support between families. The Multiple Family/Group Psychotherapy 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.
<i>Medical Necessity Criteria</i>	Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.
<i>Staff Qualifications</i>	Psychotherapy Services must be provided by clinical professionals operating within their scope of practice, as allowed by state law.
<i>Service Documentation</i>	The CSN must document how the group and/or family psychotherapy session applied to the identified beneficiary's treatment goals. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<i>Staff-to-Beneficiary Ratio</i>	<p>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.</p> <p>Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.</p>

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### *Billing Frequency*

GT is billed as an encounter. A session must last a minimum of 75-90 minutes. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. More than one session can be billed per day.

#### *Billable Place of Service*

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

#### *Special Restrictions Related to Other Services*

GT is an encounter session. Each session must be documented separately.

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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

#### *Service Description (Cont'd.)*

FT tends to be short-term treatment, with a focus on resolving specific problems such as eating disorders, difficulties with school, or adjustments to bereavement or geographical relocation. Treatment should be focused on changing the family dynamics and attempting to reduce and manage conflict. 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.

#### *Medical Necessity Criteria*

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

#### *Staff Qualifications*

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

#### *Service Documentation*

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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

*Staff-to-Beneficiary Ratio*

FT is one professional for each family unit.

*Billing Frequency*

FT is billed as an encounter and can only be rendered once per day. FT with the beneficiary can be rendered four sessions per month and FT without the beneficiary can be rendered four times a month. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

*Billable Place of Service*

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

*Special Restrictions Related to Other Services*

No restrictions.

### CRISIS MANAGEMENT (CM)

**Purpose**

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

**Service Description**

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

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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

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

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

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

- A preliminary evaluation of the beneficiary's specific crisis
- Intervention and stabilization of the beneficiary
- Reduction of the immediate personal distress experienced by the beneficiary
- Development of an action plan that reduces the chance of future crises through the implementation of preventative strategies
- 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.

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

<b>Medical Necessity Criteria</b>	<p>Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorder; experience acute psychiatric symptoms; or experience psychological and/or emotional changes that result in increased personal distress. Services are also provided to beneficiaries who are, at risk for a higher level of care, such as hospitalization or other out-of-home placement.</p> <p>Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning.</p>
<b>Staff Qualifications</b>	<p>CM must be provided by qualified clinical professionals as defined in the "Staff Qualifications" in this section.</p> <p>Bachelor's level staff providing this service must have documented intensive training in Crisis Management.</p>
<b>Service Documentation</b>	<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 data-bbox="716 1157 1443 1633" style="list-style-type: none"><li>• Start time and duration</li><li>• All participants during the service</li><li>• Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis</li><li>• Content of the session</li><li>• Active participation and intervention of the staff</li><li>• Response of the beneficiary to the treatment</li><li>• Beneficiary's status at the end of the session</li><li>• A plan for what will be worked on with the beneficiary</li></ul> <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>
<b>Staff-to-Beneficiary Ratio</b>	<p>CM requires at least one professional for each beneficiary.</p>

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

Billing Frequency	CM is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
Billable Place of Service	Services can be rendered in a community mental health center, substance abuse facility, or setting that affords an adequate therapeutic environment and protects the beneficiary's rights to privacy and confidentiality.
Special Restrictions Related to Other Services	Services provided to children must include coordination with family or guardians and other systems of care as appropriate.

#### MEDICATION MANAGEMENT (MM)

Purpose	The purpose of this face-to-face service is to train and educate the beneficiary about his or her medication, to determine any physiological and/or psychological effects of medication(s) on the beneficiary, administer necessary medications, and to monitor the beneficiary's compliance with his or her medication regime.
Service Description	<p>Medication Management (MM) is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication. During assessments, attempts should be made to obtain necessary information regarding the beneficiary's health status and use of medications.</p> <p>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.</p> <p>MM includes two or more of the following services:</p> <ul style="list-style-type: none"><li>• Management, which involves prescribing and then reviewing medications for their side effects</li><li>• Monitoring, which involves observing and encouraging people to take their medications as prescribed (frequently used with people with a poor compliance history)</li></ul>

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

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

- Administration, which is the actual giving of an oral medication by a licensed professional
- Training, which educates beneficiaries and their families on how to follow the medication regime and the importance of doing so
- Assess the need for beneficiaries to see the physician

MM may provide the following:

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

## SECTION 2 POLICIES AND PROCEDURES

### CORE REHABILITATIVE SERVICES STANDARDS

Service Description (Cont'd.)	<ul style="list-style-type: none"> <li>• Coordinate and integrate MM services within the broader health care management services being provided to the beneficiary</li> </ul>
Medical Necessity Criteria	Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services. The beneficiary must be on medication prescribed by a physician or being educated on how to take their medication appropriately.
Staff Qualifications	<p>MM services must be provided by a qualified clinical professional operating within their scope of practice as allowed by state law.</p> <p>A physician must be available in the event of an emergency.</p>
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"> <li>• 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</li> <li>• All benefits and side effects of new medications being prescribed or for medications that is potentially dangerous</li> <li>• Any change in medications and/or doses and rationale for any change, if applicable</li> <li>• Documentation of any medications being prescribed</li> <li>• Follow-up instructions for the next visit</li> <li>• Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</li> </ul>
Staff-to-Beneficiary Ratio	MM requires at least one professional for each beneficiary.
Billing Frequency	MM is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

## **SECTION 2 POLICIES AND PROCEDURES**

### **CORE REHABILITATIVE SERVICES STANDARDS**

**Billable Place of Service**

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

**Special Restrictions Related to Other Services**

MM cannot be billed with Individual Psychotherapy with the E&M codes.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

### PSYCHOSOCIAL REHABILITATIVE SERVICES (PRS) FORMALLY REHABILITATIVE PSYCHOSOCIAL

#### Purpose

The purpose of this face-to-face service is to assist beneficiaries with behavioral health and/or substance abuse disorders and to enhance the restoration or strengthening of the skills needed to promote and sustain independence and stability in their living, learning, social, and working environments. Services are a form of skill building support, not a form of psychotherapy or counseling.

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

- Life 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 the understanding and practice of daily and healthy living habits and self-care
- Interpersonal skills training that enhances the beneficiary's self-management and communication skills and ability to develop and maintain environmental supports
- Decision-making and problems-solving skills training to enhance personal empowerment

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Service Description

PRS 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.

PRS should be provided in a supportive community environment. Each beneficiary should be offered PRS in a manner that maximizes the beneficiary's responsibility, control and feelings of self-worth, and encourages ownership in the rehabilitation process.

The goals of PRS 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

PRS 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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

- 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
- 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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<b>Medical Necessity Criteria</b>	<p>Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorders. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.</p>
<b>Staff Qualifications</b>	<p>PRS is provided by qualified staff, under the supervision, of qualified clinical professionals as specified under the “Staff Qualifications” section. Staff providing the service must have, at a minimum, a high school diploma or GED, or higher educational level.</p>
<b>Service Documentation</b>	<p>PRS must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p> <p>The staff 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>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.</p>
<b>Staff-to-Beneficiary Ratio</b>	<p>PRS is 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.</p>
<b>Billing Frequency</b>	<p>PRS is billed in 15-minute unit. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

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

### BEHAVIOR MODIFICATION (B-Mod)

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

Inappropriate and/or undesirable behaviors are identified, targeted, stopped and/or redirected. BMod involves the observation of the beneficiary's behaviors and events that occur before an inappropriate and/or undesirable behavior is exhibited by the beneficiary 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.

#### Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorders and must be between the ages of 0 and 21. The results of the assessment and/or screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school, recreational settings and behaviors that present risk of harm to self or others.

#### Staff Qualifications

BMod services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the "Staff Qualifications" section. Staff providing the service must have, at a minimum, a high school diploma or GED, or be a higher educational level.

#### Service Documentation

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

The physician, or LPHA or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behavior.

**SECTION 2 POLICIES AND PROCEDURES****COMMUNITY SUPPORT SERVICES**

**Service Documentation (Cont'd.)** The staff 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.

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

**Staff-to-Beneficiary Ratio** BMod is provided individually, face-to-face with the beneficiary and a qualified professional or paraprofessional.

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

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

**Special Restrictions Related to Other Services** Services cannot be billed for group activities.

**FAMILY SUPPORT (FS)**

**Purpose** 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.

**Service Description** 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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

in the Individual Plan of Care. The documentation must 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.

Training and education are 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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<b>Service Description (Cont'd.)</b>	<ul style="list-style-type: none"> <li>• Educate families to advocate effectively for their relatives</li> <li>• Provide families with information and skills necessary to allow them to be an integral and active part of the beneficiary's treatment team</li> </ul>
<b>Medical Necessity Criteria</b>	Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance abuse disorder. The results of the assessment and/or screening tool must indicate a need for support and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work environment, school and recreational settings.
<b>Staff Qualifications</b>	FS is provided by, or under the supervision of, qualified professionals as specified under the "Staff Qualifications" section and in accordance with the South Carolina State Law.
<b>Service Documentation</b>	<p>FS must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary.</p> <p>The staff 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>
<b>Staff-to-Beneficiary Ratio</b>	FS requires one professional for each family unit.
<b>Billing Frequency</b>	FS is billed in 15-minute units. Services must be documented on the CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.
<b>Billable Place of Service</b>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.
<b>Special Restrictions Related to Other Services</b>	Services provided on the behalf of children must include coordination with family or guardians and other systems of care as appropriate.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### PEER SUPPORT SERVICES (PSS)

##### Purpose

The purpose of this service is to allow Medicaid beneficiaries over the age of 18 with similar life experiences to share their understanding with other beneficiaries to assist-in their recovery from mental health 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 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.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Service Description

Services are multi-faceted and emphasize the following:

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

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

The availability of services is a vital part of PSS to reinforce and enhance the beneficiary's ability to cope and function in the community and develop natural supports. Services must be rendered face to- face. The beneficiary must be willing to participate in the service delivery. Services are structured or planned one-to-one or group activities that promote socialization, recovery, self-advocacy, and preservation.

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

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

Service interventions include the following:

- Self-help activities that cultivate the beneficiary's ability to make informed and independent choices. Activities help the beneficiary develop a network for information and support from others who have been through similar experiences.
- Self-improvement 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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

- o How to divert from using the emergency room
- o How to make choices about alternative crisis support
- o Housing interventions instruct beneficiaries in learning how to maintain stable housing or learning how to change an inadequate housing situation.
- Social network interventions assist beneficiaries with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.
- Education and/or employment interventions assist beneficiaries in obtaining information about going back to school or getting job training. Interventions give beneficiaries an opportunity to acquire knowledge about mainstreaming back into full-time or part-time work. Additionally, they are taught how to obtain reasonable accommodations under the Americans with Disabilities Acts (ADA).

#### Services Evaluation and Outcome Criteria

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

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

- A client advisory group that consists of the peer support specialist, the clinical supervisor, and other clinical staff shall meet quarterly to discuss the services and provide guidance as needed.
- The focus group consists of the beneficiaries, clinical staff, and the peer support specialist. The group will meet to discuss comments from the suggestion box and any other issues.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Services Evaluation and Outcome Criteria (Cont'd.)

- Service satisfaction surveys and system-wide surveys must provide outcome measures in the following areas for PSS:
  - **Satisfaction with Services** — Beneficiaries will rate their satisfaction of PSS as evidenced by a survey that measures their own perception of care. Service satisfaction surveys and system-wide surveys will be used to improve access to treatment, and to improve the quality of treatment.
  - **Access to Services** — Beneficiaries will rate the accessibility of the services and how much assistance the program provided. The survey should be given at the beginning of the service and at the end of the service. The survey will assist in providing a guide to help determine treatment intensity for mental health and/or substance use disorders.
  - **Clinical Outcomes** — Beneficiaries receiving PSS will maintain or improve their functioning as evidenced by a combination of the beneficiary's self-report measure of outcome (*e.g.*, MHSIP); and a clinical measure, such as the Global Assessment of Functioning (GAF).

#### Medical Necessity Criteria

Medicaid beneficiaries over the age of 18 and diagnosed with a behavioral health and/or substance abuse disorders are eligible for services. The results of the screening tool must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

PPS facilitate the need to build community supports to increase recovery time and provides support and encouragement to beneficiaries and their families. Services should begin following the development of the IPOC and authorization as required, throughout treatment, adjustments to new medications, relapse, and discharge planning.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Staff Qualifications

##### *Peer Support Specialist*

The peer support specialist must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a certification training program, and he/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 behavioral health or substance use disorder, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and received treatment for the disorder
- Self-identify as having had a behavioral health and/or substance use disorder
- Be in a recovery program

Peer support specialists must have the following experience:

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Supervision

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

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

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

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

- Monitor the recovery process of the beneficiary
- Monitor the focus of the services provided
- Ensure that the beneficiary continues to meet the Peer Support criteria

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

#### Service Documentation

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

**SECTION 2 POLICIES AND PROCEDURES****COMMUNITY SUPPORT SERVICES**

<b>Service Documentation (Cont'd.)</b>	<p>Billable services must be documented in units on the beneficiary's CSN. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p> <p>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.</p>
<b>Staff-to-Beneficiary Ratio</b>	<p>PSS is provided one-to-one or in a group setting. When rendered in groups, PSS shall not exceed one professional per eight beneficiaries.</p>
<b>Billing Frequency</b>	<p>PSS is billed in 15-minute units with 16 units billed per day. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>
<b>Billable Place of Service</b>	<p>The only excluded settings are acute care hospitals. PSS can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.</p> <p>As a group service, PSS may operate in the same building as other day services. However, with regard to staffing, content, and physical space; a clear distinction must exist between day services during the hours the PSS is in operation. PSS do not operate in isolation from the rest of the programs in the facility.</p>
<b>Special Restrictions Related to Other Services</b>	<p>PSS cannot be billed for Medicaid beneficiaries that reside in an acute care hospital facility.</p> <p>PSS can only be provided by DMH and DAODAS.</p>

## **SECTION 2 POLICIES AND PROCEDURES**

### **COMMUNITY SUPPORT SERVICES**

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## SECTION 2 POLICIES AND PROCEDURES

### SUBSTANCE ABUSE TREATMENT SERVICES

#### PROGRAM DESCRIPTION

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

SCDHHS has adopted the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC) for the Treatment of Substance-Related Disorders as the basis for the beneficiary's placement in the appropriate levels of care. This manual specifies the policies that SCDHHS requires providers to meet, in addition to the ASAM criteria

Beneficiaries must have a diagnosis of behavioral health and/or substance use disorder from the most recent DSM or ICD manual and meet medical necessity requirements before being placed in an AOD outpatient or residential treatment program. Services must be authorized by a physician or Licensed Practitioner of the Healing Arts (LPHA).

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### PROGRAM DESCRIPTION (CONT'D.)

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

DADOAS providers may render specific services listed in the “Core Rehabilitative,” “Core Treatment,” and “Community Support” sections above. In order to be reimbursed for these services, DAODAS providers must follow the guidelines under “DAODAS Only Procedure Codes” in Section 4 of this manual.

#### PROGRAM SERVICES

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

#### Alcohol and Drug Screening (ADS) and Brief Intervention Services

##### *Purpose*

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

##### *Service Description*

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

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI — Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

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

Screenings should focus on patterns of behavioral health and/or substance use disorder and associated factors such as legal problems, mental health status, educational functioning, and living situation.

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

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

#### *Medical Necessity Criteria*

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

#### *Staff Qualifications*

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

#### *Service Documentation*

Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes ADS results should be documented during or immediately following the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Documentation must contain the following:

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Staff-to-Beneficiary Ratio</i>	ADS require one staff member for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.
<i>Billing Frequency</i>	ADS is billed as an encounter. Twelve (12) encounters are allowed in a year. Only one encounter code is allowed per day.
<i>Billable Place of Service</i>	The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions</i>	An AOD initial assessment without a physical examination cannot be billed on the same date of services as an AOD structured screening and brief intervention service.
<b>Alcohol and Drug Assessment (ADA) w/o Physical</b>	
<i>Purpose</i>	The purpose of this face-to-face assessment is to determine the need for rehabilitative services and substance abuse 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 bio-psychosocial interview and review of relevant psychological, medical, and education records.
<i>Service Description</i>	The information obtained during the assessment must lead to a diagnosis that identifies the beneficiary's current symptoms or disorder by using the current edition of the DSM or ICD. The assessment process is used to gather information 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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

records, and observation of the beneficiary.

Only diagnostic codes that are clearly and consistently supported by the documentation should be reported. Diagnoses should be updated as the condition of the beneficiary changes.

Components of the assessment service include:

- Beneficiary demographic information
- Presenting complaint or 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

#### **Follow-up Assessment**

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

A follow-up assessment should occur before the review of the IPOC, response to treatment, and need for continued participation in treatment. When changes in behavior and/or other related conditions occur or when a reassessment is completed, it must be documented separately on the CSN and comply with the service documentation requirements.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Medical Necessity Criteria</i>	All Medicaid-eligible beneficiaries who have been identified as having or at risk of a behavioral health and/or substance use disorder are eligible for this service.
<i>Staff Qualification</i>	ADA must be provided by qualified clinical professionals as defined in the “Staff Qualifications” section of this manual, who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral.
<i>Service Documentation</i>	<p>Services must be documented on the CSN with a start time and end time. Additionally; the documentation must meet all SCDHHS requirements for clinical service notes. The completed assessment tool and written interpretation of the results must be filed in the beneficiary’s clinical record within 10 working days from the date of service.</p> <p>The documentation must include the outcome of the assessment, identify any referrals resulting from the assessment and support the number of units billed.</p>
<i>Staff to Beneficiary Ratio</i>	ADA 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.
<i>Billing Frequency</i>	ADA is billed as an encounter. A session should last a minimum of 60 minutes. One encounter is allowed every six months and coordination care should occur between providers.
<i>Billable Place of Service</i>	The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary’s rights to privacy and confidentiality.
<i>Special Restriction in Relationship to Other Services</i>	The assessment can only be rendered every six months per beneficiary. Services are rendered by the staff listed in Section 4 of this manual.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Alcohol and Drug/Substance Abuse Counseling (SAC)

##### *Purpose*

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

This service provides reinforcement of the beneficiary's ability to function within the confines of society without having to rely on addictive substances. SAC addresses goals identified in the plan of care that involves the beneficiary relearning basic coping strategies, understanding related psychological problems that trigger addictive behavior, and encouraging the beneficiary to recognize opportunities to change their behavior and how to achieve their goals.

##### *Service Description*

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

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

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

#### **Substance Abuse Group - Counseling**

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

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

#### *Medical Necessity Criteria*

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

#### *Staff Qualifications*

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

#### *Service Documentation*

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

**SECTION 2 POLICIES AND PROCEDURES****COMMUNITY SUPPORT SERVICES**

<i>Staff-to-Beneficiary Ratio</i>	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.
<i>Billing Frequency</i>	Individual counseling is billed in a 15-minute unit. Group counseling is billed as an encounter. A group session should last at a minimum of 60 minutes. If the session last longer than 60 minutes, this time is not billable. Only one encounter code is allowed per day.
<i>Billable Place of Service</i>	The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions in Relationship to Other Services</i>	None
<b>Skills Training (ST) and Development Services for Children (0 to 6 years)</b>	
<i>Purpose</i>	The purpose of this service is to provide Skills Training and Development to children 0 to 6 years of age. This face-to-face service provides activities that will restore or enhance targeted behaviors and improve the child's ability to function in his or her living, learning, and social environments. Skills Training and Development is a form of skills building support. It is not a form of psychotherapy or counseling. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn needed life skills.
<i>Service Description</i>	Skills Training and Development is a means to alter behavior that is inappropriate or undesirable of the child. Services involve regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

clinically planned activities that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

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

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

Skills Training and Development interactions include the following:

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

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

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

#### *Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders and must be 0 to 6 years of age. The results of the screening and/or assessment tool must indicate a functioning level that supports the need for services and the behavior must interfere with the ability to function in at least two of these areas: daily living, personal relationships, work setting, school and recreational settings.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Staff Qualifications</i>	Skills Training and Development services are provided by qualified staff, under the supervision, of qualified clinical staff as defined in the “Staff Qualifications” section. Staff providing the service must have, at a minimum, a high school diploma or GED, or higher educational level.
<i>Service Documentation</i>	<p>The CSN must document how Skills Training and Development applies to the beneficiary’s treatment goals. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. The service must be listed on the IPOC with a planned frequency and should be documented upon contact with the beneficiary or immediately afterwards.</p> <p>The physician, LPHA, or other qualified clinical professional is responsible for developing the IPOC that includes strategies for eliminating and managing behaviors.</p> <p>The staff providing the service is responsible for completing and signing the documentation.</p> <p>In addition to general documentation requirements, the documentation of this service must include the inappropriate or undesirable behavior of the beneficiary and how the behavior was redirected.</p>
<i>Staff-to-Beneficiary Ratio</i>	Skills Training and Development is provided face-to-face with the beneficiary. The service can be rendered in groups of one staff to 12 beneficiaries, as appropriate, based on the needs of the beneficiary. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the individual is Medicaid eligible.
<i>Billing Frequency</i>	Skills Training and Development is billed in a 15-minute unit.
<i>Billable Place of Service</i>	The only exclude settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary’s rights to privacy and confidentiality.
<i>Special Restrictions in Relationship to Other Services</i>	Services provided to children must include coordination with family or guardians and other systems of care, as appropriate.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Psychological Testing and Reporting

*Purpose*

The purpose of this service is to evaluate 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 the use of other non-experimental methods of evaluation.

Psychological Testing services are provided by a qualified clinical professional. The professional provides the administering of the test and technical aspects of the test. This service is rendered face-to-face with the Medicaid-eligible beneficiary.

*Service Description*

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

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

*Medical Necessity Criteria*

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

*Staff Qualifications*

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

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

*Service Documentation*

The documentation must include the purpose of the assessment, the results of diagnostic assessment, and the name of the assessment tool utilized.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

*Staff-to-Beneficiary Ratio* Psychological Testing and Reporting requires one professional for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.

*Billing Frequency* Psychological Testing is billed as an encounter. The session should last, at a minimum, one hour. Six units can be billed per day, but only 20 units are allowed in a year. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

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

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

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

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

### MEDICAL SERVICES

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Physical Examination*

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

The examination may also be used to determine the following:

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

Physical examinations must include the following:

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Evaluation for New Patients*

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

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

- A detailed history
- A detailed examination
- A medical decision

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

#### *Evaluation for Established Patients*

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

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

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

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

#### *Medical Necessity Criteria*

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

#### *Staff Qualifications*

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Staff Qualifications (Cont'd.)</i>	<p>Qualified health care professionals include physicians, physician assistants (PA) and advanced practical registered nurse (APRN) practitioners.</p> <p>A physician must be available in the event of an emergency.</p>
<i>Service Documentation</i>	<p>The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment. The record must reflect the level of service billed.</p> <p>Services must be documented on the CSN and signed by a qualified professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.</p>
<i>Staff-to-Beneficiary Ratio</i>	<p>Services require at least one professional for each beneficiary.</p>
<i>Billing Frequency</i>	<p>Services are billed as an encounter. Only one encounter code is allowed per day.</p>
<i>Billable Place of Service</i>	<p>The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting where the beneficiary and the professional will have an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.</p>
<i>Special Restrictions in Relationship to Other Services</i>	<p>New Patient (99203) and Established Patient (99213) services are allowed one per day per service.</p> <p>When a beneficiary receives a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same medical professional, providers must document both the E/M and psychotherapy codes. The difference in the services must be significant and documented separately on the CSN.</p> <p>Only one EM encounter is allowed per day when the Individual Psychotherapy codes (90833 and 90836) are used.</p>

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Alcohol and Drug Assessment Nursing Services

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

#### *Service Description*

Alcohol and Drug Assessment Nursing Services are provided as a face-to-face interaction between a qualified health care professional and the beneficiary.

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

Alcohol and Drug Nursing Services include, but are not limited to, the following:

- Providing medical assessment(s)
- Assessing and/or monitoring the beneficiary's physical status
- Assessing and/or monitoring the beneficiary's response to treatment
- Providing medication management
- Assessing the need for referrals to other health care systems
- Monitoring the beneficiary's mental behaviors
- Verifying the beneficiary's medications, which may have been prescribed as oral or injection
- Assessing the need for the beneficiary to see the physician
- Monitoring for overt side effects related to any medication
- Monitoring for psychological effects of the medications
- Monitoring for interactions of psychiatric medications, prescribe medications, and substance abuse

#### *Medical Necessity Criteria*

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Staff Qualifications</i>	Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.
<i>Service Documentation</i>	<p>The appropriate medical documentation must appear in the beneficiary's medical record to justify medical necessity for the level of service reimbursed, including the illness, history, physical findings, diagnosis, and prescribed treatment.</p> <p>Services must be documented on the CSN or nursing progress form and signed by a qualified health care professional within the appropriate time frame for the beneficiary's level of care. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes. A nursing discharge form must be completed when the beneficiary moves to another level of service.</p>
<i>Staff-to-Beneficiary Ratio</i>	Services require at least one professional for each beneficiary.
<i>Billing Frequency</i>	When billed as a discrete service, Alcohol and Drug Nursing Services are billed in a 15-minute unit.
<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or a setting where the beneficiary and the professional will have an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions in Relationship to Other Services</i>	Nursing Services may be billed when providing discrete services, IOP, or Day treatment/Partial Hospital services.
<b>Medication Administration (MA)</b>	The purpose of this service is to allow a health care professional to administer an injection to the beneficiary. The medical record must substantiate the medical necessity for this treatment.
<i>Service Description</i>	Medication Administration is rendered in response to a physician, PA, or APRN order. The order must be documented on a Physician Medical Order (PMO) form. The qualified health care professional must ensure the form is properly completed and included in the medical record to

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Service Description (Cont'd.)</i>	confirm the initial and any subsequent contacts with the beneficiary.
<i>Medical Necessity Criteria</i>	Beneficiaries eligible for this service must have a diagnosis of a behavioral health and/or substance use disorder. Providers must have a prescription or medical order from a qualified health care professional to administer the prescription drug Vivitrol.
<i>Staff Qualifications</i>	Services must be provided by qualified health care professionals operating within their scope of practice, as allowed by state law.
<i>Service Documentation</i>	<p>Medication Administration must be listed in the plan of care and PMO and be documented on a CSN as the service to be rendered.</p> <p>The provider of the service must include the following items on the CSN in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:</p> <ul style="list-style-type: none"><li>• A list of the beneficiary's current prescribed medications and over-the-counter medications</li></ul> <p><b>Note:</b> Providers can reference a PMO or other documentation in the medical record that lists all the medications prescribed to the beneficiary.</p> <ul style="list-style-type: none"><li>• The quantity and strength of the dosage given</li><li>• The injection route (I.M., I.D., I.V.)</li><li>• The injection site</li><li>• The side effects or adverse reactions of medications</li><li>• All benefits of the medications being prescribed</li><li>• Any change in medications and/or doses and the rationale for any change, if applicable</li><li>• Follow-up instructions for the next visit</li></ul>
<i>Staff-to-Beneficiary Ratio</i>	Medication Administration requires at least one qualified health care professional for each beneficiary.
<i>Billing Frequency</i>	Medication Administration is billed as an encounter and must be billed with the injection code. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a community mental health center, substance abuse facility, or setting where the beneficiary and the professional will have an adequate therapeutic environment that protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions in Relationship to Other Services</i>	Medication Administration is billed in conjunction with injection code J2315.
<b>Injectable Medication</b>	
<i>Purpose</i>	This code is the specific Injectable Medication, provided by a qualified health care professional with a medical prescription or order. The purpose of the treatment is to restore, maintain, or improve a beneficiary's behavior or substance use disorder.
<i>Service Description</i>	The qualified health care professional must ensure the injection medication order is properly completed and included in the medical record to confirm the initial and any subsequent administration to the beneficiary. The procedure code for the injection is billed in conjunction with procedure code 96372.
<i>Medical Necessity Criteria</i>	Beneficiaries eligible for these services must have a diagnosis of behavioral health and/or substance use disorders by a qualified health care professional.
<i>Staff Qualifications</i>	A qualified health care professional who is authorized in the state of South Carolina to give an injectable medication can render this service.
<i>Service Documentation</i>	<p>Injectable Medication is required to be listed on the PMO. The injection must be documented on the CSN as the service. The documentation should include the following items in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:</p> <ul style="list-style-type: none"><li>• The medication administered</li><li>• The quantity and strength of the dosage given</li><li>• The injection route (I.M., I.D., I.V.)</li></ul>

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

*Service Documentation  
(Cont'd.)*

- The injection site
- The side effects or adverse reactions of the medication

*Billing Frequency*

The injectable procedure code is billed as an encounter and is rendered only one time a month to the beneficiary.

*Billable Places of Service*

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

*Special Restriction in  
Relationship to Other  
Services*

A qualified health care professional must provide a prescription for the injection.

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

**Substance Abuse  
Outpatient and Residential  
Treatment Services**

To provide services all providers must meet appropriate federal and state licensure, and all requirements outlined in the SCDHHS provider enrollment policy and this manual.

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Purpose*

The purpose of this array of services is to provide intervention for the treatment and management of substance abuse and addictive disorders in an outpatient or residential treatment settings. Services must have a rehabilitative and a recovery focus designed to promote skills for coping with and managing behavioral health and/or substance use symptoms and behaviors. Services must address the beneficiary's lifestyle, disposition and behavioral problems that have the potential to undermine the participation and successful completion of the treatment. Treatment services assist the beneficiary with managing withdrawal from substances of abuse and achieving abstinence, effectively responding to or avoiding identified precursors or triggers that would put them at risk of use and relapse in their natural environment. Participation in services that provide supportive counseling, focused therapeutic interventions, emotional and behavioral management, problem solving, social and interpersonal skills, psychotherapy services, psychosocial rehabilitation, family support and medication management and daily and independent living skills in order to improve functional stability to adapt to community living.

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

#### *Outpatient Substance Abuse Treatment Overview*

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

#### *Alcohol and/or Drug - Intensive Outpatient - (IOP) Services (Level II.I)*

IOP services are supervised structured treatment services provided to beneficiaries who are in need of more than discrete outpatient treatment services or as an alternative to residential treatment. The appropriate level of care takes into consideration the beneficiary's cognitive and

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Alcohol and/or Drug - Intensive Outpatient - (IOP) Services (Level II.I) (Cont'd.)

emotional experiences that have contributed to substance abuse or dependency. IOP allows the beneficiary opportunities to practice new coping skills and strategies learned in treatment, while still within a supportive treatment relationship and their “real world” environment.

#### *Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders.

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

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

#### *Service Description*

The IOP service is comprised of the following services:

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

The following services may be billed as discrete services:

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

#### **Staff providing services:**

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

#### **Length of Stay Criteria / Continued Stay Criteria**

IOP generally provides 9 – 19 hours of clinically intensive programming per week based on the beneficiary's plan of care. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment. The amount, frequency, and intensity of the services must reflect the needs of the beneficiary and must address the objectives of the beneficiary's plan of care.

#### *Service Documentation*

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

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

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

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

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

**SECTION 2 POLICIES AND PROCEDURES****COMMUNITY SUPPORT SERVICES**

<i>Staff-to-Beneficiary Ratio</i>	The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.
<i>Billing Frequency</i>	Alcohol and/or Drug Intensive Outpatient - IOP services are billed as an hourly inclusive rate.
<i>Billable Place of Service</i>	The only excluded settings are acute care hospitals. Services can be rendered in a substance abuse facility, or setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.
<i>Special Restrictions in Relationship to Other Services</i>	All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.
<b>Alcohol and Drug Outpatient -Day Treatment /Partial Hospitalization — Level II.5</b>	<p>The treatment program is a structured and supervised intense treatment program that provides frequent monitoring/ management of the beneficiary's medical and emotional concerns in order to avoid hospitalization. The program has access to psychiatric, medical, and laboratory services. Intensive services at this level of care provide additional clinical support in a community setting</p> <p>These conditions will provide the beneficiary with the opportunity to practice skills learned in treatment and apply them in their natural environment.</p>
<i>Medical Necessity Criteria</i>	<p>Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder.</p> <p>The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM dimensions below:</p>

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Medical Necessity Criteria (Cont'd.)*

- Direct admission to Level II.5 is warranted for the beneficiary who meets specification on Dimension 2 (if any biomedical conditions or problems exist) and specifications in one of Dimensions 4, 5, or 6.
- Transfer to Level II.5 is warranted for the beneficiary who has met treatment objectives at a more intensive level of care and requires Level II.5 service intensity in at least one dimension.
- Transfer to Level II.5 may be warranted when services provided at Level I or Level II.1 has been insufficient to address the beneficiary's needs. In addition, transfer to this level is appropriate when motivational interventions provided have prepared the beneficiary for participation in a more intensive level of care.

#### *Service Description*

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

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

The following may be billed as discrete services:

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

Staff providing services:

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

Length of Stay Criteria / Continued Stay Criteria:

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Documentation*

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

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

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

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

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

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

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

#### *Billing Frequency*

Alcohol and/or Drug Treatment Outpatient - Day Treatment/Hospitalization services are billed as an hourly inclusive rate.

#### *Billable Place of Service*

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Special Restrictions in Relationship to Other Services*

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

#### Discharge/Transition Criteria From Outpatient Programs

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

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

The beneficiary should be re-evaluated for services before discharged from a particular level of care.

#### RESIDENTIAL SUBSTANCE ABUSE TREATMENT OVERVIEW

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### RESIDENTIAL SUBSTANCE ABUSE TREATMENT OVERVIEW (CONT'D.)

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

#### Alcohol and /or Drug - Sub-acute Detox -Clinically Managed Residential Detoxification - Level III.2- D

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

#### *Medical Necessity Criteria*

Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders.

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

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

#### *Service Description*

The program is comprised of the following services:

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

The following may be billed as discrete services:

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

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

The following services are included in the program:

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

Staff providing services:

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

Length of Stay/Continued Stay Criteria:

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

The following guidelines are used to determine length of stay:

- The beneficiary's withdrawal signs and symptoms are sufficiently resolved and symptoms can be safely managed at a less intensive level of care
- The beneficiary's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification is indicated.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

- The beneficiary may be transferred to a more intensive level of care or the addition of other clinical services are needed when the following occurs:
  - The Beneficiary is unable to complete detoxification at this level of care despite an adequate trial.
  - Symptoms complicating the withdrawal indicate the need to transfer the beneficiary to another level of care.

#### *Service Documentation*

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

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

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

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

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

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

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Billing Frequency</i>	Alcohol and/or Drug Sub-acute Detox - Clinically Managed Residential Detoxification services are billed at a daily per diem rate.
<i>Billable Place of Service</i>	Services can only be rendered in a 16 bed or less substance abuse facility.
<i>Special Restrictions in Relationship to Other Services</i>	All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.
<b>Alcohol and /or Drug Acute Detox -Medical Monitored Residential Detoxification Services – Level III.7-D</b>	<p>The program provides 24-hour supervision, observation, and support for beneficiaries who are intoxicated or experiencing withdrawal in a residential setting.</p> <p>At this level of care, physicians are available 24 hours per day and are available to assess the beneficiary within 24 hours of admission (or sooner, if medically necessary) and must be available to provide onsite monitoring of care and further evaluation on a daily basis.</p> <p>Primary emphasis is placed on ensuring that the beneficiary is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal), assessing for adequate bio-psychosocial stability, intervening immediately to establish bio-psychosocial stability and facilitating effective linkage to other appropriate residential and outpatient services.</p> <p>A registered nurse, or other qualified nursing specialist, will be present to administer a Nursing Admission History. A nurse is responsible for overseeing the monitoring of the beneficiary’s progress and medication administration on an hourly basis, if needed.</p>
<i>Medical Necessity Criteria</i>	<p>Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorder.</p> <p>The beneficiary must meet ASAM criteria for this level of care placement, with the appropriate documentation reflecting applicable medical necessity on each of the ASAM dimensions:</p>

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Medical Necessity Criteria (Cont'd.)*

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

#### *Service Description*

The program is comprised of the following services:

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

The following may be billed as discrete services:

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

The following services are included in the program:

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

Staff providing services:

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

Length of Stay/Continued Stay Criteria:

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

Treatment typically lasts 3–5 days. The duration of treatment varies with the severity of the beneficiary's illness, and response to treatment. The following guidelines are used to determine length of stay:

- The beneficiary's withdrawal signs and symptoms are sufficiently resolved to be safely managed at a less intensive level of care
- The beneficiary's withdrawal signs and symptoms have failed to respond to treatment and have intensified such that transfer to a Level IV-D detoxification service is indicated

#### *Service Documentation*

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

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

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

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

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

<i>Staff-to-Beneficiary Ratio</i>	The staff-to-beneficiary ratio must not exceed the allowed ratio set by specific services listed in this manual. The ratio applies to all beneficiaries receiving services by a provider, regardless of whether or not the beneficiary is Medicaid eligible.
<i>Billing Frequency</i>	Alcohol and/or Drug Acute Detox - Medical Monitored Residential Detoxification Services are billed at a daily per diem rate.
<i>Billable Place of Service</i>	Services can only be rendered in a 16 bed or less substance abuse facility.
<i>Special Restrictions in Relationship to Other Services</i>	All services must be authorized except for Diagnostic assessments, AOD assessment, AOD screening, AOD Nursing assessment, Service Plan Development, Crisis intervention, and Medical Evaluation and Management services. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.
<b>Behavioral Health Long Term Residential - Clinically Managed High-Intensity Residential Treatment - (Level III.5-R)</b>	The program is designed to promote abstinence from substances and antisocial behavior and to effect an overall change in the lifestyle, attitude and values of persons who have significant social and psychological problems. The defining characteristics of these beneficiaries are found in their emotional/behavioral and cognitive conditions (Dimension 3) and their living environments (Dimension 6). This service provides a comprehensive, multi-faceted treatment to beneficiaries who have multiple deficits, which may include criminal activity, and psychological problems (including serious and persistent mental disorders).
<i>Medical Necessity Criteria</i>	<p>Beneficiaries eligible for these services must have a diagnosis of a behavioral health and/or substance use disorders.</p> <p>The beneficiary must meet ASAM criteria for this level of care placement, with documentation reflecting applicable medical necessity on each of the ASAM Dimensions:</p> <ul style="list-style-type: none"><li>• The beneficiary has no withdrawal signs or symptoms or withdrawal can be safely managed in this level of care</li></ul>

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Medical Necessity Criteria (Cont'd.)*

- Biomedical problems are stable or not severe enough to warrant hospital treatment, but are sufficient to distract from treatment or recovery efforts
- Emotional, behavioral, or cognitive conditions render the beneficiary unable to control substance use and the resulting level of dysfunction precludes participation in less structured level of care
- The beneficiary has not reached the motivational stage of change required due to intensity and chronicity of the substance use problem
- The beneficiary has not developed insight into connection between substance use and life problems and blames external factors for his or her problems
- The beneficiary does not recognize relapse triggers and is not committed to continuing care
- The beneficiary is unable to control substance use, little ability to interrupt the relapse process
- The beneficiary is experiencing addiction symptoms and is unable to employ skills to prevent a relapse
- The beneficiary is in a crisis situation with imminent danger of a relapse
- The beneficiary continues to use substances despite recent active participation in the treatment program at a less intensive level of care
- The beneficiary's living environment is characterized by high risk of victimization, criminal behavior, antisocial norms and values, or other factors that make it unlikely he or she will be able to achieve or maintain recovery at a less intensive level of care.

#### *Service Description*

The program is comprised of the following services:

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

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

The following may be billed as discrete services:

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

The following services are included in the program:

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

Staff providing services:

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

Length of Stay/Continued Stay Criteria:

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Documentation*

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

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

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

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

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

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

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

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

#### *Billing Frequency*

Behavioral Health Long Term Residential - Clinically Managed High-Intensity Residential Treatment services are billed at a daily per diem rate.

#### *Billable Place of Service*

Services can only be rendered in a 16 bed or less substance abuse facility.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Special Restrictions in Relationship to Other Services*

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

#### **Behavioral Health Short Term Residential - Medically Monitored Intensive Residential Treatment – (Level III.7-R)**

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

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

#### *Medical Necessity Criteria*

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

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

*Medical Necessity Criteria  
(Cont'd.)*

combination of deficits in Dimensions 1, 2 or 3, which indicates a need for the intensity of services in Level III.7-R.

*Service Description*

The program is comprised of the following services:

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

The following may be billed as discrete services:

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

The following services are included in the program:

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

Staff providing services:

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

Length of Stay/Continued Stay Criteria:

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

**SECTION 2 POLICIES AND PROCEDURES****COMMUNITY SUPPORT SERVICES***Service Description (Cont'd.)*

the weekends The average length of stay is 30 days.

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

*Service Documentation*

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

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

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

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

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

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

*Staff-to-Beneficiary Ratio*

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

*Billing Frequency*

Behavioral Health Short Term Residential - Medically Monitored Intensive Residential Treatment services are billed at a daily per diem rate.

*Billable Place of Service*

Services can only be rendered in a 16 bed or less substance abuse facility.

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Special Restrictions in Relationship to Other Services*

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

#### **Behavioral Health Short Term Residential - Medically Monitored High-Intensity - Residential Treatment Services Residential - Level III.7-RA**

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

Treatment program may include the following activities:

- Activities designed to develop and apply recovery skills and promote development of a social network supportive of recovery,
- Enhance the beneficiary's understanding of addictions,
- Promote successful involvement in regular productive daily activity,
- Enhance personal responsibility and developmental maturity,
- Promote successful reintegration into community living.

#### *Medical Necessity Criteria*

#### Medical Necessity Criteria

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

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Medical Necessity Criteria (Cont'd.)*

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

#### *Service Description*

The program comprises the following services:

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

The following may be billed as discrete services:

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

The following services are included in the program:

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### *Service Description (Cont'd.)*

- 24-hour medical observation, monitoring and treatment
- Emergency medical services available as needed
- Laboratory screening as needed
- Medication order by a qualified health care professional
- Physical examination within 24 hours after admission and provide face-to face evaluations at least once a week.
- The beneficiary must have a registered nurse who is responsible for overseeing the monitoring of the beneficiary's progress and medication administration.

#### Staff providing services:

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

#### Length of Stay/Continued Stay Criteria:

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

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

#### *Service Documentation*

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

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

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

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

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

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

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

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

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

#### *Billing Frequency*

Behavioral Health Short Term Residential - Medically Monitored High-Intensity - Residential Treatment services are billed at a daily per diem rate.

#### *Billable Place of Service*

Services can only be rendered in a substance abuse facility.

#### *Special Restrictions in Relationship to Other Services*

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

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

#### *Discharge/Transition Criteria from Residential Services*

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

- The beneficiary's level of functioning has significantly improved

## SECTION 2 POLICIES AND PROCEDURES

### COMMUNITY SUPPORT SERVICES

#### Discharge/Transition Criteria from Residential Services (Cont'd.)

- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC.
- The beneficiary has achieved the goals as outlined in the IPOC or reached maximum benefit.
- The beneficiary has developed the skills and resources needed to transition to a lower level of care.
- The beneficiary requested to be discharged from treatment and is not imminently dangerous to self or others.
- The beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals.

The beneficiary should be re-evaluated for services before discharged from a particular level of care.