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POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (DHHS) provides Medicaid reimbursement for medically necessary services provided to Medicaid-eligible individuals in the Local Education Agency (LEA). This includes, but is not limited to, children under the age of 21 who have or are at risk of developing sensory, emotional, behavioral, or social impairments, physical disabilities, medical conditions, mental retardation, developmental disabilities or delays, or autism.

Each Local Education Agency (LEA) recognized as such by the South Carolina Department of Education has contracted with DHHS to provide Medicaid-reimbursable School-Based Services to Medicaid-eligible children with special needs. Individual service providers employed or contracted by an LEA must meet the specified Medicaid provider qualifications.

Medicaid reimbursement is available for the following School-Based Services:

- Applied Behavior Therapy
- Audiological
- Physical Therapy
- Occupational Therapy
- Speech and Language Pathology
- Psychological Testing and Evaluation
- Orientation & Mobility
- Behavioral Health Services
    - Therapeutic Behavioral Services (Center Based)
    - Therapeutic Behavioral Services (Home Visit)
    - Psychosocial Rehabilitation Services
- Nursing Services for Children Under 21
- Administrative Claiming
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Non Emergency Transportation

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

GENERAL INFORMATION (CONT'D.)

The development of an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP) is a requirement of the Individuals with Disabilities Education Act (IDEA). Medicaid requires School-Based Services to be indicated on the IEP, IFSP or the Individualized Treatment Plan (ITP). However, Medicaid will not reimburse for any administrative or direct services performed for pre-IEP/IFSP activities. Medicaid will not reimburse for the IEP team member meetings or the cost related to attendance at those meetings by medical professionals.

EVALUATIONS

Evaluations must result in the development of an IEP or IFSP in order to be reimbursed by Medicaid and the treatment services are indicated on the IEP or IFSP. Psychological Testing and Evaluation Services may be billed without the requirement of an IEP or IFSP.

Medicaid will not reimburse for providers attending an IEP or an IFSP meeting.

The following policies apply when an LEA relies upon Social Security Act §1903(c) (42 U.S.C. 1396b(c)) as its basis for billing Medicaid:

- Medicaid-reimbursed School-Based Rehabilitative Therapy Services must be included in the Individual Education Program (IEP) or Individual Family Service Plan (IFSP). Rehabilitative Therapy Services include Applied Behavior Therapy Services (ABTS), Audiology, Nursing Services, Orientation & Mobility Services, Occupational and Physical Therapy Services, School Psychology Services, and Speech Language Pathology Therapy.
- Medicaid-reimbursed School-Based Rehabilitative Behavioral Health Services are not required to be included in the IEP, IFSP, or Individual Treatment Plan (ITP). Rehabilitative Behavioral Health Services include Therapeutic Behavioral Services (Center Based) (formerly Therapeutic Child Treatment), Therapeutic Behavioral Services (Home Visit), and Psychosocial Rehabilitation Services (formerly Clinical Day Programming).

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GENERAL INFORMATION

GENERAL INFORMATION (CONT'D.)

- Medicaid-reimbursed Medicaid Adolescent Pregnancy Prevention Services (MAPPS) are not required to be included in the IEP, IFSP, or ITP.

LEAs must adhere to the applicable IDEA requirements when Medicaid-reimbursed School-Based Services are included in the IEP or IFSP. However, Rehabilitative Behavioral Health Services must be indicated on an ITP. The IEP or IFSP may be used as the ITP if all of the minimum components are indicated. If IDEA permits the Medicaid-reimbursed School-Based Service to be documented in attachments to the IEP file, then such documentation meets these requirements.

PROVIDER QUALIFICATIONS

LEAs and/or sub-contractors must meet all applicable Medicaid provider qualifications as well as the applicable state licensure regulations in addition to any specified requirements by the State Department of Education for the provision of Medicaid School-Based Services. The contracted LEA is responsible for ensuring the individuals rendering Medicaid School-Based Services are approved, credentialed, or licensed.

LEAs may contract with any qualified provider for School-Based Services. The LEA must utilize the subcontract format approved and provided by DHHS. This can be found in the applicable appendix of the LEA contract. This format includes the federal and state contractual components that are required to ensure that Medicaid reimbursement is available. There may be additional state and/or federal requirements for approval by DHHS. LEAs may include other terms and conditions necessary to fully define the responsibilities of both parties.

All subcontracts (*i.e.*, billing contracts, contracted providers, etc.) are subject to the terms of the LEA's contract with DHHS and the LEA provider is held solely responsible for the performance of the subcontractor. Additionally, a copy of the LEA's contract with DHHS, if applicable, must be provided to the subcontractor by attachment to the subcontract. Please contact your Medicaid program manager if a copy of the current DHHS subcontract format is needed.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

PROVIDER QUALIFICATIONS (CONT'D.)

Medicaid reimbursement is available for School-Based Rehabilitative Services (*i.e.,* Speech-Language Pathology, Audiology, Physical Therapy, Occupational Therapy, and Orientation & Mobility Services) when provided by or under the direction of the qualified rehabilitative therapy provider for which the beneficiary has been referred. Referrals must be made by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law.

Supervision/Under the Direction of

In accordance with Centers for Medicare and Medicaid Services (CMS) directives, CMS has interpreted the term "under the direction of" to mean that the provider is individually involved with the patient and accepts ultimate legal responsibility for the services rendered by the individuals that he or she agrees to direct. The supervisor is responsible for all the services provided or omitted by the individual that he or she agrees to directly supervise.

At no time may the individual being supervised perform tasks when the supervisor cannot be reached by personal contact, phone, pager, or other immediate means. The supervisor must make provisions, in writing, for emergency situations including designation of another qualified provider who has agreed to be available on an as-needed basis to provide supervision and consultation to the individual when the supervisor is not available.

The supervisor must be readily available to offer continuing supervision. "Readily available" means that the supervisor must be physically accessible to the individual being supervised within a certain response time based upon the medical history and condition of the beneficiary and competency of personnel. Supervision should involve specific instructions from the supervisor to the individual regarding the treatment regimen, responses to indications of adverse beneficiary reactions, and any other issues necessary to ensure the appropriate provision of the Medicaid-reimbursable services.

The supervisor must adhere to any provisions as required by the South Carolina Labor Licensing and Regulations (LLR).

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GENERAL INFORMATION

Referrals

Referral by Other Licensed Practitioners of the Healing Arts for Rehabilitative Therapy Services Only (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Orientation & Mobility Services, and Audiology)

Referral means that the physician or other LPHA has asked another qualified health provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies and equipment.

When the IEP/IFSP multi-disciplinary team is used as the referral source for Rehabilitative Therapy Services, the team must include an individual who meets the other LPHA as defined by Medicaid. The other LPHA initial referral must be obtained from a Licensed Practitioner of the Healing Arts (LPHA) other than the individual direct provider of the Rehabilitative Service.

The referral documentation must occur prior to the provision of the initial Medicaid Rehabilitative Therapy Service to include evaluation. The referral must meet the following requirements:

- Be updated no later than the annual renewal of the IEP
- Be obtained from an LPHA other than the direct provider of services
- Be clearly documented in the clinical record with the name, date, and title of the provider
- Explain reason for referral

The following list indicates the professional designations of those considered as Licensed Practitioners of the Healing Arts for the purpose of Medicaid reimbursement of School-Based Services (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Orientation & Mobility Services, and Audiology):

- Licensed Physicians Assistant
- Licensed Psychologist
- Certified School Psychologist II or III
- Registered Nurse (RN)

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GENERAL INFORMATION

Referrals (Cont'd.)

- Licensed Practical Nurse (LPN)
- Advanced Practice Registered Nurse
- Speech-Language Pathologist
- Licensed Audiologist
- Licensed Physical Therapist
- Licensed Occupational Therapist
- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Other staff as approved in writing by DHHS

Please refer to other sections of this manual for LPHAs for services other than Rehabilitative Therapy Services.

The following list indicates the professional designations of those considered as Licensed Practitioners of the Healing Arts for the purpose of Medicaid reimbursement of Children's Behavioral Health Services (Psychosocial Rehabilitative Services and Therapeutic Behavioral Services):

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

Please refer to the Children's Behavioral Health Services section of this manual for applicable service standards.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Referrals (Cont'd.)

Please refer to Other Medicaid-Covered School-Based Services and other standards sections of this manual for other Licensed Practitioners of the Healing Arts requirements, if applicable.

Documentation Requirements

Clinical Records

As a condition of participation in the Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid beneficiary. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care. Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by DHHS. It is essential that an internal records review be conducted by each LEA to ensure that the services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policy and procedure.

LEAs are required to maintain a clinical record on each Medicaid-eligible child that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid payment. Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of the services provided and progress toward treatment goals. The information in the clinical services notes must be clearly linked to the goals and objectives listed on the IEP/IFSP. For example, descriptions should be used to clearly link information from goals and objectives to the interventions performed and progress obtained in the clinical service notes. Clinical records should be arranged logically so that information may be easily reviewed, copied, and audited.

The provider of services is required to maintain clinical records on each Medicaid-eligible child. Each clinical record must include the following:

- A Release of Information form signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the child (this

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GENERAL INFORMATION

Clinical Records (Cont'd.)

may be incorporated into a Consent for Treatment form)

- A referral for services by a physician or other Licensed Practitioner of the Healing Arts, if applicable
- A current and valid Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) indicating the child's need for services
- Test results and evaluation reports
- A current and valid ITP, when applicable
- Clinical Service Notes
- Progress Summary Notes

Clinical Service Notes

Services should be documented in Clinical Service Notes. A Clinical Service Note is a written summary of each treatment session. The purpose of these notes is to record the nature of the child's treatment by capturing the services provided and summarizing the child's participation in treatment. In the event that services are discontinued, the provider must indicate the reason for discontinuing treatment on the Clinical Service Notes.

Clinical Service Notes must:

1. Provide a pertinent clinical description of the activities that took place during the session, including an indication of the child's response to treatment as related to stated goals and objectives as listed in the IEP, IFSP, or ITP
2. Reflect delivery of a specific billable service as identified in the physician's or other LPHA's referral and the child's IEP, IFSP, or ITP
3. Document that the services rendered correspond to billing as to date of service, type of service rendered, and length of time of service delivery
4. Be individualized with patient's level of participation and response to intervention when documenting group services

When completing Clinical Service Notes:

1. Each entry must be individualized and patient-specific. Each entry must stand on its own and may

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Clinical Service Notes (Cont'd.)

not include arrows, ditto marks, "same as above," etc.

2. All entries must be made by the provider delivering the service and should be accurate, complete, and recorded immediately.
3. All entries must be typed or legibly handwritten in dark ink. Copies are acceptable, but must be completely legible. Originals must be available if needed.
4. All entries must be dated and legibly signed with the provider's name or initials and professional title.
5. All entries must be filed in the child's clinical record in chronological order by discipline.

All Clinical Service Notes used must include a narrative summary. The documentation must justify the number of units billed.

Error Correction Procedures

The child's clinical record is a legal document. Therefore, extreme caution should be used when altering any part of the record. Appropriate procedures for the correction of errors in legal documents must be followed when correcting an error in a clinical record. Errors in documentation should never be totally marked out and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature/initials and date next to the correction. If warranted, an explanation of the correction may be appropriate.

Medical Necessity

Medicaid will pay for service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.

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SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Medicaid reimbursement is available for the following School-Based Rehabilitative Therapy Services:

- Applied Behavior Therapy
- Audiological
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Psychological Testing and Evaluation
- Orientation & Mobility

Beneficiary Requirements

Eligibility for Services

In order to be eligible for School-Based Rehabilitative Therapy Services, a Medicaid-eligible individual must:

- Be under the age of 21
- Have a current and valid Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination that identifies the need for rehabilitative therapy services

APPLIED BEHAVIOR THERAPY SERVICES

Program Description

Applied Behavior Therapy Services (ABTS) consist of the assessment and treatment of children with a diagnosis of autism. Based on an individual child's strengths and weaknesses, a discrete trial training method of service is utilized to provide one-on-one therapy sessions. Children referred to Applied Behavior Therapy Services need an intensively structured, individualized curriculum that includes the management of difficult behaviors. Trained therapists implement and oversee the program of Applied Behavior Therapy Services for purposes of remediation of

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Description (Cont'd.)

the learning, behavioral, communication, and social deficits that are central to autism. Applied Behavior Therapy Services are provided in coordination with public education services for children ages three to 21 years of age. The goal of the service is to produce sufficient change so that the child can function within limits of more acceptable behaviors in a less restrictive setting.

Medicaid will utilize the Local Education Agency (LEA) as the authorizing agent for children referred to Applied Behavior Therapy Services. Services will be provided and coordinated through the LEA. Medicaid will only provide reimbursement for Applied Behavior Therapy Services to the LEA.

Medical Necessity

Applied Behavior Therapy Services shall be recommended by a multi-disciplinary team that shall include, but is not limited to, a specialist knowledgeable and experienced in the education of students with autism, a certified school Psychologist, and a Speech-Language Pathologist.

A child diagnosed with autism who has been recommended by the multi-disciplinary team is eligible for services if four or more of the following indicators are present:

- Exhibits or previously exhibited disturbances in developmental rates and/or sequences
- Exhibits or previously exhibited disturbances in responses to sensory stimuli
- Exhibits impaired or unusual comprehension and/or use of speech, language, and communication
- Exhibits impaired abilities to relate to people, objects, or events
- Exhibits a significant rating on a standardized autism rating scale

The certified school psychologist will complete, sign, and date a Medical Necessity Statement form prior to the delivery of the service that will be placed in the child's record authorizing the service delivery.

Program Staff

The LEA will be responsible for designating qualified individuals for the Applied Behavior Therapy Services (ABTS) staff positions. It is understood that parents/families are key members of their child's treatment

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff (Cont'd.)

team and may in some instances be the lead therapist or hold other staff positions listed below; however, Medicaid will not reimburse for ABTS services provided to a child by a family member. A family member is defined as parents/caregivers, siblings, grandparents, or any member of the child's household.

There are three staff positions in the ABTS program: Applied Behavior Therapy Assistant (ABTA), Applied Behavior Lead Therapist (ABLT), and Applied Behavior Coordinator (ABC). When necessary, it is acceptable for persons who meet the qualifications to hold two positions simultaneously.

Applied Behavior Therapy Assistant

An **Applied Behavior Therapy Assistant (ABTA**) is an individual who has a minimum of a high school education and meets all of the following training requirements:

- Has successfully completed 12 hours of competency-based training in the implementation of Applied Behavior Therapy
- Has completed three hours of training in autism

Applied Behavior Lead Therapist

An **Applied Behavior Lead Therapist (ABLT)** is an individual who has a minimum of a high school education and meets all of the following training requirements:

- Must have documentation verifying the completion of a minimum of 45 hours of competency-based training in the implementation of Applied Behavior Therapy, regardless of when the hours of training were taken.

  A minimum of 18 hours is required upon assuming the duties of the ABLT. If additional hours are needed to fulfill the 45 hours requirement, the ABLT shall have a period of 24 months from the date of hire to complete the training requirement. The 18 hours may count towards the 45 hours training requirement.
- Have at least one year of experience in the application of Applied Behavior Therapy, six months of which has been under supervision
- Must have documentation verifying the completion of a minimum of 18 hours of training in autism

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Applied Behavior Lead Therapist (Cont'd.)

All hours of training in autism acquired by an individual who is an ABLT will count toward the total 18 hours, regardless of when these hours of training were taken. If additional hours are needed to fulfill this requirement, the ABLT shall have a period of 24 months from date of hire to complete the requirements.

Applied Behavior Coordinator

An **Applied Behavior Coordinator (ABC)** is an individual who is accessible and available to program staff and must meet one of the following educational requirements:

- Have certification from the South Carolina State Department of Education in special education, school psychology, speech correction, or related specialties
- Have a South Carolina license in a health and human services field, such as counseling, psychology, social work, and/or speech therapy
- Have a graduate degree in Applied Behavior Analysis

An **Applied Behavior Coordinator (ABC)** must meet all of the following training requirements:

- Must have documentation verifying the completion of a minimum of 45 hours of competency-based training in the implementation of Applied Behavior Therapy, regardless of when the hours of training were taken.

  A minimum of 18 hours is required upon assuming the duties of the ABC. If additional hours are needed to fulfill the 45 hours training requirement, the ABC shall have a period of 24 months from the date of hire to complete the training requirement. The 18 hours may count towards the 45 hours training requirement.
- Have at least one year of experience in the supervision and application of Applied Behavior Therapy
- Must have documentation verifying the completion of a minimum of 45 hours of training in autism

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Applied Behavior Coordinator (Cont'd.)

All hours of training in the spectrum of autism acquired by an individual who is an ABC will count toward this total 45-hour training requirement, regardless of when these hours of training were taken. If additional hours are needed to fulfill this requirement, the ABC shall have a period of 24 months from date of hire to complete the requirements.

Supervision

Program Director

The Program Director shall provide program oversight for Applied Behavior Therapy Services and be available for consultation regarding treatment issues of the child as well as for program management issues.

The Program Director must meet the criteria equivalent to that specified by the State Department of Education's Director of Special Services or any of the following: Licensed School Psychologist, Licensed Psycho-Educational Specialist, School Psychologist Level II, or School Psychologist Level III.

Program Staff

The Applied Behavior Coordinator (ABC) is responsible for the Applied Behavior Therapy Services and supervises the therapy staff. The ABC is required to chair a staffing meeting during which administrative and child treatment issues are considered. Staffing for each beneficiary will occur at a minimum of once each month. All staffing shall be documented.

The Applied Behavior Lead Therapist (ABLT) is responsible for supervision of the ABTAs. Newly hired ABTAs should receive supervision twice each week for the first six weeks and weekly thereafter.

When treatment issues of the child are being discussed during staff supervision, Medicaid will only reimburse for one staff position.

Training

Please contact the South Carolina Department of Education for information regarding training opportunities and competency guidelines.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Staff-to-Case Ratios

Applied Behavior Therapy direct services are rendered one child to one staff member.

Service Description

Applied Behavior Therapy Services shall be provided to each child based on assessed needs and must be documented in the child's IEP. The services listed below are the components of ABTS.

Initial and Ongoing Behavioral Assessment Services

Initial Assessment Services include intake information, observation of child and child with family, family conferences, and review of current diagnostic and treatment information. The information acquired during the assessment process will be used in the development of the child's individual treatment plan.

On-going Behavioral Assessment Services include a continuing process of assessing the status of the child and the child's current level of functioning while the child is receiving ABTS.

One-on-One Therapy

One-on-One Therapy is intensive individualized therapy services delivered by staff directly to the child in a home, school, or other environment, as specified in the individualized treatment plan. These face-to-face interactions between staff and child are directed toward the development and/or enhancement of skills necessary for emotional, cognitive, behavioral, language, and interpersonal growth.

Shadow Services

Shadow Services provide opportunities for staff to observe and prompt the child's social interactions and school performance and enable staff to monitor the progress of interventions rendered during ABTS. Shadow Services also provide opportunities to modify the treatment plan.

Crisis Management

Crisis Management is an intense service provided immediately to the identified child following abrupt or substantial changes in the child's functioning during Applied Behavior Therapy intervention.

Coordination Services

An integral part of the implementation of Applied Behavior Therapy Services is program coordination. All data relative to the treatment program must be reviewed and adjustments made to the child's treatment program as

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Coordination Services (Cont'd.)

appropriate. The coordination of services involves scheduling of therapeutic interventions, the facilitation of meetings with therapists and teachers, and the supervision of staff involved in the child's treatment.

Applied Behavior Therapy Assistant Services

T1024-HI

Applied Behavior Therapy Assistant Services are services performed by an Applied Behavior Therapy Assistant and consist of individual one-on-one therapeutic interventions involving child-staff interactions designed to direct the child toward acceptable, adaptive behaviors. The following services may be provided by an ABTA and reimbursed as an Applied Behavior Therapy Assistant Service:

- Ongoing Behavioral Assessment Services
- One-on-One Therapy
- Shadow Services
- Crisis Management

Applied Behavior Lead Therapy Services

T1024-HM

Applied Behavior Lead Therapy Services are services performed by an Applied Behavior Lead Therapist and consist of individual one-on-one therapeutic interventions involving child-staff interactions designed to direct the child toward acceptable, adaptive behaviors. The following services may be provided by an ABLT and reimbursed as an Applied Behavior Lead Therapy Service:

- Initial and Ongoing Assessment Services
- One-on-One Therapy
- Shadow Services
- Crisis Management
- Treatment Planning and Quarterly Reviews
- Coordination Services, when applicable

Applied Behavior Coordination Services

T1024-HN

Applied Behavior Coordination Services are services performed by an Applied Behavior Coordinator and consist of the coordination of Applied Behavior Therapy Services including program supervision, coordination of service

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Applied Behavior Coordination Services (Cont'd.)

provision and program development, program monitoring, and adjusting and reviewing individual treatment programs. The following services may be provided by an ABC and reimbursed as an Applied Behavior Coordination Service:

- Initial and Ongoing Assessment Services
- Treatment Planning and Quarterly Reviews
- Shadow Services
- One-on-One Therapy
- Crisis Management
- Coordination Services

Documentation

See Documentation Requirements under General Information earlier in this section.

Clinical Record

Medicaid reimbursement is directly related to the delivery of treatment services. Each client record must contain adequate documentation to support the treatment services rendered. The documentation of the treatment services provided to the child, the child's response to treatment, and the staff's interaction and program involvement will justify and support the services billed to Medicaid. At a minimum, each clinical record shall contain the following information:

- Medical Necessity Statement
- Individual Treatment Plan with evidence of quarterly reviews
- Progress Summary Notes

Individual Treatment Plan

Initial Treatment Plan

An individual treatment plan must be developed for each child by or before the 15th day the child is present in the program. The plan must be signed and dated by the child's parent/caregiver. The ABC and the ABLT shall date and sign the plan. Others on the treatment team may also sign the treatment plan if appropriate. The treatment plan shall be based on the initial assessment of the strengths and weaknesses of the child and family, and shall address the following:

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Individual Treatment Plan (Cont'd.)

- Specific behaviors requiring treatment
- Treatment goals and objectives
- Frequency of interventions

Treatment Plan Review

The treatment plan must be reviewed at a minimum of every 90 days. However, the treatment plan is a working document that shall be adjusted as objectives are accomplished and new objectives are added. All treatment plan modifications or adjustments must be signed/initialed and dated by the ABC/ABLT.

Progress Summary Notes

The Progress Summary Note (PSN) must be completed for each session rendered. A complete account of the service is entered on the PSN in the appropriate column, and must be documented (per session or other billable activity) per day, and dated/signed/initialed by the staff providing the service. The child's participation and/or psychosocial and behavioral status and functioning during the session should be documented in the Results column. The Results column should document the summation of other activities (*i.e.,* treatment planning, coordination activities, etc.).

Note: A credentials file must be maintained at the School District ABTS Program verifying the qualifications of each individual who is being reimbursed for providing ABTS. These credentials must meet the minimum qualifications outlined in Program Staff.

AUDIOLOGICAL SERVICES

Program Description

Audiological Services include diagnostic, screening, preventive, or corrective services provided to individuals with hearing disorders by or under the direction of an Audiologist. Individuals must be referred by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law to receive these services. A referral is when the physician or other LPHA has asked another qualified health provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies and equipment.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Description (Cont'd.)

Audiological Services involve testing and evaluation of hearing-impaired children under 21 years of age that may or may not be improved by medication or surgical treatment and includes services related to hearing aid use and professional consultation.

Program Staff

Audiological Services are services provided by or under the direction of an Audiologist.

An **Audiologist** is an individual who is currently licensed by the South Carolina State Board of Examiners in Speech-Language Pathology and Audiology and meets **one** of the following requirements:

- Has a certificate of clinical competence from the American Speech and Hearing Association
- Has completed the equivalent educational requirements and work experience necessary for the certificate
- Has completed the academic program and is acquiring supervised work experience to qualify for the certificate

Supervision

See Supervision under Provider Qualifications earlier in this section.

Hearing Aids

Hearing aids may be provided for individuals under the age of 21 when the need is established through an audiological evaluation. The attending Audiologist may send a request for a hearing aid or aids, along with a physician's statement completed within the last six months indicating that there is no medical contraindication to the use of a hearing aid, to the South Carolina Department of Health and Environmental Control's (DHEC) local Children's Rehabilitative Services (CRS) office. DHEC will then arrange for the provision of the requested hearing aids. Children birth to 18 years of age should be enrolled in the CRS program. Requests for hearing aids for children 18 to 21 years of age should be sent to:

CRS Central Office
Robert Mills Complex
Box 101106
Columbia, SC 29211

For more information, call CRS at (803) 898-0784.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Service Description

Audiological Evaluation **92557**

An audiological evaluation is the evaluation of pertinent history, air and bone conduction thresholds, speech recognition scores, tympanometry, impedance testing, and a written report with recommendations. When these measurements are not obtainable, speech awareness and localization responses may be substituted. Other procedures may be included in the evaluation if necessary to complete the evaluation. This service may be performed once every 12 months.

Audiological Re-evaluation **92557-52**

An audiological re-evaluation is when appropriate components of the initial evaluation are re-evaluated and provided as a separate procedure. The necessity of a audiological re-evaluation must be appropriately documented. This service may be performed five times every 12 months.

Hearing Aid Evaluation **92590**

A Hearing Aid Evaluation — Amplification Selection consists of computerized prescriptive methods, real ear measurements, loudness discomfort level measurements, ANSI instrument specification and/or functional gain assessment (which may include aided speech reception threshold, communication questionnaires, and aided speech recognition scores in both quiet and noise), aided pure tone testing, and a written report with recommendations. When these measurements are not obtainable, speech awareness and localization responses may be substituted. Amplification includes hearing aids and assistive listening technologies. This service may be performed five times every 12 months.

Hearing Aid Re-Check **92592-52**

A Hearing Aid Re-check — Amplification Follow-up is when appropriate components of the initial Amplification Selection, Fitting, and Programming are re-checked and provided as a separate procedure. This service may be performed five times every 12 months.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Hearing Aid Orientation — Amplification Fitting, Programming, and Orientation

V5011-HA

A Hearing Aid Orientation — Amplification Fitting, Programming, and Orientation consists of computerized prescriptive methods, real ear measurements, and/or functional gain assessment (which includes aided speech), recognition thresholds, speech recognition scores in both quiet and noise, and pure tone testing). Instruction should be provided to the parent/guardian, teacher, and/or child on the use of the amplification to include care, safety, and warranty procedures. This service may be provided five times every 12 months.

Right Ear Mold

V5265-RT

A Right Ear Mold is a mold impression of the right ear and includes fabricating, modifying, and fitting the ear mold. This service may be performed five times every 12 months.

Left Ear Mold

5265-LT

A Left Ear Mold is a mold impression of the left ear and includes fabricating, modifying, and fitting the ear mold. This service may be performed five times every 12 months.

Hearing Aid Analysis — Amplification Analysis

92592

A Hearing Aid Analysis—Amplification Analysis is a physical inspection, listening check, and/or electro-acoustical analysis of the function of the amplification device(s) by accepted methods and instruments, when provided as a separate procedure. This service may be performed five times every 12 months.

Pure Tone Air Conduction Testing

92552

Pure Tone Air Conduction Testing is a testing of pure tone air conduction thresholds, when provided as a separate procedure. This service may be provided five times every 12 months.

Impedance Testing

92567

Impedance Testing is a testing of tympanograms and/or acoustic reflex, when provided as a separate procedure unrelated to the hearing evaluation process. This service may be performed five times every 12 months.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Handling Fee

V5090

The Handling Fee is time spent in handling amplification repairs. This service may be performed five times every 12 months.

Aural Rehabilitation Following Cochlear Implant With or Without Speech Processor Programming

92510

An Aural Rehabilitation Following Cochlear Implant with or without Speech Processor Programming is the measurement of patient responses to electrical stimulation used to program the speech processor and functional gain measurements to assess a patient's responses to his or her cochlear implant. Instructions should be provided to the parent/guardian, teacher, and/or patient on the use of a cochlear implant device to include care, safety, and warranty procedures. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed 10 times a year.

Electrocochleography

92584

An Electrocochleography tests the internal components of the implanted receiver and connected electrode array. This procedure verifies the integrity of the implanted electrode array and is completed immediately after the operation. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed once per implantation.

Documentation

See Documentation Requirements under General Information earlier in this section.

PHYSICAL THERAPY SERVICES

Program Description

Physical Therapy Services are services referred by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Physical Therapist. It includes any necessary supplies and equipment.

Physical Therapy Services involve evaluation and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Description (Cont'd.)

Physical Therapy involves the use of physical agents, mechanical means, and other remedial treatment to restore normal physical functioning following illness or injury.

Program Staff

Physical Therapy Services are provided by or under the direction of a Physical Therapist.

Physical Therapist

A **Physical Therapist (PT)** is an individual who is:

- Currently licensed by the South Carolina Board of Physical Therapy Examiners
- A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent

Physical Therapist Assistant

A **Physical Therapist Assistant (PTA)** is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners.

Supervision of Physical Therapy Assistants

Physical Therapist Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Physical Therapist. Additionally, the supervising therapist must review and initial each Summary of Progress completed by the assistant. These licensed individuals must adhere to any provisions as required by the South Carolina Department of Labor Licensing and Regulations (LLR).

Service Description

Physical Therapy Evaluation

97001-HA

A Physical Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Physical Therapy Association and South Carolina Board of Physical Therapy Examiners guidelines, the physician or other LPHA, the Physical Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records, an observation of the patient, and an interview, when possible. The evaluation must include diagnostic testing and assessment, and a written report with recommendations.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Individual and Group Physical Therapy

Individual 97110

Group 97150

Individual and Group Physical Therapy is the development and implementation of specialized Physical Therapy programs that incorporate the use of appropriate modalities; performance of written and/or oral training of teachers and/or family regarding appropriate Physical Therapy activities/therapeutic positioning in the school or home environment; recommendations on equipment needs; and safety inspections and adjustments of adaptive positional equipment. Physical Therapy performed on behalf of one child should be documented and billed as Individual Physical Therapy. Physical Therapy performed on behalf of two or more children should be documented and billed as Group Physical Therapy. A group may consist of no more than six children.

Documentation

See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Initial Treatment Plan

If an evaluation indicates that therapy is warranted, the Physical Therapist must develop and maintain a treatment plan that outlines long-term goals, short-term objectives, as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service the child should be receiving (*i.e.,* individual or group therapy). Indicating the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the Physical Therapist and the date signed.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Individual Treatment Plan (Cont'd.)

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed and a new referral for services by a physician or other Licensed Practitioner of the Healing Arts must be obtained annually.

Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the physical therapy practitioner every three months from the start date of treatment. The purpose of the Progress Summary is to record the longitudinal nature of the child's treatment, describe the child's attendance at therapy sessions, document progress toward treatment goals and objectives, and establish the need for continued participation in therapy.

The Progress Summary must be written by the physical therapy practitioner, contain the therapist's signature and title as well as the date written, and must be filed in the child's clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled "Progress Summary."

OCCUPATIONAL THERAPY SERVICES

Program Description

Occupational Therapy Services are services referred by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Occupational Therapist. Referral means that the physician or other LPHA has asked another qualified health provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies and equipment.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Description (Cont'd.)

Occupational Therapy Services involve evaluation and treatment recommended by a physician or other Licensed Practitioner of the Healing Arts to develop, improve, or restore functional abilities related to self-help skills, adaptive behavior, fine/gross motor visual, sensory motor, postural, and emotional development that have been limited by a physical injury, illness, or other dysfunctional condition. Occupational therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Program Staff

Occupational Therapy Services are provided by Occupational Therapists or Occupational Therapy Assistants.

Occupational Therapist

An **Occupational Therapist (OT)** is an individual who is currently licensed as a Registered Occupational Therapist (OTR/L or OT) by the South Carolina Board of Occupational Therapy.

Occupational Therapy Assistant

An **Occupational Therapy Assistant (OTA)** is an individual who is currently licensed as a Certified Occupational Therapy Assistant (COTA/L or OTA) by the South Carolina Board of Occupational Therapy.

Supervision of Occupational Therapy Assistants

Occupational Therapy Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Occupational Therapist. Additionally, the supervising therapist must review and initial each Progress Summary completed by the assistant. These licensed individuals must adhere to any provisions as required by South Carolina Department of Labor Licensing and Regulations (LLR).

Service Description

Occupational Therapy Evaluation

97003-HA

An Occupational Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Occupational Therapy Association and South Carolina Board of Occupational Therapy guidelines, the physician or other LPHA referral, the Occupational

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Occupational Therapy Evaluation (Cont'd.)

Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records and an observation of the patient and interview, when possible. The evaluation must include diagnostic testing and assessment and a written report with recommendations.

Individual and Group Occupational Therapy

Individual 97110-GO

Group 97150-GO

Individual and Group Occupational Therapy is the development and implementation of specialized Occupational Therapy programs that incorporate the use of appropriate interventions, occupational therapy activities in the school or home environment, and recommendations on equipment needs and adaptations of physical environments.

Occupational therapy performed directly to or on behalf of one child should be documented and billed as Individual Occupational Therapy. Occupational Therapy performed for two or more individuals should be documented and billed as Group Occupational Therapy. A group may consist of no more than six children.

Fabrication of Orthotic

Lower Extremities L2999

Upper Extremities L3999

Fabrication of Orthotic is the fabrication of orthotics for lower and upper extremities.

Fabrication of Thumb Splint

L3805

Fabrication of Thumb Splint is the fabrication of orthotic for the thumb.

Fabrication of Finger Splint

L3800

Fabrication of Finger Splint is the fabrication of orthotic for the finger.

Documentation

See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Initial Treatment Plan

If an evaluation indicates that therapy is warranted, the Occupational Therapist must develop and maintain a

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Individual Treatment Plan (Cont'd.)

treatment plan that outlines long-term goals, short-term objectives, as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care that outlines the services required to address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service(s) the child should be receiving (*i.e.,* individual or group therapy). Indicating the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the Occupational Therapist and the date signed.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed and a new referral for services by a physician or other Licensed Practitioner of the Healing Arts must be obtained annually.

Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the occupational therapy practitioner every three months from the start date of treatment. The purpose of the Progress Summary is to record the longitudinal nature of the child's treatment, describe the child's attendance at therapy sessions, document progress toward treatment goals and objectives, and establish the need for continued participation in therapy.

The Progress Summary must be written by the occupational therapy practitioner, contain the therapist's signature and title as well as the date written, and must be

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Progress Summary Notes (Cont'd.)

filed in the child's clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled "Progress Summary."

SPEECH-LANGUAGE PATHOLOGY SERVICES

Program Description

Speech-Language Pathology Services include diagnostic, screening, preventive, or corrective services provided to individuals with speech and language disorders by or under the direction of a Speech-Language Pathologist. Individuals must be referred by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law to receive these services. A referral is when the physician or other LPHA has asked another qualified health provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies and equipment.

Speech-Language Pathology Services involve the evaluation and treatment of speech and language disorders for which medication or surgical treatments are not indicated. Services include preventing, evaluating, and treating disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition/communication, auditory and/or visual processing and memory, and interactive communication; as well as the use of augmentative and alternative communication systems (sign language, gesture systems, communication boards, electronic automated devices, mechanical devices) when appropriate.

Program Staff

Speech Language Pathology Services are provided by or under the direction of a Speech-Language Pathologist. We recognize that some individuals in the school setting will be licensed through LLR as Speech-Language Pathologists, Speech-Language Pathology Assistants, or Speech-Language Pathology Interns. These licensed individuals will need to adhere to any provisions as required by LLR. The licensed Speech-Language Pathologist can supervise the licensed Speech-Language Pathology Intern and Speech-Language Pathology Assistant.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff (Cont'd.)

A **Speech-Language Pathologist** in accordance with the Code of Federal Regulations (CFR) is an individual who meets one of the following requirements:

- Has a certificate of clinical competence from the American Speech and Hearing Association
- Has completed the equivalent educational requirements and work experience necessary for the certificate
- Has completed the academic program and is acquiring supervised work experience to qualify for the certificate

Existing Speech-Language Therapists who do not meet the credentials outlined in the CFR must render services under the direction of a Speech-Language Pathologist pursuant to federal regulations above.

A **Speech-Language Pathology Assistant** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology. The Speech-Language Pathology Assistant must be supervised by a licensed Speech-Language Pathologist as required by LLR.

A **Speech-Language Pathology Intern** is an individual who is currently licensed by the South Carolina Board of Speech-Language Pathology and is seeking the academic and work experience requirements established by the American Speech and Hearing Association (ASHA) for the Certification of Clinical Competence in Speech-Language Pathology. The Speech-Language Pathology Intern must be supervised by a licensed Speech-Language Pathologist as required by LLR.

Supervision

See Supervision under Provider Qualifications earlier in this section.

Service Description

Speech-Language Pathology Services

Reimbursable Speech-Language Pathology Services are evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (*i.e.,* curriculum-based assessments, portfolio assessments, criterion referenced assessments,

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Speech-Language Pathology Services (Cont'd.)

developmental scales, and language sampling procedures) may be used. Tests or measures described as "teacher-made" or "informal" are not acceptable for purposes of Medicaid reimbursement. The following services are components of Speech-Language Pathology Services.

Speech Evaluation

92506

Upon receipt of the physician or other LPHA referral a Speech Evaluation is conducted. This is a face-to-face interaction between the Speech-Language Pathologist/Therapist and the child for the purpose of evaluating the child's dysfunction and determining the existence of a speech disorder. Evaluation should include review of available medical history records and must include diagnostic testing and assessment, and a written report with recommendations.

Individual Speech Therapy

92507

Individual Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps to a child whose speech and/or language patterns deviate from standard based on evaluation and testing, including training of teacher or parent.

Individual Speech Therapy services may be provided in a regular education classroom.

Group Speech Therapy

92508

Group Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps in a group setting to children whose speech and/or language patterns deviate from standard based on evaluation and testing, including training of teacher or parent. A group may consist of no more than six children.

Group Speech Therapy services may be provided in a regular education classroom.

Speech Language Disorders

Reimbursement is available for assessment and treatment of the following categories of speech-language disorders.

1. **A Developmental Language Disorder** is the impairment of deviant development of comprehension and/or use of a spoken, written, and/or other symbol system. The disorder may

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Speech Language Disorders (Cont'd.)

involve: form of language (phonologic, morphologic, and syntactic systems); content of language (semantic system); and/or function of language in communication (pragmatic system) in any combination (ASHA, 1983).

2. An **Acquired Language Disorder (Non-Developmental)** occurs after gestation and birth with no common set of symptoms. Causes may include focal acquired lesions, diffuse lesions associated with traumatic brain injury, acquired childhood aphasia secondary to convulsive disorder, and other kinds of brain injury or encephalopathy (N. Wolf-Nelson). Categorical factors associated with childhood language disorders include: central factors (specific language disability, mental retardation, autism, attention-deficit hyperactivity disorder, acquired brain injury); peripheral factors (hearing, visual, or physical impairment); environmental and emotional factors (neglect and abuse, behavioral and emotional development problems); and mixed factors.
3. An **Articulation/Phonological Disorder** is a deviant production of speech sounds (Morris, 1993). Phonology refers to the rules that govern combining of sounds into syllables and words.
4. A **Fluency Disorder** is an abnormal flow of verbal expression characterized by impaired rate and rhythm that may be accompanied by struggle behavior (ASHA, 1982).
5. A **Voice Disorder** is the absence or abnormal production of vocal quality, pitch, loudness, resonance, and/or duration (ASHA, 1992).
6. A **Resonance Disorder** is hypernasality, nasal escape, weak plosives, or denasality (McWilliams, Morris, and Shelton, 1990).
7. **Dysphagia** is difficulty in swallowing requiring evaluation, dietary and food consistency considerations, and/or assistance with feeding (Logemann, 1983).

Documentation

See Documentation Requirements under General Information earlier in this section.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Individual Treatment Plan

Treatment Plan

If an evaluation indicates that treatment is warranted, the Speech-Language Pathologist must develop and maintain a treatment plan that outlines short- and long-term goals as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service the child should be receiving (*i.e.* individual or group therapy). Addressing the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the Speech-Language Pathologist and the date signed.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed annually. In the event that the services are discontinued, the Speech-Language Pathologist must indicate the reason for discontinuing treatment on the treatment plan.

PSYCHOLOGICAL SERVICES

Program Description

Psychological Services involve the evaluation of the intellectual, emotional, and behavioral status of a child for the purpose of developing and/or reviewing therapeutic interventions designed to alleviate dysfunction or distress.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff

Psychological Services are provided by a school Psychologist.

A school **Psychologist** is an individual who is currently certified by the State Department of Education as a School Psychologist I, II, or III or as an Educational Evaluator.

Psychological Services provided by an Educational Evaluator or a School Psychologist I must be supervised by a School Psychologist II or III, and each evaluation report completed by an Educational Evaluator or School Psychologist I must be signed by the supervising school Psychologist.

Note: Annual/Transfer Review (90885) is no longer a Medicaid-covered service.

Service Description

Psychological Testing/Evaluation

96100

Psychological Testing/Evaluation is a face-to-face interaction between the school Psychologist and the child for the purpose of evaluating the child's intellectual, emotional, and behavioral status. Testing involves measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, personality characteristics, and utilization of other non-experimental methods of evaluation as appropriate. Evaluation consists of review of available medical history records, diagnostic testing and assessment, and a written evaluation report with recommendations. Evaluation should include an observation and interview when appropriate.

A Psychological Services Log Form must be completed for each Medicaid-reimbursable testing/evaluation service provided. The ICD-9-CM diagnosis code and the time spent on each service component must be documented on a Log form. If more than one school Psychologist is involved in providing services, each must sign the Log form and initial the service components/tasks that they provided.

A re-evaluation of a child is considered as a separate evaluation on its own and all components/tasks involved are billable to Medicaid.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Documentation

See Documentation Requirements under General Information earlier in this section.

ORIENTATION AND MOBILITY (O&M) SERVICES

Program Description

Orientation and Mobility (O&M) Services are provided to assist individuals who are blind and visually impaired to achieve independent movement within the home, school, and community settings. O&M Services utilize concepts, skills, and techniques necessary for a person with visual impairment to travel safely, efficiently, and independently through any environment and under all conditions and situations. The goal of these services is to allow the individual to enhance existing skills and develop new skills necessary to restore, maximize, and maintain physiological independence.

Program Staff

O&M Services are performed by an Orientation and Mobility Specialist.

An **Orientation and Mobility (O&M) Specialist** is an individual who holds a current and valid certification in Orientation and Mobility from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or an individual who holds a current and valid certification in Orientation and Mobility from the National Blindness Professional Certification Board (NBPCB).

Beneficiary Requirements

To be eligible to receive Medicaid-reimbursable O&M Services, an individual must meet all of the following requirements:

- Be a Medicaid beneficiary under the age of 21 whose need for services is identified through a current and valid Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)
- Have a vision report completed by an Optometrist or Ophthalmologist that verifies visual impairment or blindness

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Provider Qualifications

- The service must be recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.
- The service must be provided for a defined period of time, for the maximum reduction of physical or mental disability and restoration of the individual to his or her best possible functional level.
- The service must be furnished by individuals working under a recognized scope of practice established by the state or profession.

Service Description

Assessment **T1024**

An Orientation & Mobility Assessment is a comprehensive evaluation of the child's level of adjustment to visual impairment and current degree of independence with or without assistive/adaptive devices, including functional use of senses, use of remaining vision, tactile/Braille skills, and ability to move safely, purposefully, and efficiently through familiar and unfamiliar environments. Assessment must include a review of available medical history records, diagnostic testing and assessment, and written report with recommendations.

Reassessment **T1024-TM**

An Orientation & Mobility Reassessment is an evaluation of the child's progress toward treatment goals and determination of the need for continued services. Reassessment may consist of a review of available medical history records and diagnostic testing and assessment, but must include a written report with recommendations. Reassessment must be completed at least annually but more often when appropriate.

Services

Orientation & Mobility Services is the use of systematic techniques designed to maximize development of a visually impaired child's remaining sensory systems to enhance the child's ability to function safely, efficiently, and purposefully in a variety of environments. O&M Services enable the child to improve the use of technology designed to enhance personal communication and

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Services (Cont'd.)

functional skills such as the long cane, pre-mobility and adapted mobility devices, and low vision and electronic travel aids.

O&M Services may include training in environmental awareness, sensory awareness, information processing, organization, route planning and reversals, and training in balance, posture, gait, and efficiency of movement. O&M Services may also involve the child in group activities to increase their capacity for social participation, or provide adaptive techniques and materials to improve functional activities such as eating, food preparation, grooming, dressing, and other living skills.

Documentation

See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Initial Treatment Plan

If an assessment indicates that O&M Services are warranted, the O&M specialist must develop and maintain a treatment plan that outlines short- and long- term goals as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals and objectives of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service the child is receiving (*i.e.* individual or group therapy). Addressing the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the O&M specialist and the date signed.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

NURSING SERVICES FOR CHILDREN UNDER 21

Program Description

Nursing Services for Children Under 21 are those specialized health care services including nursing assessment and nursing diagnosis; direct care and treatment; administration of medication and treatment as authorized and prescribed by a physician or dentist and/or other licensed/authorized healthcare personnel; nurse management; health counseling; and emergency care. A Registered Nurse as allowed under state licensure and regulation must perform acts of nursing diagnosis or prescription of therapeutic or corrective measures.

The need for services must be appropriately documented in an Individualized Education Program (IEP), Individualized Family Services Plan (IFSP), Treatment Plan, or Clinical Service Notes, when appropriate.

Program Staff

A **nurse** is defined as an individual who is currently licensed as a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) by the State Board of Nursing for South Carolina.

Nursing Services performed by health room aides, nurses' aides or any other unlicensed medical personnel are not Medicaid reimbursable even if provided under supervision or delegation of a registered nurse.

Licensed Practical Nurse

An LPN must adhere to the following when providing Nursing Services:

1. An LPN must be supervised at all times by a RN. The RN may either be physically present or accessible by phone or pager (Exceptions to on-site supervision are allowable in accordance with SC Code of Law, Title 40-33-770).
2. The LPN can provide any service allowable under state licensure and regulations.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Licensed Practical Nurse (Cont'd.)

3. The LPN must follow the policies, procedures, and guidelines for the employing entity.
4. The RN supervisor will provide the initial assessment of the child's condition as appropriate and establish a plan of care based on the child's medical condition in accordance with state licensure and regulation. If the LPN receives additional information regarding the child's health condition after the initial assessment, the LPN will consult with the RN in accordance with Advisory Opinion #23 of the South Carolina Board of Nursing.
5. Supervision by the RN of the LPN must be performed at a minimum of every 60 days. This can be done through direct observation or a review of clinical service notes.

Physician Oversight

Medicaid recognizes Nursing Services as those that fall within the scope of practice of an RN or LPN as authorized by the South Carolina State Board of Nursing. Nursing Services may be billed to Medicaid provided all services rendered are allowed under state law. Administering prescription medications and conducting medical acts must be under the direction of a physician, dentist, or other authorized personnel or included in a written protocol. If a nurse is practicing in an "Extended Role" according to the Nurse Practice Act (§ 40-33-270 of the 1976 code), a written physician preceptor agreement and a written protocol must be agreed upon by the physician and nurse, signed and dated by both parties, and reviewed annually. The preceptor agreement and written protocols must be readily available for review by DHHS upon request.

All requirements stated in the Nurse Practice Act (§40-33-270 of the 1976 code) and the Medical Practice Act (§40-47-10) must be met and followed. Additionally, specific requirements for written protocols may be found in these statutes. If a physician preceptor agreement and written protocols are in place, the physician must be readily available and be able to be contacted in person or by telecommunications or other electronic means to provide consultation and advice when needed.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Service Description

Services that are part of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination are not reimbursable under this program. However, services rendered subsequent to and as a result of an anomaly discovered during an EPSDT exam are reimbursable. EPSDT provides a comprehensive and preventive, well child screening program in South Carolina. EPSDT provides comprehensive and preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. If you would like additional information about the EPSDT program, contact the Division of Physician Services at (803) 898-2660. Mass screenings are not reimbursable under this program; however, vision and hearing assessments are reimbursable if they are performed in conjunction with a nursing assessment for IEP services.

Reimbursement is available for services that conform to accepted methods of diagnosis and treatment for appropriate personnel. Reimbursement is not available for time spent documenting services, time spent traveling to or from services, or for cancelled visits and missed appointments. Medicaid will only pay for nursing direct service provision. Observation is included in the direct services payment as long as the nurse (RN or LPN) is attending to one individual during a face-to-face encounter. If the child needs monitoring after a specific service provision, then his or her Plan of Care documentation must reflect the ongoing need for monitoring. Although the nurse may be accountable for the time the child is in the Health Room, it may not be Medicaid-billable time.

Reimbursable nursing services under this program will include any service that an RN or LPN is allowed to provide under state licensure and regulation. Nursing Services may include nursing assessments, nursing procedures, emergency care or individual/group health counseling. These services are listed in more detail below.

Nursing Assessment

The following nursing care assessments are covered under Medicaid:

- Nursing assessment of applicants registering for early child development programs

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Nursing Assessment (Cont'd.)

- Nursing assessment of children referred for special education eligibility evaluation
- Nursing assessment related to the IEP, IFSP, or ITP
- Nursing assessment of new or previously identified medical/health problems based on child initiated or teacher/staff referral to nurse, including substance use assessment, child abuse assessment, pregnancy confirmation, etc.
- Home visits for comprehensive health, developmental, and/or environmental assessment
- Referral to child's physician when the child has missed medical appointments or when health status warrants
- Referral to a county health department for Preventive Services for Primary Care Enhancement or Rehabilitative Services for Primary Care Enhancement (Family Support Services), as indicated

Nursing Care Procedures

The following nursing care procedures are covered under Medicaid:

- Administration of immunizations to children in accordance with state immunization law
- Medication assessment, monitoring, and/or administration
- Interventions related to the IEP, IFSP, or ITP
- Nursing procedures required for specialized health care including, but not limited to, feeding, catheterization, respiratory care, ostomies, medical support systems, collecting and/or performance of test, other nursing procedures, and development of health care and emergency protocols (See chart on following page)

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

NURSING PROCEDURES REIMBURSED BY MEDICAID	
Feeding	• Nutritional assessment • Naso-gastric feeding • Gastrostomy feeding • Jejunostomy tube feeding • Parenteral feeding (IV) • Naso-gastric tube insertion or removal • Gastrostomy tube reinsertion
Catheterization	• Clean intermittent catheterization • Sterile catheterization
Respiratory Care	• Postural drainage • Percussion • Pharyngeal suctioning • Tracheostomy tube replacement • Tracheostomy care
Medical Support Systems	• Ventricular peritoneal shunt monitoring • Mechanical ventilator monitoring and emergency care • Oxygen administration • Nursing care associated with Hickman/Broviac/IVAC/IMED • Nursing care associated with peritoneal dialysis • Apnea monitoring • Medications: Administration of medications-oral, injection, inhalation, rectal, bladder, instillation, eye/ear drops, topical, intravenous
Collecting and/or Performance of Test	• Blood glucose • Urine glucose • Pregnancy testing
Other Nursing Procedures	• Sterile dressing • Soaks
Development of Health Care and Emergency Protocols	• Health care procedures • Emergency Protocols • Health objectives for Individual Education Plan (IEP), Individual Family Services Plan (IFSP), or Individualized Treatment Plan

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Emergency Care

Emergency Care is the assessment, planning, and intervention for emergency management of a child with a chronic or debilitating health impairment.

The provision of emergency care may include the following:

- Nursing assessment and emergency response treatment (*e.g.*, CPR, oxygen administration, seizure care, administration of emergency medication, and triage).
- Post-emergency assessment and development of preventive action plan

Individual/Group Health Counseling

Individual/Group Health Counseling is the nursing assessment, health counseling, and anticipatory guidance for a child's identified health problem or developmental concern. There is no reimbursement for Health Education.

Documentation

See Documentation Requirements under General Information earlier in this section.

SECTION 2 POLICIES AND PROCEDURES

SOUTH CAROLINA MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING

Some of the activities routinely performed by school districts are activities that could be eligible for Medicaid reimbursement under the School District Administrative Claiming (SDAC) Program. The South Carolina Medicaid School-Based Administrative Claiming Guide is intended to provide information for schools, State Medicaid Agencies, Centers for Medicare & Medicaid Services staff, and other interested parties on the existing requirements for claiming Federal Financial Participation (FFP). To obtain a copy of the Guide, contact your Medicaid Program Manager.

SECTION 2 POLICIES AND PROCEDURES

SOUTH CAROLINA MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING

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SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Community-Based Children's Behavioral Health Services are designed to provide necessary treatment services and support to children and their families within the context of each child's current home and community. By intervening while the child is still in his or her home, more restrictive interventions may be avoided.

Enrollment Procedures

Potential providers of Therapeutic Behavioral Services (formerly Therapeutic Child Treatment) and Psychosocial Rehabilitation Services (formerly Clinical Day Programming) must complete the following steps in order to become an enrolled Medicaid provider.

The enrollment process comprises four steps.

Step 1

The first step will consist of the provider submitting a detailed proposal describing the services to be rendered. Proposals must be page numbered. All of the following information must be provided to DHHS Behavioral Health Services (BHS) for review by the BHS staff. The proposal must address the following:

1. A detailed program description outlining how the service is to be provided which includes the following:
    - Mission Statement
    - Organizational Chart
    - Program Structure
    - Treatment Philosophy and Model(s)
    - Population to be Served
    - Program Policies
    - History and Background
    - Financial Assurance that the financial system to be used will adequately safeguard the public funds to be received

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Step 1 (Cont'd.)

- If an independent audit of the organization has been conducted within the past two years, a copy of the Independent Auditor's Report Statement should be enclosed.
- Copies of all Provider Proposed Forms

2. A copy of the program's Standard Operating Policy and Procedures, including a copy of the Personnel Manual
3. Staff training and credentials, including a plan for completion of all pre-enrollment training
4. A completed budget outlining reasonable, anticipated costs and specifying the number of children to be served by the program. No "start-up" funds can be provided (refer to Behavioral Health Services program staff).
5. Letters of support from the referring agencies and any applicable Memoranda of Agreement with collaborative agencies

Incomplete proposals will be returned. Three copies of the proposal should be submitted to:

Program Manager, Behavioral Health Services
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

All providers of Community-Based Children's Behavioral Health Services will be subject to applicable state fire, health, and licensor regulations. Therapeutic Behavioral Services providers must be licensed as Daycare Centers by the Department of Social Services. A provider must be a public or private entity, which is governed by a Board of Directors and/or is part of an established entity/corporation that provides administrative oversight. Providers who are part of the Department of Mental Health (DMH) or the Department of Alcohol and Other Drug Abuse Services (DAODAS) network should be referred to their provider manuals for more specific enrollment requirements.

Step 2

The second step involves BHS initiating the review and approval process when the completed proposal is received. Providers should allow three to six months for this internal

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Step 2 (Cont'd.)

review process to be completed. The provider will be notified regarding any additional information needed for program approval. The Division of Ancillary Reimbursements within DHHS, along with BHS, will determine the potential provider's Medicaid treatment rate based on the budget submitted for Psychosocial Rehabilitation Services.

Once enrolled, providers are required to submit an annual cost report within 90 days following the close of their fiscal year for each Medicaid service they are enrolled to provide.

Program Expansion

Providers wishing to expand the scope of their services, thus increasing the number of children served, must obtain approval from the appropriate program manager prior to expansion. Providers will be required to submit an updated program description, any changes in policies and procedures since initial approval, and new budget information.

Unit of Service

Community-Based Children's Behavioral Health Services must be billed in units as defined in the service standard. For the purpose of Therapeutic Behavioral Services programs, a billable unit is defined as a 15-minute block of time that the child receives Medicaid-reimbursable treatment services from a treatment provider. Medicaid may be billed for a unit of service only if the child received some treatment services during that time period. Additionally, Therapeutic Behavioral Services programs may be reimbursed for home visits.

For the purpose of Psychosocial Rehabilitation Services (PRS), a billable unit is defined as a day that the child receives Medicaid-reimbursable treatment services from a treatment provider. Providers can only claim reimbursement for days when client is present and receives PRS.

Providers must maintain adequate documentation to support the number of units billed. For Psychosocial Rehabilitation Services, the LCS should place a "P" in the appropriate blocks on the Progress Summary Note for each day the child received treatment. An "A" should be used for each day the child is absent. This denotes a non-billable day. The date of discharge should be annotated

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Unit of Service (Cont'd.)

with a "D". Psychosocial Rehabilitation Services "Transition" days should be documented with a "T". Treatment services are billable from the date of admission.

Staff Requirements

Clinical Staff

Clinical Staff

Children's Behavioral Health Services must be rendered by Lead Clinical Staff (LCS) or by staff under the supervision of the LCS. In addition to provision or supervision of service delivery, the LCS is responsible for continually assessing and evaluating the condition of the children receiving services. The LCS must spend as much time as necessary to ensure that children are receiving services in a safe, efficient manner according to accepted standards of clinical practice.

Each provider of Children's Behavioral Health Services shall maintain a credentials file for each LCS substantiating that each staff member meets LCS qualifications. This shall include employer verification of the LCS's credentials and work experience. The treatment provider must maintain a signature sheet that identifies all LCS names, signatures, and initials. Individuals wishing to be designated in one of the categories requiring a professional license must be licensed to practice in the state in which they are employed.

Individuals wishing to be designated as LCS must be able to document experience working with the population to be served. "Experience working with the population to be served" is defined as direct work experience with the type of children served in the applicable level of care (*i.e.,* children who have been diagnosed as having an emotional or behavioral disorder, children who are victims of child abuse and/or neglect, or children deemed to be "at risk" of developing an emotional or behavioral disorder because of life circumstances). A "year of experience" is defined as paid and/or volunteer experience that is equivalent to 12 months of full-time work experience. Practicum or internship placements as part of a degree program are acceptable as work experience.

The following professionals qualify as LCS:

- A **Psychologist** holds a doctoral degree in psychology from an accredited university or college

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Clinical Staff (Cont'd.)

who is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling areas and has a minimum of one year of experience working with the population to be served.

- A **Registered Nurse** is a licensed registered nurse who has a baccalaureate degree from an accredited university or college and who has a minimum of three years of experience working with the population to be served.
- A **Mental Health Counselor** holds a doctoral or master's degree from an accredited university or college in a program that is primarily psychological in nature (*e.g.,* psychology, counseling, guidance, or social science equivalent) and has a minimum of one year of experience working with the population to be served.
- A **Social Worker** holds a master's degree from an accredited university or college, a license from the State Board of Social Work Examiners, and has a minimum of one year of experience working with the population to be served.
- A **Mental Health Professional Master's Equivalent** holds a master's degree in a closely related field that is applicable to the bio-psycho-social sciences or to treatment of the mentally ill; or a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement; or professional who is credentialed as a Licensed Professional Counselor and has a minimum of one year of experience working with the population to be served.
- A **Clinical Chaplain** holds a Master of Divinity degree from an accredited theological seminary and has one year of Clinical Pastoral Education that includes provision of supervised clinical services and has a minimum of one year of experience working with the population to be served.
- **Child Service Professional** holds a baccalaureate degree from an accredited university or college in psychology, social work, early childhood education, child development, or a related field including, but not limited, to criminal justice,

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Clinical Staff (Cont'd.)

rehabilitative counseling, elementary or secondary education; or holds a baccalaureate degree in another field and has additional training (a minimum of 45 documented hours of training that could include undergraduate or graduate courses, workshops, seminars, conferences in issues related to child development, children's mental health issues and treatment) in one or more of the above disciplines. A minimum of three years of experience working with the population to be served is required for the child service professional.

- A **Licensed Baccalaureate Social Worker** holds a baccalaureate degree from an accredited university or college, has been licensed by the State Board of Social Work Examiners, and has a minimum of three years of experience working with the population to be served.
- A **Certified Addictions Counselor** holds a baccalaureate degree from an accredited university or college, has been credentialed by the Certification Commission of the South Carolina Association of Alcoholism and Drug Abuse Counselors, the NAADAC (The Association for Addictions Professionals), or an International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse approved certification board, and has a minimum of three years of experience working with the population to be served.

Providers shall ensure that all staff, subcontractors, volunteers, interns, or other individuals under the authority of the provider who come into contact with referring agency clients are properly qualified.

All LCS and Non-LCS who are providers of Therapeutic Behavioral Services or Psychosocial Rehabilitation Services musts show documentation of 40 hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems prior to rendering services.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

PSYCHOSOCIAL REHABILITATION SERVICES

Program Description

Psychosocial Rehabilitation Services (PRS) (formerly Clinical Day Programming) is a comprehensive system of individual, family, and group treatment services dedicated to the mitigation of the effects of serious emotional and/or behavioral disturbances on children and adolescents. Children referred to Psychosocial Rehabilitation Services are typically needing a structured educational/social setting in which their maladaptive behaviors may be therapeutically remediated with the ultimate goal of producing sufficient change so that the children can function successfully in a less restrictive setting.

Psychosocial Rehabilitation Services are provided in coordination with public education services for children ages six to 21 years. Treatment is provided within a psychosocial context involving programming that integrates therapeutic interventions in an educational setting designed to provide a more effective response to the individual needs of children and their families.

At the level of the individual child, interventions designed to enhance social problem solving skills, positive interaction skills, and anger control will be delivered in accordance with a formal treatment curriculum that includes group and individualized programming as well as classroom goal-setting exercises. Aversive parent-child interaction, inconsistent discipline, and disruptions in the parent-child affective bond (*e.g.*, parental rejection) are associated with serious behavior problems in children. Research has demonstrated that the failure to address these issues is associated with the failure of treatment to produce behavior changes in children. Therefore it is essential that parenting interventions be conducted within the context of PRS.

For the purposes of this program, family may be defined as any of the following:

- Biological parent(s)
- Step-parent(s)

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Description (Cont'd.)

- Relative(s) who have legal guardianship
- Adoptive parent(s)
- Permanent caregiver

When a child is in an out-of-home placement, the primary significant other in the child's life (*i.e.*, case manager, group home staff, etc.) is expected to be an integral part in the implementation of the child's treatment plan.

Expected outcomes of this service are to prevent more costly and restrictive treatment options and to aid children in functioning successfully within their home and school environments.

Treatment objectives shall be developed that will enable the student to:

1. Show a significant reduction in behaviors that could constitute a risk to the safety of self or others and/or should demonstrate manageable behaviors in any and all environments
2. Develop adaptive interaction styles, as well as adaptive problem solving and coping strategies
3. Demonstrate an enhanced ability to learn as evidenced by increased attention span, increased ability to engage in developmentally and socially appropriate activities, and increased capability to interact appropriately with adults and peers across various situations
4. Successfully transition to a less restrictive educational placement

Treatment options shall be developed that will enable the family to:

1. Learn effective strategies for managing problem behaviors and interacting with their child
2. Identify and develop a collaborative and supportive relationship with school personnel aimed at optimizing the child's academic and social functioning

Although an intensive service, Psychosocial Rehabilitation Services should be provided in a setting with a level of restrictiveness that is commensurate with the client's

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Description (Cont'd.)

needs. This service is intended to be community-based and may be provided by public and private providers in both traditional and non-traditional educational settings. Such programming is to be regarded as a treatment service rather than a place, so that flexibility and individualization are a natural consequence. For continuity of care, services should be rendered five days per week.

Medical Necessity and Prior Authorization

Services shall be recommended by a physician or other Licensed Practitioner of the Healing Arts for a child who meets one or more of the following descriptions:

1. The child currently displays behavior problems serious enough to jeopardize current school and/or home placement and/or makes the child a risk to the safety of self or others.
2. The child is emotionally disturbed or mentally ill to the extent that a diagnosis using the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is applicable. This includes the use of appropriate V-codes for diagnostic purposes.
3. The child is returning home or to a family-like setting following a psychiatric hospitalization or a residential placement, and Psychosocial Rehabilitation Services is considered the most appropriate setting prior to the child returning to a less restrictive school placement.

The physician or other Licensed Practitioner of the Healing Arts will complete a Medical Necessity Statement (See Section 5) authorizing the service delivery. The Medical Necessity Statement must substantiate the need for Psychosocial Rehabilitation Services as evidenced by the above criteria. The Medical Necessity Statement must be received from the referring state agency/entity within 10 days of admission to the program, and placed in the client's record with the initial treatment plan. If the child is readmitted to this service following a discharge, a new Medical Necessity Statement must be completed.

If applicable, services must be pre-authorized by a designated agent. This is accomplished through completion of the Referral Form/Authorization for Services (DHHS Form 254), which is presented to the

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

provider by the referring agency at time of admission. The Referral Form is required when state agencies refer to private treatment providers. See Section 5 for an example of this form.

Program Staff

Program Director

Qualifications

Psychosocial Rehabilitation Services supervision and treatment services shall be under the direction of a Program Director who may also be the Supervising Lead Clinical Staff (LCS). Individuals holding a professional license must be licensed to practice in the state in which they are employed. The Program Director shall be a professional who must meet one of the following qualifications:

- A **Psychiatrist** is an M.D. who has completed residency in psychiatry and has a minimum of one year of experience working with the population to be served.
- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners and has a minimum of one year of experience working with the population to be served.
- A **Psychologist** holds a doctoral degree in psychology from an accredited university or college and licensed by the appropriate State Board of Examiners in the clinical, school, or counseling areas.
- A **Mental Health Counselor** holds a master's or doctoral degree from an accredited university or college in a program that is primarily psychological in nature (*e.g.*, counseling, guidance, or social science equivalent).
- A **Mental Health Professional Master's Equivalent** holds a master's degree in a field that is closely related to the bio-psycho-social sciences or treatment of the mentally ill, or holds a master's degree in a reasonably related field that is augmented by graduate courses and experience in a closely related field and has a minimum of one year

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Director (Cont'd.)

of experience working with the population to be served. Also, appropriate Ph.D. candidates who have bypassed the master's degree but have more than enough hours to satisfy a master's requirement; as well as professionals who are credentialed as Licensed Professional Counselors or Marriage and Family Therapists can be considered Mental Health Professional Master's Equivalent.

- A **Social Worker** holds a master's degree from an accredited college or university and is licensed by the appropriate State Board of Social Work Examiners and has a minimum of one year of experience working with the population to be served.
- A **Clinical Chaplain** holds a Master of Divinity degree from an accredited theological seminary and has two years of pastoral experience and one year of Clinical Pastoral Education that includes provision of supervised clinical services.
- A **Psychiatric Nurse** is a registered nurse with a master's degree in psychiatric nursing.

Responsibilities

The Director shall provide program oversight and be available for consultation regarding treatment issues and special client needs.

Lead Clinical Staff

Qualifications

Psychosocial Rehabilitation Services shall be supervised and rendered by a Lead Clinical Staff (LCS) who must meet the professional standards as defined by DHHS. For the purposes of Psychosocial Rehabilitation Services, the following professionals may serve as Lead Clinical Staff in addition to those listed under **Clinical Staff** (see Staff Requirements under Children's Behavioral Health Services earlier in this section):

- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners and has a minimum of one year of experience working with the population to be served.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (Cont'd.)

- A **Psychiatrist** is a licensed M.D. who has completed residency in psychiatry and has a minimum of one year of experience working with the population to be served.
- An **Early Childhood Specialist** holds a master's degree in early childhood education/child development and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse** is licensed to practice as a registered nurse with advanced practice certification in the state in which he or she is rendering services, is practicing under a physician preceptor according to a mutually agreed-upon protocol, and has a minimum of one year of experience working with the population to be served.
- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist in the state in which he or she is rendering services and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse Specializing in Psychiatric Nursing** is licensed to practice as a registered nurse with advanced practice certification in the state in which he or she is rendering services, and is practicing under a physician preceptor according to a mutually agreed-upon protocol. Additionally, this advanced practice nurse has completed advanced study and clinical practice, as in a master's program in psychiatric nursing, has gained expert knowledge in the care and prevention of mental disorders, and has a minimum of one year of experience working with the population to be served.

Prior to rendering the PRS service, all Lead Clinical Staff (LCS) must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (Cont'd.)

The LCS must attend a minimum of 20 documented contact hours of training annually.

Responsibilities

The Lead Clinical Staff (LCS) will specify program content to be addressed based on client needs. The LCS shall be responsible for the following:

- The LCS must make available to all treatment staff, the minimum equivalent of 20 training hours annually, with additional in-service training provided as needed. All training activities shall be documented and maintained on file at the program site. Case supervision and consultation do not supplant training requirements.
- The LCS must provide case supervision and consultation a minimum of two hours per week. Supervision hours may be incrementally distributed throughout the week as the LCS deems appropriate. The LCS must maintain supervision records.
- The LCS must assure that services are provided to children in a safe, efficient manner in accordance with accepted standards of clinical practice, and must be privileged by the program to render the treatment service.
- The LCS must be involved in each child's assessment and treatment, including participation in the planning and implementation of the child's individualized treatment plan, 90-day treatment plan reviews, and the development of the weekly Progress Summary Notes.

Non-Lead Clinical Staff

Qualifications

Non-Lead Clinical Staff (Non-LCS) must meet the following qualifications in order to render Psychosocial Rehabilitation Services:

- The Non-LCS must either possess a bachelor's degree from an accredited university or college or be a non-degreed paraprofessional who demonstrates the theoretical and/or practical knowledge of treatment of emotional and behavioral child and adolescent disturbances.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Non-Lead Clinical Staff (Cont'd.)

- Prior to rendering PRS, all Non-LCS must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.
- The Non-LCS must be privileged by the program to render PRS under supervision of the LCS.
- The Non-LCS must have a minimum of 20 documented contact hours of training per year.

All Non-LCS shall receive a minimum of two hours of case supervision per week, provided by the LCS staff.

Responsibilities

The Non-LCS will conduct observations and treatment interventions as specified in the child's Individual Treatment Plan and as directed by the Supervising LCS.

Staff-to-Client Ratio

All of the following apply:

- There shall be a minimum of one treatment staff to each eight clients.
- Each PRS service will have a minimum of two treatment staff. There shall be a minimum of two treatment staff at each PRS site. One of the treatment staff must be the LCS.
- Treatment staff shall have direct contact with children during program hours.

Service Content

Each PRS program will provide specific treatment activities within a structured environment that supports the development of appropriate behaviors, skills, emotional growth and satisfactory family and peer relationships. Each child's participation in the activities provided will be summarized in a weekly Progress Summary Note. Activities that are purely educational are necessary components of Psychosocial Rehabilitation Services but are not Medicaid-reimbursable services. Educational services are rendered in addition to and in collaboration with Psychosocial Rehabilitation Services.

The services listed below are the components of PRS.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Assessment and Evaluation

Behavioral, emotional, and environmental assessment and evaluation services provide a determination of the nature of the child and/or family's problems, factors contributing to the problems, and the strengths and resources of the client and family. Psychosocial Rehabilitation Services provides a safe environment in which to evaluate the client's functioning level and respond with structured interventions.

Group Interventions

Psychosocial Rehabilitation Services includes face-to-face process interactions between staff and clients. These interactions are directed to focus on the development of age-appropriate emotional, intellectual, behavioral, and interpersonal role functioning within groups. Settings for this intervention may vary from group discussion to "play therapy" or other group modalities facilitating problem identification, processing, and resolution. Client outcomes of these interventions should be directly related to the child's ITP and may include, but are not limited to: enhanced self-esteem; improved problem solving skills and task completion abilities; demonstrated self control; improved peer, teacher, and parent interactions; enhanced communication skills; improved direction-following capabilities; enhanced self-understanding; and appropriate use of leisure time. Group Interventions shall be delivered by the LCS a minimum of one time per week.

Individual Interventions

Client-staff interactions designed to direct the child toward acceptable, adaptive behavior are included as part of the program's treatment. Staff will provide face-to-face therapeutic interactions with individual children on an "as-needed" basis. The purpose of such interventions is to facilitate individualized opportunities for children and staff to identify problems, examine impediments to achieve desired results, and to reframe problems in ways that formulate solutions. Individual Interventions shall be delivered by the LCS a minimum of one-time per week.

Rehabilitative Psychosocial Therapy

Rehabilitative Psychosocial Therapy services are therapeutic activities designed to improve or preserve the child's level of functioning. This component is designed to facilitate therapeutic interaction between staff, children, and community; as well as to provide children with reality orientation, minimize self-involvement, improve inter-

Rehabilitative Psychosocial Therapy (Cont'd.)

personal skills, and improve concentration when participating in these goal-directed activities.

Coordination and Linkage

Psychosocial Rehabilitation Services includes the provision of coordination and linkage with needed community services and resources. These efforts should not duplicate or replace efforts of the child's designated case manager. Regular communication and collaboration with any or all disciplines involved in serving the child and his or her family should be incorporated within the structure of Psychosocial Rehabilitation Services. Treatment planning meetings and progress assessment staffing should encourage participation from all disciplines relative to the needs of the child.

Crisis Management

Crisis Management is an intense component provided immediately to the identified child following abrupt or substantial changes in the child's functioning. Crisis Management can be employed to reduce the immediate personal distress, to assess the precipitant(s) that resulted in the crisis, and/or to reduce the chance of future crisis situations through the implementation of preventive strategies.

Family Involvement

Psychosocial Rehabilitation Services includes planned interactions between staff, the child, and the child's family and/or significant others. Staff must be culturally competent and work with parents as partners in every way possible. The purpose of family involvement should be to identify and address any family related barriers to the success of PRS and to mobilize family resources to support the treatment goals of PRS. Monthly family involvement is strongly encouraged. One home visit (*e.g.*, to the child's current living arrangement) is required per school year. If extenuating circumstances prevent the program staff from completing the home visit, the reasons preventing the visit shall be documented in the child's clinical record.

Transitioning

The overriding goal of Psychosocial Rehabilitation Services is for the child to make sufficient progress so that he or she may be returned to a less restrictive school setting. When a child changes from a treatment setting that is highly structured, predictable, and interpersonally supportive to a less restrictive school setting that provides

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Transitioning (Cont'd.)

less support and guidance, it is very difficult for the child to transfer the skills gained in the treatment settings. In order to increase the likelihood of a successful transition, a clear plan of transition activities should be part of the child's treatment plan. The program should develop a schedule for the implementation of the child's transition, indicating when Transition Days are to be used.

Transition activities include client visits to the proposed receiving site and return visits, as needed, to PRS services. When applicable, return visits to the program are reimbursable as long as the services are rendered within the dates provided on the Referral Form (DHHS Form 254). Return visits must be documented on the weekly Progress Summary Note and the client's treatment plan must be current and reflect the objective of these visits.

Programs may bill Medicaid for a maximum of 20 Transition Days per client program admission. The program should annotate Transition Days with a "T" in the attendance documentation section of the weekly Progress Summary Note. Clinical documentation of Transition Days shall include but is not limited to the following:

- The length and nature of the visit to the proposed receiving school
- Staff interventions and support on behalf of the client
- The client's progress on treatment goals and objectives
- Any collaborative activity with personnel at the receiving school that is in support of the treatment goals and objectives

Length and Frequencies of Services

The Psychosocial Rehabilitation Services program shall meet the following operational guidelines:

- The Psychosocial Rehabilitation Services program day must last a minimum of four hours.
- A therapeutic schedule must be in place authenticating the activities that constitute the length of the program day.
- Treatment should be offered a minimum of five days per week.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Length and Frequencies of Services (Cont'd.)

- Treatment services delivered on the child's last day in the program are billable.
- The Psychosocial Rehabilitation Services program must be operational a minimum of 180 days during the year. This does not preclude the program offering PRS services during the summer.
- Wraparound Services **may not** be billed concurrently with Psychosocial Rehabilitation Services (during PRS program hours).

Documentation

Medicaid reimbursement is directly related to the delivery of services. Each clinical record must contain adequate documentation to support the services rendered and billed. Documentation of the treatment services provided to the child, the child's responsiveness to the treatment, and the interaction and involvement of the staff with the child and family should justify and support the services billed to Medicaid.

Clinical Records shall include, at a minimum, the following:

- Medical Necessity Statement
- Referral Form/Authorization for Services (DHHS Form 254), if appropriate
- Signed and dated treatment plan(s)
- Signed and dated Progress Summary Notes

Individual Treatment Plan

Initial Treatment Plan

An individual treatment plan must be developed for every child by or before the 30th day of admission in the program. If a treatment plan is not developed within 30 days, services rendered from the 31st day until the date of completion of the treatment plan are not Medicaid-reimbursable. The treatment plan shall be based on an assessment of the strengths and needs of the child and family, and shall address the following:

- Specific problems or behaviors requiring treatment
- Treatment goals and objectives
- Methods and frequency of interventions
- Target dates for completion

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Individual Treatment Plan (Cont'd.)

Treatment plans must be completed, signed, and dated on each page by the LCS on or before the 30th day present in the program. The child and the family should review and sign the treatment plan on or before the child's 30th day in the program.

Treatment Plan Review

Treatment plan reviews must be conducted quarterly, 90 days from the date the treatment plan is signed, to assure services and treatment goals continue to be appropriate to the child's needs and to assess the child's progress and continued need for services. The review of the treatment plan is a clinical opportunity to revise or note the completion of objectives. New objectives may be added during this review. The LCS must sign and date the treatment plan at each review. The treatment plan is a working document and should be continuously refined and revised as progress is made and/or new therapeutic issues arise. Modifications should be signed and dated by the LCS.

Treatment Plan Reformulation

The treatment plan must be reformulated annually (*i.e.*, at the beginning of each new school year).

Progress Summary Notes

The Progress Summary Note summarizing program participation, psychosocial/behavioral status and functioning, and progress on treatment goals and objectives must be completed every week. The weekly note should be placed in the client's record within one week following the last service rendered. In order to provide a pertinent clinical description, the documentation must address the following:

- A general observation of the child's condition
- The child and child's family activity and participation in the treatment program
- The child's progress on treatment goals and response to treatment
- Activities of the treatment staff (The involvement of the staff in service provision is required and shall be documented.)
- Future plans for working with the child

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Progress Summary Notes (Cont'd.)

Lead Clinical Staff must sign and date the Progress Summary Note as the person responsible for the provision of service. The LCS's signature verifies that the services were provided in accordance with these standards.

Program Evaluation and Outcome Criteria

To the extent measurable, programs will be evaluated on their effectiveness in the prevention of more costly and restrictive treatment options and in assisting children to function successfully within their home and school environments. Programs will be expected to meet the following outcome criteria targets. Programs shall submit an annual report to the DHHS Program Manager describing their progress in meeting the Outcome Criteria (OC) 90 days after the close of the state fiscal year.

Outcome Criteria (OC) are as follows:

OC1: After planned discharge, 90% of the children that were enrolled in Psychosocial Rehabilitation Services will have achieved 75% of the objectives on their individual treatment plans.

OC2: Seventy-five percent of children who have been successfully discharged are residing with a consistent, stable caregiver/family for at least three months following discharge. (See the definition of "family" at the beginning of Psychosocial Rehabilitation Services.)

OC3: Seventy-five percent of children and families indicate satisfaction with the PRS services.

OC4: The child's attendance in the PRS is improved over the child's attendance in his/her previous school placement. The child's unexcused absences shall decrease by 50%.

OC5: For those children returning to a less restrictive school environment following discharge, 80% will experience 50% fewer suspensions/disciplinary actions than before their enrollment in PRS.

OC6: For those children not returning to the public school system because of age, 50% will be engaged in one of the following:

- Completion of their GED
- Vocational training

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Evaluation and Outcome Criteria (Cont'd.)

- Gainful employment

OC7: For those children successfully discharged from PRS, 80% will not return to PRS or a higher level of care within six months from date of discharge.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

THERAPEUTIC BEHAVIORAL SERVICES

Program Description

Therapeutic Behavioral Services (TBS) (formerly Therapeutic Child Treatment) is a psychosocial and developmental system of services for young children (ages 0 through 6). The goal of these services is to cultivate the psychological and emotional well being of children and to promote their developing competencies.

In order to qualify for TBS services, the child must show significant problem indicators in any one or more of the following developmental areas: behavioral, emotional, social, cognitive, bonding, self-help, receptive/expressive language, and physical.

Service delivery is facilitated through direct treatment services to the child and intervention with the family. An integrated complement of services provided by staff includes a well-structured treatment environment; monitoring and changing interactions of the child and family; individual, group and family therapy; and in-home observation and intervention modalities.

Expected outcomes of this service are the prevention of child maltreatment, the relief of the effects of abuse and neglect, and the empowerment of families to meet the therapeutic needs of their children.

Medical Necessity and Prior Authorization

Therapeutic Behavioral Services (TBS) must be recommended by a physician or other Licensed Practitioner of the Healing Arts, within the scope of his or her practice under state law. Determination of medical necessity shall include a developmental and emotional screening tool comparable to the Denver Developmental Screening Test II as used in Early and Periodic Screening Diagnosis and Treatment (EPSDT) screenings.

Medicaid-eligible children may be referred for Therapeutic Behavioral Services when they:

- Are not able to attend regular child care due to substantiated developmental or behavioral problems
- Have substantiated cases of abuse/neglect with developmental or behavior problems

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

- Are in imminent danger of being removed from the home and display substantiated developmental or behavioral problems

The Medical Necessity for a child's placement in a TBS program must be substantiated with a diagnosis using the most current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This includes the use of appropriate V Codes for diagnostic purposes.

The Medical Necessity Statement authorizes the placement of the child in TBS. The Medical Necessity Statement shall include the developmental and emotional screening tool, completed by a physician or other Licensed Practitioner of the Healing Arts. The developmental and emotional screening tool must be completed by the 15th day of service. These forms shall be placed in the child's clinical record upon completion of the screening tool. (See Section 5 for a copy of the Medical Necessity Statement for TBS).

The Referral Form/Authorization for Services (DHHS Form 254) is required when state agencies refer to private treatment providers. When applicable, this form must also be maintained in the child's clinical record.

If the child is re-entering this service, a new Medical Necessity Statement must be completed using the medical necessity criteria listed above.

Program Staff

Supervising Lead Clinical Staff (Supervising LCS)

Qualifications

- The Supervising LCS must meet the current Therapeutic Behavioral Services LCS criteria. The qualifications for Supervising Lead Clinical Staff are the same as those for Lead Clinical Staff.
- Each site must designate one LCS as the Supervising LCS.
- The Supervising LCS shall complete a minimum of 20 contact hours of training per year.
- Prior to rendering TBS services, all Supervising LCS must show documentation of 40 contact hours

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Supervising Lead Clinical Staff (Supervising LCS) (Cont'd.)

of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.

Responsibilities

The Supervising LCS shall be responsible for all decision making in evaluating, assessing, and treating children who are receiving Therapeutic Behavioral Services.

The Supervising LCS is responsible for providing supervision to all staff. Every staff person must receive a minimum of two hours of supervision per week. Supervision may take place in either a group or individual setting. Periods of supervision can be scheduled incrementally, as deemed appropriate by the Supervising LCS. Supervision must include opportunities for discussion of treatment plans and client progress. The Supervising LCS shall maintain a supervision log documenting all staff supervision. This log will also include weekly case consultation with staff. Case supervision and consultation do not supplant training requirements.

The Supervising LCS in each Therapeutic Behavioral Services program will be responsible for maintaining a written program description that includes the following:

- A developmentally appropriate curriculum
- A treatment protocol outlining the program methodology for enhancing/stimulating appropriate behaviors
- An outline of the procedures and instruments in place to provide the assessment services
- A description of treatment services for the child's family

Lead Clinical Staff (LCS)

Qualifications

The LCS must meet the professional standards as outlined in Clinical Staff under Staff Qualifications earlier in this section. Individuals wishing to be designated in one of the categories requiring a professional license must be licensed to practice in the state in which they are employed. For the purposes of Therapeutic Behavioral Services, the following

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (LCS) (Cont'd.)

professionals may serve as Lead Clinical Staff in addition to those listed under **Clinical Staff** (see Staff Requirements under Children's Behavioral Health Services earlier in this section):

- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners and has a minimum of one year of experience working with the population to be served.
- An **Early Childhood Specialist** holds a master's degree in early childhood education or child development and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse** is licensed to practice as a registered nurse with advanced practice certification, is practicing under a physician preceptor according to a mutually agreed-upon protocol, and has a minimum of one year of experience working with the population to be served.
- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist in the state in which he or she is rendering services and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse Specializing in Psychiatric Nursing** is licensed to practice as a registered nurse with advanced practice certification and is practicing under a physician preceptor according to a mutually agreed-upon protocol. Additionally, this advanced practice nurse has completed advanced study and clinical practice, as in a master's program in psychiatric nursing, has gained expert knowledge in the care and prevention of mental disorders, and has a minimum of one year of experience working with the population to be served.

Training Requirements

- The LCS shall complete a minimum of 20 contact hours of training per year.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (LCS) (Cont'd.)

- Prior to rendering TBS services, all LCS must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and/or the identification and treatment of children's mental health problems.

Responsibilities

- At least one LCS shall be on call during all program hours
- The LCS must assure that services are provided to children in a safe, efficient manner in accordance with accepted standards of clinical practice.
- The LCS's involvement in each child's assessment and treatment shall include but not be limited to participation in the planning and implementation of the child's Individualized Treatment Plan (ITP), treatment plan reviews, annual treatment plan reformulation, and the development of the weekly Progress Summary Notes (PSN).
- An LCS shall be involved in the active treatment for each child, including group and individual therapies as appropriate.

Non-Lead Clinical Staff (Non-LCS)

Qualifications

Non-LCS treatment staff must be supervised by an LCS, be 21 years of age or older, receive supervision to assure services are rendered in accordance with accepted clinical practice, and meet one of the following standards:

1. Hold a bachelor's degree from an accredited university or college and have a minimum of one year of experience in working with young children
2. Possess an associate's degree or technical college diploma in early childhood education/child development or the equivalent and have a minimum of one year of experience in working with young children
3. Have a high school diploma or GED, a Child Development Associate (CDA) credential and one year of experience in working with young children

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Non-Lead Clinical Staff (Non-LCS) (Cont'd.)

4. Have a high school diploma or GED; demonstrate theoretical and practical knowledge of the treatment of abused/neglected children; have at least three years of experience in working with young children; and within two years of beginning the Non-LCS position, either obtain a Child Development Associate (CDA) credential (or other nationally recognized credential) or complete 60 hours of training approved by DHHS. For any staff to meet this standard, a written plan must be in place that demonstrates the individual is actively working toward achieving this credential/training.

Prior to rendering TBS services, all Non-LCS must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.

The Non-LCS shall complete a minimum of 20 contact hours of training per year.

Responsibilities

The Non-LCS will conduct observations and treatment interventions as specified in the child's Individual Treatment Plan and directed by the Supervising LCS.

Staff Assistant (SA)

Qualifications

Staff Assistants (SAs), must be 18 years of age or older with a high school diploma or a GED. Under the supervision of an LCS, SAs may assist in carrying out program activities. SAs must receive the equivalent of 25 hours of training annually.

Responsibilities

The SA will assist the Supervising LCS, other LCS, and Non-LCS staff as needed.

Service Content

Each Therapeutic Behavioral Services program will provide specific treatment activities within a nurturing, structured environment that supports the development of appropriate behaviors, skills, emotional growth, and family relationships. The following services are the components of TBS.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Assessment and Evaluation

Assessment is the professional determination of the child's and family's functioning. At a minimum, an assessment shall include an age-appropriate evaluation of the child's developmental as well as emotional/behavioral domains, a description of the nature of the child/family's identified problem(s) and the factors contributing to those problems, a family history and assessment of strengths and needs, and a home environmental assessment. Results of observations of child, caregiver, and caregiver-child interactions must also be documented.

Treatment

A general treatment milieu will consist of direct interventions with the child and with the caregiver, provided by the Supervising LCS, other LCS and Non-LCS staff with support, as needed from staff assistants.

Skill Development

Children will participate based on need as defined in the initial assessment. Interventions with the child shall include activities aimed at promoting fine motor, gross motor, personal-social, communication, and cognitive skills. These activities, provided by treatment staff, will be represented on the child's individual treatment plan and modifications will be made as the child progresses.

Emotional-Behavioral Interventions

Interventions at this level will be accomplished through therapeutic activities based on the results of the assessment and shall be indicated on the child's Individual Treatment Plan (ITP). These therapies shall include interactions with treatment staff one-on-one, in child groups, and with child and family. Individualized techniques for enhancing/stimulating age-appropriate behaviors and emotional and developmental progression must be part of the milieu.

Rehabilitative Psychosocial Therapy

These activities are designed to improve the child's level of functioning and facilitate therapeutic interaction between treatment staff, child, family, and community. These activity therapies provide children with opportunities for reality orientation, minimizing self-involvement, and developing improved interpersonal skills as well as improved concentration abilities.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Treatment (Cont'd.)

Group Therapy

These groups should be designed to be family friendly and culturally sensitive with specific efforts made to work with parents as partners as much as possible. Appropriate TBS therapies may include Living Skills, but Living Skills classes are not Medicaid-reimbursable services. Group therapy sessions shall focus on treatment collaboration between staff and caregivers in the sharing of information, teaching of familial interventions, and exploring of child development theory and behavior management techniques. These sessions should be directed toward empowering families to be active participants in the treatment process. Although not required, programs are encouraged to offer group therapy to families.

Family Therapy

Family therapy is employed both in the center and in the child's home. Treatment staff assists the family in the development of skills to manage child behaviors that put undue stress on the parent and counsel with the family on resolving issues contributing to difficulties in successfully parenting the child. Family therapy presents the opportunity to monitor parent/caregiver-child interactions and provide situational counseling as appropriate.

Home Visit

The home visit is a face-to-face encounter with the TBS child and/or primary caregivers. The objective of the home visit is to conduct assessments of the child's family unit environment. Treatment staff should initiate interventions within the family's home environment thereby enabling the primary caregiver(s) to address the child's behavior problem and/or developmental delay. Treatment staff, in collaboration with the child's caregiver(s), should use this time to share information, teach familial interventions, and explore child development and behavior management techniques. Interventions should include continued access to appropriate and available services.

A home visit must meet the following criteria:

1. The TBS home visit must be conducted by a Supervising LCS or an LCS in order to be reimbursable as a TBS home visit.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Treatment (Cont'd.)

2. The home visit component should be delivered in the home or other setting where caregiver(s)/child interactions can be monitored and appropriate interventions implemented in accordance with the child's treatment plan.

Mainstreaming

The child may be mainstreamed in a regular daycare setting where appropriate. In accordance with the child's treatment plan, TBS staff will work in collaboration with the child's caregivers and regular day care staff to:

- Maintain current TBS skills
- Monitor behavior
- Initiate interventions

Coordination and Linkage

Therapeutic Behavioral Services providers should incorporate into their service delivery coordination and linkage with other disciplines involved or potentially involved in serving children and their families. Providers should work in collaboration with case managers to arrange needed services for the child and family who are jointly served.

Staff-to-Client Ratio for Center-Based Services

Staffing patterns shall provide for the adult supervision of children at all times and the immediate availability of additional adult(s) for assistance whenever needed. The following minimum staff-to-client ratios shall apply:

1. Through age two, one staff to every three children
2. Age three through age six, one staff to every five children

When children through age two are part of activities in a mixed age group, the staff-to-child ratio for children through age two shall be maintained.

When serving children whose special needs warrant staff attention exceeding the standard minimums, this attention must be provided.

When Staff Assistants are included in the ratio an LCS or Non-LCS treatment staff must also be a part of that ratio. For example, if there is a group consisting of eight five- and six-year olds, the ratio may be accomplished with

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Staff-to-Client Ratio for Center-Based Services (Cont'd.)

either an LCS or a Non-LCS treatment staff and a Staff Assistant. An LCS or Non-LCS treatment staff must always be a part of staff-to-client ratio.

Lengths and Frequencies of Services

Center Based

- The TBS program day must last a minimum of four hours.
- A therapeutic schedule must be in place authenticating the activities that constitute the length of program day.
- Treatment should be offered a minimum of five days per week.
- The TBS program must be open a minimum of 200 days during the year.
- Each unit of service is 15 minutes during which the LCS or Non-LCS is either monitoring the child or engaging the child in interventions.
- The maximum number of billable units each day is 16.
- Time spent in regular (non-mainstreamed) day care services may not be included in the TBS unit of service.
- Mainstreaming — Units for interventions rendered in this setting are reimbursable when TBS program staff are in the mainstreamed classroom with the TBS child, monitoring or engaging the child in TBS interventions as they relate to the classroom activities.

Home Visit

The home visit component should be delivered in the home or other setting where caregiver(s)/child interactions can be monitored and appropriate interventions implemented in accordance with the child's ITP. Each child's family unit is required to receive a minimum of one face-to-face home visit every two weeks. The maximum billable frequency of this service shall be once a week. TBS rendered while the caregiver and child are housed in a Residential Service Facility are not billable as home visits.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Service Duration

In most cases, all of the TBS goals should be met within the first 12 months of initiation of TBS services. **TBS services for a child are not intended to exceed 18 months**. However, based upon clinical evaluation and progress of the treatment interventions, both of which document unusual circumstances, the clinical determination may be made that a longer period of intervention is clinically warranted. Services may be extended with the approval and authorization of the referring agency.

Documentation

Medicaid reimbursement is directly related to the delivery of treatment services. All documentation must justify and support the Medicaid billing. Each child's record must contain adequate documentation to support the treatment service rendered. The TBS clinical record shall contain the following information:

- A developmental and emotional screening tool comparable to the Denver Developmental Screening Test II as used in Early and Periodic Screening Diagnosis and Treatment (EPSDT) screenings
- Medical Necessity Statement
- Referral Form/Authorization for Services (DHHS Form 254), if appropriate
- Signed/titled and dated Assessment Forms
- Signed/titled and dated (on each page) Treatment Plan(s)(reviews and reformulations must be initialed)
- Signed/titled and dated weekly Progress Summary Notes

Individual Treatment Plan

Initial Treatment Plan

An Individualized Treatment Plan (ITP) is a comprehensive plan of care developed by a multi-disciplinary treatment team following review of an initial assessment and other pertinent clinical information. The ITP and reviews must be developed, signed, and dated on each page by the LCS. The plan shall be developed on or before the 15th day the child is present in the program. If a treatment plan is not developed within 15 days, services

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Individual Treatment Plan (Cont'd.)

rendered from the 16th day until the date of completion of the treatment plan are not Medicaid reimbursable. The child's family should be a part of the planning team. The caregiver must review and sign the ITP. In all cases the treatment plan must be completed by the 30th calendar day from the child's admission into the program.

The signature, with date, of the Supervising Lead Clinical Staff is also required on each page of the ITP. This signature and date demonstrate that the ITP has been developed within the timelines set forth in this standard, and that the strategies outlined in the plan are sufficient to meet child/family treatment needs. The Supervising LCS is responsible for ensuring that the plan is implemented in accordance with the Medicaid standard for Therapeutic Behavioral Services.

At a minimum, the ITP shall include the following elements:

- A description of the child's and family's presenting problems including the long-term goals of the treatment plan
- Outcome-based objectives for remediation of the presenting problems, and targeted objective completion dates. When the objective is reached, the actual completion date shall also be documented.

When a TBS child is mainstreamed (placed in the least restrictive environment in a regular day care setting), documentation in the child's treatment plan must show all of the following:

- The expected benefits the TBS child will receive by being mainstreamed with non-TBS children
- The continued need for TBS
- The level of intensity of service (Example: two hrs/day)

TBS providers may use the DHHS Individual Treatment Plan form format (DHHS Form 562). See Section 5 for an example of this form.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Individual Treatment Plan (Cont'd.)

Treatment Plan Review

Treatment plan reviews shall be conducted at least quarterly (every 90 days) to assure that services and treatment goals continue to be appropriate to the child. The review should assess the child's progress and continued need for services. The LCS and the Supervising LCS must both sign/title and date the reviewed plan. The Supervising LCS's signature verifies that the ITP is designed for the child in accordance with the Medicaid standard for Therapeutic Behavioral Services. The ITP is a working document and may be modified at any time. Modifications must be signed and dated by the LCS, the Supervising LCS, and the child's primary caregiver.

Treatment Plan Reformulation

A reformulated treatment plan must be developed every 12 months, and signed and dated by the LCS, the Supervising LCS, and the child's primary caregiver.

In the event a child should re-enter this service, a reformulated treatment plan must be developed, signed, and dated by the LCS, the Supervising LCS, and the child's primary caregiver.

Discharge Planning

Discharge planning shall be documented on the ITP prior to discharge and shall include at a minimum:

- A follow-up plan to maintain skills TBS developed
- If applicable, a brief description of presenting problems that are unresolved
- Coordination and linkage established to provide ongoing resources to address remaining barriers and deter the resurgence of the initial presenting problems

Progress Summary Notes

The weekly Progress Summary Note summarizes program participation of the child and family and must be documented weekly. Days present and absent in the program must be included in the note. The summary should be placed in the child's record within one week following the service rendered. The documentation should address the following areas in order to provide a pertinent clinical description and to assure that the service conforms

Progress Summary Notes (Cont'd.)

to the service description:

- A general observation of the child's physical condition and the child's/family's interaction
- The child's/family's activity and participation in the treatment program, and documentation of the client's response to treatment
- Interactions between the treatment staff and child/family. The involvement of the staff in service provision is required and shall be documented.
- Long- and short-term barriers. Goals and interventions from case staffing are to be written so that they are clear, measurable, and obtainable.
- Group Therapy session attendance, when provided. Documentation should include reasons for non-attendance.
- Home visits. The home visit documentation shall also include at a minimum:
  - Date, time, and place of last visit and next visit
  - Physical and emotional status of the caregiver and/or child
  - Environmental (health and safety) factors

TBS providers shall use the DHHS Weekly Progress Summary Notes form format (DHHS Form 561). A sample of this form can be found in Section 5.

The Supervising LCS shall sign and date the Weekly Progress Summary Note as the person responsible for the provision of service. The Supervising LCS's signature verifies that the services were provided in accordance with the Medicaid standard for Therapeutic Behavioral Services.

If a Non-LCS is compiling the Weekly Progress Summary Notes under the direction of the LCS/Supervising LCS, the signature of the Non-LCS and date are required on the Weekly Progress Summary Notes.

Assessment

The assessment must be completed prior to the development of the child's ITP and must address the following areas:

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Assessment (Cont'd.)

- A description of the strengths of the child, family, and other systems in the ecology
- A list of impacted participants in the child's treatment (*e.g.,* primary caregiver, secondary caregiver, other family, TBS child, school/day care, neighborhood/community)
- Initial goals and desired outcomes for each participant in the TBS child's treatment
- Strengths and barriers for each participant in the TBS child's treatment
- A genogram of the family structure
- The presenting problem and the impacting issues

The assessment must be developed, signed/titled and dated by the LCS or the Supervising LCS. The Supervising LCS shall sign/title and date the assessment form as the person responsible for the provision of service. TBS providers shall use the DHHS Assessment. An example of this form can be found in Section 5, though it is a suggested format only; any forms used by a program should be individualized for the program. The primary caregiver shall sign and date the assessment form.

Program Evaluation

To the extent measurable, programs will be evaluated on their effectiveness in prevention of child maltreatment, evidence of diminished effects of abuse and neglect, evidence that the indicators prompting the referral have been reduced, and the displayed knowledge of the families' enhanced ability to meet the therapeutic needs of the child. Outcome criteria have been established and will be one of the instruments used to measure the program's effectiveness. (See the Consumer Satisfaction Survey in Section 5.) Within 90 days after the close of the state fiscal year, programs shall submit an annual report to the DHHS program manager describing their progress in meeting the Outcome Criteria.

OC1: After planned discharge, 80% of the children that were enrolled in Therapeutic Behavioral Services are still residing with a consistent, stable caregiver. A consistent stable caregiver is defined as a person in the child's natural ecology who provides appropriate developmental stimulation, nurturing, and safety for a one-year period.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Evaluation (Cont'd.)

OC2: For those children enrolled in a regular day care or school program following the successful completion of TBS, 80% of the children will remain in the regular setting for one year. For those children not enrolled in a regular day care or school program following the successful completion of TBS, 80% of the children will not return to TBS or a higher level of care within a one-year period.

OC3: Ninety percent of caregivers indicate satisfaction with Therapeutic Behavioral Services.

OC4: At the time of planned discharge, 90% of children will have achieved 75% of the objectives on their individual treatment plans.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

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SECTION 2 POLICIES AND PROCEDURES

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

EFFECTIVE JULY 1, 2005, MAPPS PROGRAM GUIDELINES WILL CHANGE. PROVIDERS OF MAPPS SERVICES WILL NEED TO REFER TO THE NEW GUIDELINES AFTER JUNE 30, 2005.

PROGRAM DESCRIPTION

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) provide family planning services to Medicaid at-risk youth that will enhance their understanding of individual and societal implications of human sexuality.

MEDICAL NECESSITY

MAPPS are designed to prevent teenage pregnancy among at-risk youths, promote abstinence, and educate youth to make responsible decisions about sexual activity (including postponement of sexual activity or the use of effective contraception). MAPPS should not be included in the reproductive health education that is required of all students under the South Carolina Comprehensive Health Education Act. Students should not receive a grade or school credit towards their diploma for MAPPS. Providers should review the South Carolina Comprehensive Education Act and their local school board plan before implementing a MAPPS program.

ELIGIBILITY REQUIREMENTS

In order to be eligible for MAPPS an individual must be:

- A Medicaid beneficiary
- Between the ages of eight and 19 and enrolled in school (regular, homebound, alternative, etc.)

Priority for participation is based on the following at-risk factors:

- Parent and/or sibling were teen parents
- Participant and/or teen sibling is a parent
- Participant may be sexually active or abstinent

SECTION 2 POLICIES AND PROCEDURES

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

PROGRAM STAFF

Individuals providing MAPPS must, at a minimum, be licensed or certified by appropriate state authorities as health care professionals, or be directly supervised by a licensed or certified health care professional or other DHHS approved staff person. Staff can be classified as professional (degreed in any discipline) and paraprofessional (non-degreed).

SERVICE DESCRIPTION

Screening to Determine Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol

Screening to Determine Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol, per 15 minutes (T1023-FP)

There are two components for Screening to Determine Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol. These two components are:

1. A needs assessment must be completed and filed in each beneficiary's record. Relevant information should be gathered and analyzed to determine social, psychological, environmental, and health risk factors contributing to the participant's family planning problems. The needs assessment must also identify the capacities and resources of the participant and the participant's family that may help address the family planning problems. The needs assessment will determine interventions to rectify identified problems and develop an initial service or case plan. Individual and family member interviews, referrals, and recommendations may all be used in the completion of the needs assessment process. All contact for the purpose of gathering information for the needs assessment must be face to face. A reassessment may be conducted as necessary.
2. A written intervention case plan must be completed based on the results of the needs assessment and placed in the record. The case plan should be reviewed every six months and updated every 12 months. The six-month review can be conducted as a desk review because it is not necessary to obtain the signatures of the participant and parent/caregiver.

SECTION 2 POLICIES AND PROCEDURES

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

Screening to Determine Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol (Cont'd.)

However, the participant, parent/caregiver, and worker must sign the annual review. The needs assessment and case plan must be completed prior to providing Patient Education and Non-Medical Family Planning Education services for new participants. The case plan must include family planning goals and objectives based on the assessment time frames for completion of the goals and objectives, the worker's signature, the signature of the participant and parent/caregivers, and the date.

Patient Education

Patient Education, Individual, Per Session (S9445-FP)
Patient Education, Group, Per Session (S9446-FP)

Patient education may be conducted in the form of individual or group sessions.

An individual session is a face-to-face consultation designed to assist reproductive age individuals in making informed decisions regarding family planning and voluntary utilization of appropriate birth control methods, therefore preventing unwanted or unintended pregnancies.

When conducting a group session a provider must use an evidence-based curriculum.

Levels of Counseling

Family Planning Education may be billed using two levels of counseling (comprehensive and standard), based on the intensity of service.

Comprehensive Level

Documentation for individual or group sessions at the comprehensive level of counseling should be related to family planning and include **five or more** of the following criteria:

- Importance of compliance with prescribed family planning methods and follow up visits
- Identification of family planning problems
- Treatment plan to resolve identified family planning problems (*i.e.,* lifestyle changes, etc.)
- The client's response and participation level as it relates to family planning

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MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

Levels of Counseling (Cont'd.)

- Information on STDs and prevention of STDs as it relates to family planning
- Information on the importance of family planning and it being a health priority
- Discussion of the benefits of abstinence
- Discussion of the benefits of delaying sexual activity
- Discussion of the benefits of delaying pregnancy
- Discussion of the availability of other health care resources related to family planning
- Discussion of the long- and short-term health risks related to early sexual activity
- Discussion of adolescent development as it relates to human growth, development and sexuality

Standard Level

Documentation for individual or group sessions at the standard level of counseling should include **three or more** of the criteria listed above.

Non-Medical Family Planning Education

Non-Medical Family Planning Education, Per Session (H1010-FP)

Non-Medical Family Planning Education is a one-on-one consultation designed to assist reproductive age individuals in making informed decisions regarding family planning and voluntary utilization of appropriate birth control methods, thereby preventing unwanted or unintended pregnancies.

Levels of Counseling

Non-Medical Family Planning Education may be billed using two levels of counseling, based on the intensity of service.

Comprehensive Level

Documentation for Non-Medical Family Planning Education at the comprehensive level of counseling should be related to family planning and include **three or more** of the following criteria:

- Discussion of the options and issues of birth control methods, including abstinence

SECTION 2 POLICIES AND PROCEDURES

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

Levels of Counseling (Cont'd.)

- Outlining the benefits and risks of long-term birth control methods
- Instruction on the proper or appropriate use of birth control methods
- Response and participation of the client as it relates to family planning
- Non-compliance where family planning issues are discussed
- Outlining the long- and short-term health risks related to early sexual activity
- Discussion of adolescent development as it relates to human growth, development and sexuality

Standard Level

Documentation for Non-Medical Family Planning Education at the standard level of counseling should be related to family planning and include **one or two** of the criteria listed above.

DOCUMENTATION

The Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol; Patient Education Individual; Patient Education Group; and Non-Medical Family Planning Education must be appropriately documented in the beneficiary's record. All documentation must include identification of the level of counseling, date of service, and signature of the provider. All documentation of services provided by paraprofessional staff must be co-signed by the supervisory professional staff.

Documentation of Patient Education Individual, Patient Education Group, and Non-Medical Family Planning Education must reflect services specific to the client. This includes individualization of all documented services, the purpose, and the objective of the session.

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MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

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SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

The Special Needs Transportation Program is designed to provide transportation to Medicaid-eligible school students with special needs requiring transportation to medically necessary services in school-based settings provided directly by the Local Education Agency (LEA). This population includes but is not limited to children under the age of 21 who have sensory impairments, physical disabilities, mental retardation, and/or developmental disabilities or delays. Each LEA recognized by the State Department of Education (SDE) is responsible for the arrangement and coordination of Special Needs Transportation services.

REQUIREMENTS FOR PARTICIPATION IN SPECIAL NEEDS TRANSPORTATION

In order to participate in the Special Needs Transportation Program, the LEA must meet all participatory requirements set forth in the program's contractual agreement with the SDE. The term "Local Education Agency" refers to any of the local entities that are recognized by SDE as school districts. Information concerning participation in the Medicaid Transportation Program may be obtained from the Division of Family Services, Department of Transportation Services at (803) 898-2565 or Post Office Box 8206, Columbia, SC 29202-8206.

Special Needs Transportation providers (LEAs) shall provide required transportation services to meet the needs of Medicaid-eligible school students with special needs in a vehicle adapted to serve the needs of the disabled. This shall include a specially adapted school bus used for transporting beneficiaries to and from reimbursable Medicaid services that are provided at a school or other facility when identified in the Individualized Education Plan (IEP).

COVERED SERVICES

Special Needs Transportation reimbursement is available for transportation provided to the following rehabilitative therapy and related health care services:

- Applied Behavior Therapy
- Audiological

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

COVERED SERVICES (CONT'D.)

- Physical Therapy
- Occupational Therapy
- Speech and Language Pathology
- Psychological Testing and Evaluation
- Orientation and Mobility (O&M)
- Behavioral Health Services
- Nursing Services for Children Under 21
- Administrative Claiming
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Non-Emergency Transportation

An appropriate Medicaid-reimbursable School-Based Service other than transportation must be rendered on the date of transport to be reimbursable for Special Needs transportation. Medicaid transportation is not reimbursable when the requirement for transportation service is not identified in the IEP.

SPECIAL CIRCUMSTANCES

Beneficiary Escorts

The SDE does not receive an additional reimbursement for an escort to accompany the beneficiary to an authorized medical service. The rate of reimbursement agreed upon in the contract is considered sufficient to cover the cost of an escort, attendant or other passenger that is required to accompany the Medicaid Special Needs student. The assignment of an escort to a Special Needs bus should be indicated in the student's IEP. If upon arrival at pickup a student requires an escort and one is not present, LEA providers should follow SDE procedures established to respond to such circumstances.

Beneficiary Complaints

Beneficiaries with complaints regarding Special Needs Transportation services should first contact their LEA provider. If the complaint cannot be resolved, a meeting should be scheduled with the LEA, SDE, and the complainant. If the complaint still cannot be resolved, SDE should contact the Special Needs Transportation program representative at DHHS at (803) 898-2565. The complainant should contact DHHS directly at 1-888-549-0820.

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SPECIAL NEEDS TRANSPORTATION PROGRAM

Vehicle Requirements

For the purpose of establishing the vehicle requirements relating to Special Needs Transportation services, LEAs will utilize a vehicle adapted to serve the needs of the disabled to include a specially adapted school bus and the current policies and procedures as defined by the State Department of Education, Board of Education in accordance with Section 59-67-20, Code of Laws of South Carolina for the Operation of the Public Pupil Transportation Services Reg. No. R 43-80 (as amended).

DOCUMENTATION

Records

Records shall be accurate, legible, and easily reconciled; therefore, extreme caution should be used when altering any part of a record. All documentation must be in permanent ink. Errors in documentation should never be totally marked through. Corrective fluid or tape may not be used to make corrections. To make a correction, mark a single line through the log entry and write "error" to the side. Skip to the next available clear line and complete the entry correctly and add signature/initials and date next to the correction. If warranted, an explanation of the correction may be appropriate. At any time during normal business hours and as often as DHHS, the State Auditor's Office, the Office of the Attorney General, the General Accounting Office (GAO), and/or any of the designees of the above may deem necessary during the contract period and for three years thereafter, SDE and LEAs shall make all program and financial records and service delivery sites open to representatives of the aforementioned agencies.

DHHS, the State Auditor's Office, the Office of the Attorney General, the General Accounting Office (GAO), and/or any of the designees of the above shall have the right to examine and make copies, excerpts, or transcripts from all records and contracts, conduct private interviews with provider clients and employees, and perform on-site reviews of all matters relating to service delivery.

If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the three-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three-year period, whichever is later.

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SPECIAL NEEDS TRANSPORTATION PROGRAM

Trip and Passenger Pupil Log Form

A Trip and Passenger Pupil Log Form is used daily by the driver to record route information and other ridership data as required by DHHS for billing and claims reimbursement for each Medicaid passenger (pupil) accessing transportation each day. This SDE or LEA form will provide basic information for completion of transportation billing and claims generation for reimbursement for each Medicaid passenger (pupil).

These forms are required to be kept in the provider's files as secure documentation. All information on the form is necessary for performance and financial audit purposes. If you choose to format a different version of the SDE-approved form, you are required to submit it to SDE for approval before using it.

District forms shall include:

1. District Name, Address, Phone Number
2. Service Area (County)
3. Route Number (as applicable)
4. Driver (Name)
5. Vehicle Number/License Tag Number/District Number
6. Date
7. Passenger Name

Upon completion, drivers are required to sign the log in the space provided.

Summary Sheets

Transportation summary sheets that summarize information from the Trip and Passenger Log Forms are essential to the success of effective financial and program review. All Medicaid transportation providers are required to develop a transportation summary sheet.

PROGRAM COMPLIANCE REVIEW

A program review will be conducted at least once during the contract year to evaluate compliance with program policies and procedures. Contract compliance reviews are conducted to identify areas where programmatic development or improvement is needed and to ensure that Medicaid policy is being met. The completed review will identify service delivery problems and recommend

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

PROGRAM COMPLIANCE REVIEW (CONT'D.)

corrective action utilizing quality assurance methodologies approved by DHHS. This is also an opportunity to note program strengths and recognize the dedication and commitment the LEA provides to Medicaid beneficiaries.

During a compliance review, the following will be evaluated:

1. Verification of an appropriate Medicaid-reimbursable service other than transportation has been rendered on the date of transport as compared with the Trip Dispatch/Passenger Log
2. Verification of the requirement for transportation service has been identified in the IEP for a Medicaid-eligible Special Needs student
3. Compliance with policy and procedures of the Medicaid Transportation Program to be reimbursable for Special Needs transportation

Non-emergency contractual transportation services may be provided by the LEAs for Medicaid-eligible students requiring transport off-site to and from Medicaid-reimbursable services. Transportation services must be contracted directly through DHHS. The LEA must not bill Medicaid for contractual transportation services on any date of service when Special Needs Transportation reimbursement has been claimed. Medicaid will not reimburse for contractual and Special Needs Transportation on the same date of service.

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SPECIAL NEEDS TRANSPORTATION PROGRAM

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