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PROGRAM OVERVIEW

The purpose of this manual is to provide pertinent information to alcohol and other drug (AOD) abuse service providers for successful participation in the South Carolina Medicaid program. This manual provides a comprehensive overview of the program standards and polices and procedures for Medicaid compliance. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (SCDHHS) and will be made in writing to all providers.

SCDHHS encourages the use of and promotes the access to "evidenced-based" practices and "emerging best practices" in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis, and treatment planning, and fosters improvement in the delivery system of AOD treatment services to children and adults in the most effective and cost effective manner.

SCDHHS and the South Carolina Department of Alcohol and Other Drug Abuse Services (SCDAODAS) have implemented a statewide system to coordinate AOD treatment services that are critical to serving eligible clients with AOD-related problems.

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

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PROGRAM REQUIREMENTS

PROVIDER RESPONSIBILITIES

It shall be the responsibility of SCDAODAS to ensure that all AOD service providers meet the following criteria:

1. Providers must have written agreements to document the availability of support systems that are not a direct service of the provider.
2. Providers shall make admission, continued stay, and discharge decisions based on the ASAM criterion that has been adopted by SCDHHS for delivery of AOD services.
3. Providers must have relationships with other providers to ensure that their clients have access to other levels of care for AOD services, support systems that are not a direct service of the provider, and access to the appropriate referral sources. When an assessment indicates that another level of care is required, these contacts shall be used if the provider does not offer the entire range of treatment services.
4. Providers shall participate in scheduled reviews with SCDHHS and/or SCDAODAS on the impact of these criteria on service quality, cost, outcome, and access.
5. Providers shall maintain the appropriate state and federal licensing and meet Medicaid requirements when rendering direct medical, psychological, psychiatric, laboratory, or toxicology services.
6. Providers should have written agreements with referral sources for levels of care that they do not provide.
7. Providers should have a written agreement specifying expectations that meet ASAM criteria if they do not directly provide a 24-hour emergency service.
8. Providers will define access requirements for routine, urgent, and emergency care for treatment services. Pregnant women not in treatment will be included in the definition of urgent care.
9. Providers' Medicaid reimbursement is limited to

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PROVIDER RESPONSIBILITIES (CONT'D.)

those services approved under the contractual agreement between SCDAODAS and SCDHHS.

10. Providers shall coordinate with SCDAODAS for certification of any new level of care or modification of levels of care offered by the provider. All services must be certified by SCDAODAS to be Medicaid reimbursable.
11. Providers with a facility providing 24 hours per day, seven days per week services are limited to 16 or fewer beds in order to receive Medicaid reimbursement. (Federal policy prohibits Medicaid payments to Institutions of Mental Disease.)

SECLUSION AND RESTRAINT

Any provider, community-based or residential, who intends to employ the use of seclusion and/or restraint with the population to be served, must ensure that:

- **Staff is adequately and appropriately trained. Training for staff who initiate or terminate seclusion and/or restraint should be aimed at minimizing the use of such measures, as well as ensuring client safety.**
- **Staff successfully completes a course from a certified trainer in the prevention and management of aggressive behavior.**
- **Staff receives training in the prevention and management of aggressive behavior prior to participating in any form of restraint.**
- **Staff has training in the application and removal of restraints, recognizing signs of physical distress, addressing circulation needs, and recognizing and assisting the client to become ready for release.**
- **All staff involved in the use of seclusion and restraint must use the necessary and appropriate skills, knowledge, and expertise to judiciously apply interventions in a safe manner.**
- **Documentation verifying seclusion and restraint training should be placed in the personnel files for authorized staff.**

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MEDICAL NECESSITY

Definition

All AOD services provided to clients should be designed to meet the clients' specific needs and be medically necessary. A service is medically necessary when it meets all of the following conditions:

- It is required to diagnose, treat, cure, or prevent an illness which has been diagnosed or is reasonably suspected, to relieve pain, or improve and preserve health, or be essential to life.
- It is consistent with the client's symptoms, diagnosis, level of care, or ability to function in their roles, and not in excess of the client's needs.
- It is consistent with generally accepted medical standards and is not experimental or investigational.
- It is not primarily provided for the convenience of the client, the client's caretaker, or the provider.

Clients must meet medical necessity requirements before being placed in AOD treatment services. Medical necessity must be substantiated with a diagnosis from the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Outpatient services and residential and/or inpatient services must be authorized by a physician or other Licensed Practitioner of the Healing Arts (LPHA) who certifies the identified client meets the DSM criteria. Residential and/or inpatient services also require a physical exam to be completed within the specified time frame by a qualified professional.

The following professionals are considered to be Licensed Practitioners of the Healing Arts:

- Physician
- Licensed Physician Assistant
- Licensed Psychologist
- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Nurse Practitioner
- Registered Nurse with a Master's Degree in Psychiatric Nursing

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Definition (Cont'd.)

- Licensed Psychiatric Nurse Practitioner
- Licensed Doctor of Osteopathy
- Licensed Professional Counselor (master's and doctoral level only)
- Licensed Family Therapist (master's and doctoral level only)
- Certified Addiction Registered Nurse (CARN)

COORDINATION OF CARE

Coordination of care must occur for clients who are being served by multiple agencies and/or providers. Each provider is responsible for attempting to identify during the intake process whether a client is already receiving treatment from another Medicaid provider and notifying any other involved Medicaid providers of the client's need for services. Needed services should never be denied to a client because another provider has been identified as the service provider. Each provider should also notify other involved agencies or providers immediately if a client in an overlapping situation discontinues their services.

STAFF REQUIREMENTS

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

Bio-psycho-social assessments and therapeutic services are conducted by one of the following professionals:

- One who is a South Carolina Association of Alcoholism and Drug Abuse Counselors (SCAADAC) credentialed Certified Addiction Counselor (CAC), a Certified Addiction Counselor II (CAC II) or a Certified Counselor Supervisor (CCS) with a minimum of a bachelor's degree in a health or human services related field.
- One who is certified as a National Association of Alcohol and Drug Abuse Counselor II (NAADAC II) with a South Carolina certification or a Master Addition Counselor (MAC) with a South Carolina certification.
- One who is in the process of becoming a SCAADAC credentialed CAC with a minimum of a bachelor's degree in a health or human services-

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STAFF REQUIREMENTS (CONT'D.)

related field. (See **Note** below regarding "In-Process" staff.)

To render Medicaid-reimbursable treatment services, clinicians entering the system prior to July 1, 1997 must be one of the following:

- Certified by the SCAADAC Certification Commission as a CCS or a Certified Addiction Counselor I (CAC I) or a CAC II
- Licensed by the state of South Carolina in counseling, social work, psychology, or other related field

To render Medicaid-reimbursable treatment services, clinicians entering the system on or after July 1, 1997 must meet all of the following:

- Hold a bachelor's degree in a health or human services-related field
- Be employed by a county Alcohol and Other Drug Abuse Authority
- Be credentialed as a CCS, a CAC-I, or a CAC-II by the SCAADAC Certification Commission.
- Be certified as an NAADAC II with South Carolina certification or a MAC with South Carolina certification

Staff "In Process"

Staff "In Process" is defined as staff that are in the process of becoming SCAADAC certified who are under active and ongoing clinical supervision.

Any staff that is "In-Process" must have the following qualifications:

1. Holds a master's or bachelor's degree in a human services-related field from an accredited university prior to application for certification
2. Has a plan to obtain and achieve certification within a maximum of three years of application
3. Submits an application for certification before being authorized to provide any Medicaid-sponsored direct client service. Evidence of the application for certification must be available in the personnel file.

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Staff "In Process" (Cont'd.)

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

Note: Clinical supervisors who are employed in this capacity before July 1, 2006, but do not have the requisite credentials, are considered to be "In-Process" and must obtain the requisite credentials within three years or not later than June 30, 2009. In addition, those clinical supervisors who are employed in this capacity prior to July 1, 2006 and do not have a master's degree will not be required to obtain a master's degree.

4. An internal clinical supervision plan developed and implemented for "In-Process" staff addressing the frequency and type of clinical supervision.
5. Clinical documentation (assessment, clinical assessment summary, treatment plan, transition plan, and discharge summary) completed by an "In Process" staff person and co-signed by the clinical supervisor or designee in his or her absence.

Students and/or interns in the process of obtaining a master's degree in human services from an accredited program may offer direct client services only under active and ongoing clinical supervision.

Supervision guidelines for students and/or interns include the following:

- There must be a designated clinical supervisor and a clinical supervision plan developed outlining the clinical objectives of the internship/field placement. The supervision plan also includes the frequency and quantity of review for clinical service notes. The clinical supervision plan must be individualized to each clinician's needs and the plan must be updated at least once a year.
- Supervision for students and/or interns must be provided by a CCS, an NCAC-II, a MAC, an LPC, an LMSW, or licensed psychologist who is also credentialed by SCAADAC or have at least four years of AOD counseling experience and at least

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Staff "In Process" (Cont'd.)

five hours of clinical supervision training.

- All clinical documentation (assessment, clinical assessment summary, treatment plan, transition plan, and discharge summary) for students and/or interns must be cosigned by the designated supervisor.

Lead Clinical Staff (LCS)

Providers of Mental Health Services Not Otherwise Specified (MHS-NOS) and/or Therapeutic Behavioral Services (TBS) shall maintain a credentials file for each Lead Clinical Staff (LCS) substantiating that each staff member meets LCS qualifications. This file shall include employer verification of the LCS credentials and work experience. Individuals wishing to be designated in one of the categories requiring a professional license must be licensed to practice in the state in which the facility at which they are employed is located.

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.)

"One 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 **Licensed Psychologist** holds a doctoral degree in psychology from an accredited university or college, is licensed in the state where the facility is located 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** holds a bachelor's degree from an accredited university or college, is licensed to practice in the state in which the facility is

Lead Clinical Staff (LCS)

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(Cont'd.)

located, and 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, is licensed by the State Board of Social Work Examiners to practice in the state in which the facility is located, 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 the treatment of the mentally ill; or is a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement; or is a professional who is credentialed as a LPC to practice in the state in which the facility is located 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, 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.
- A **Child Service Professional** has a minimum of three years of experience working with the population to be served, and fulfills **one** of the following descriptions**:**
    - Holds a bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development, or a related field including, but

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(Cont'd.)

not limited to, criminal justice, rehabilitative counseling, and elementary or secondary education

- Holds a bachelor's degree in another field and has a minimum of 45 documented hours of additional training (*i.e.,* undergraduate or graduate courses, workshops, seminars, and conferences) on issues related to child development and children's mental health issues and treatment in one or more of the above disciplines

Lead Clinical Staff (LCS)

- A **Licensed Baccalaureate Social Worker** holds a bachelor's degree from an accredited university or college, is licensed by the State Board of Social Work Examiners to practice in the state in which the facility is located, and has a minimum of three years of experience working with the population to be served.
- A **Certified Addictions Counselor** holds a bachelor's degree from an accredited university or college, is credentialed by the Certification Commission of the SCAADAC, the NAADAC, 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.
- A **Physician** is a doctor of medicine and osteopathy, is currently licensed in the state in which he or she is rendering services 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 from an accredited university or college in early childhood education or child development and has a minimum of one year of experience working with the population to be served.
- A **Licensed Nurse Practitioner** is licensed to practice as a registered nurse and certified nurse practitioner (CNP) in the state in which he or she is

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(Cont'd.)

rendering services, and practices under a physician preceptor according to a mutually agreed-upon protocol. Additionally, a licensed nurse practitioner 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.
- A **Licensed Psychiatric Nurse Practitioner** is licensed to practice as a registered nurse and licensed as a CNP in the state in which he or she is rendering services, practices under a physician preceptor according to a mutually agreed-upon protocol, has completed advanced study and clinical practice as in a master's program in psychiatric nursing and 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.

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PROGRAM REQUIREMENTS

Staff Requirements by Service

Service	Staff Qualifications
Assessment	Must have at least a bachelor's degree in a health or human services field, and/or hold credentials/licensure as a NCAC-II, a MAC, or a LPHA
Case Management — Case Manager	1. Must be privileged to provide service 2. Must have completed Case Management training 3. Must meet staff qualifications for assessment or have a bachelor's degree in social sciences or a related discipline.
Case Management — Assistant Case Manager	1. Must be privileged to provide service 2. Must have completed Case Management training 3. Must have no less than a high school degree or GED 4. Must work under the supervision of a case manager
Crisis Management	Same as Assessment
Mental Health Services Not Otherwise Specified	LCS as specified in the service standard.
Physical Examination	MD, PA, CNP, or CNS functioning in the extended role with prescriptive authority
Medical Services	MD, PA, CNP, or CNS functioning in the extended role with prescriptive authority
Psychiatric Medical Assessment	MD
Psychological Testing	Licensed Clinical Psychologist
Therapeutic Behavioral Services Treatment	LCS as specified in the service standard

Staff Requirements by Level of Care

Level Of Care	Staff Qualifications
LEVEL I Outpatient Treatment (Individual Counseling — Outpatient)	Same as Assessment criteria listed above ASAM Criteria
LEVEL I Group Counseling by Clinician (Group Counseling — Outpatient)	Same as Assessment criteria listed above ASAM Criteria
LEVEL I-D Ambulatory Subacute Tx/Detox (Ambulatory Detox without Extended On-Site Monitoring)	ASAM criteria May also be provided by "In Process" staff

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Staff Requirements by Level of Care (Cont'd.)

Level Of Care	Staff Qualifications
LEVEL II.1 Intensive Outpatient (Intensive Outpatient Treatment)	ASAM Criteria
LEVEL II.5 Day Treatment (Substance Abuse Treatment)	Same as Assessment criteria listed above ASAM criteria May also be provided by "In Process" staff
LEVEL II-D AMB Setting Subacute Tx/Detox Ambulatory Detox with Extended On-Site Monitoring	ASAM criteria May also be provided by "In Process" staff
LEVEL III.1 Abuse Halfway House (Clinically Managed Low-Intensity Residential Services)	ASAM criteria Allied health professionals must be trained in CPR and first aid and know procedures for accessing emergency care. May also be provided by "In Process" staff
LEVEL III.2-D Subacute Detox — Residential Addiction — Outpatient (Clinically Managed Residential Detox)	ASAM criteria May also be provided by "In Process" staff
LEVEL III.5 Behavioral Health Long-Term Residential (Clinically Managed High-Intensity Residential Services)	Same as Assessment criteria listed above ASAM criteria May also be provided by "In Process" staff
LEVEL III.7 Behavioral Health Short-Term Residential (Medically Monitored Intensive Inpatient Treatment)	Same as Assessment criteria listed above ASAM criteria May also be provided by "In Process" staff
LEVEL III.7-A Behavioral Health Short-Term Residential — Adolescent (Medically Monitored Intensive Inpatient Treatment — Adolescent)	Same as Assessment criteria listed above ASAM criteria May also be provided by "In Process" staff
LEVEL III.7-D Acute Detox (Medically Monitored Inpatient Detox)	ASAM criteria May also be provided by "In Process" staff
LEVEL IV-D* Hospital — Detox (Medically Monitored Intensive Inpatient Treatment)	ASAM criteria May also be provided by "In Process" staff
LEVEL IV-R* Hospital — Rehabilitation (Medically Monitored Intensive Inpatient Treatment)	ASAM criteria May also be provided by "In Process" staff

***Clinicians with a bachelor's degree and SCAADAC credentialed as a CAC, employed by County Alcohol and Other Drug Abuse Authorities prior to July 1, 1997, will be allowed to continue to provide Medicaid-reimbursable services. Clinicians entering the system after July 1, 1997 are required to meet staff qualifications as stated above.**

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Staff Coverage Requirements by Level of Care

Level Of Care	Staff Qualifications
LEVEL I Outpatient Treatment (Individual Counseling — Outpatient)	ASAM criteria
LEVEL I Group Counseling by Clinician (Group Counseling — Outpatient)	ASAM criteria
LEVEL I-D Ambulatory Subacute Tx/Detox (Ambulatory Detox without Extended On-Site Monitoring)	ASAM criteria
LEVEL II.1 Intensive Outpatient (Intensive Outpatient Treatment)	ASAM criteria
LEVEL II.5 Day Treatment (Substance Abuse Treatment)	ASAM criteria and the intensity of medical and nursing care are appropriate for the services being provided and the needs of those being served.
LEVEL II-D AMB Setting Subacute Tx/Detox Ambulatory Detox with Extended On-Site Monitoring	ASAM criteria
LEVEL III.1 Abuse Halfway House (Clinically Managed Low-Intensity Residential Services)	ASAM criteria
LEVEL III.2-D Subacute Detox — Residential Addiction — Outpatient (Clinically Managed Residential Detox)	ASAM criteria
LEVEL III.5 Behavioral Health Long-Term Residential (Clinically Managed High-Intensity Residential Services)	ASAM criteria and professional staff (*i.e.* professional addictions counselor, registered nurse, physician, physician assistant, certified nurse practitioner, or clinical nurse specialist who is authorized by the South Carolina Board of Nursing to function in the extended role with prescriptive authority and child-care specialist who meet the criteria for Therapeutic Behavioral Services Lead Clinical Staff) shall provide 50 hours of clinical services per week. These hours consist of eight hours a day, Monday through Friday, and five hours a day, Saturday and Sunday. Residential staff shall provide coverage during the rest of each day. Physician monitoring and nursing care and observation are available as needed, based on clinical judgment.
LEVEL III.7 Behavioral Health Short-Term Residential (Medically Monitored Intensive Inpatient Treatment)	ASAM criteria plus the requirements for Level III.5

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Staff Coverage Requirements by Level of Care (Cont'd.)

Level Of Care	Staff Qualifications
LEVEL III.7-A Behavioral Health Short-Term Residential — Adolescent (Medically Monitored Intensive Inpatient Treatment — Adolescent)	ASAM criteria plus the requirements for Level III.5
LEVEL III.7-D Acute Detox (Medically Monitored Inpatient Detox)	ASAM criteria
LEVEL IV-D* Hospital — Detox (Medically Monitored Intensive Inpatient Treatment)	ASAM criteria
LEVEL IV-R* Hospital — Rehabilitation (Medically Monitored Intensive Inpatient Treatment)	ASAM criteria

***South Carolina Medicaid reimburses these services through the Diagnostic Related Group (DRG) payment system when provided in an acute care general hospital.**

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INDIVIDUAL TREATMENT PLAN (ITP)

DEFINITION

An individual treatment plan (ITP) is an integral part of the assessment process and should be initiated prior to the client entering services. An ITP is developed to guide the client and the clinician through the treatment process. The ITP is used to identify the type and frequency of service needed by the client based on goal statements.

Treatment plan goals must be of a therapeutic nature, be individualized, and be supported by the information in the clinical assessment. Initial treatment plan goals must be logically and directly linked to the needs of the client.

Treatment goal objectives should describe the desired behavior or result that reflects the attainment of the goal. The objective provides the means to monitor progress on treatment goals. Objectives should be expressed in outcome terms that are observable, measurable, time-bound, and understandable to all disciplines and the client. Specific objectives provide the client and the clinician with a clear perspective of the anticipated treatment goal outcome and the expectation of the client. Clinicians must consider the treatment goals when providing treatment services.

The expected duration of an ITP is 12 months from the date of the physician's signature on the ITP. The ITP is a working document that must be updated with client input as new information is obtained. Updates must be made when there is a change in the frequency or type of service or when new goals and/or objectives are needed as treatment progresses. All changes to the ITP must be initialed and dated by the clinician who made the changes on the ITP. If a staff member who did not write the original ITP makes a change, then that staff member must include his or her full signature, title, and the date.

In the ITP, the estimated frequency of the service must be reflected on a time per week basis, or as otherwise needed. Examples of frequency of service documentation on the ITP are:

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INDIVIDUAL TREATMENT PLAN

DEFINITION (CONT'D)

Group Counseling by Clinician	1 x week
Behavioral Health Counseling and Therapy	1 x every 2 weeks
Intensive Outpatient	daily

The ITP should not include a limit on the number of weeks of service. For example, clinicians should **not** write:

Behavioral Health Counseling and Therapy	1 x week for 8 weeks

The service ordered should reflect the greatest frequency expected. For example, clinicians should **not** write "once or twice per month."

Targeted Case Management (TCM), Case Management (CM), Psychological Testing, Assessment, and Medical Services are the only services that may be listed in the treatment plan with a frequency of PRN (as needed).

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SUPPLEMENTAL V-CODES

Providers may be reimbursed for services rendered to clients and their families who are deemed "high-risk" or "at-risk" for substance use, abuse, or dependency. A V-code diagnosis from the DSM may be used in this situation. The diagnosis should be based on the assessed relationship between the risk factors and condition being treated.

ACCEPTABLE V-CODES

Acceptable DSM supplemental V-codes include the following:

- V61.10 Counseling Marital and Partner Problems (Unspecified)
- V61.20 Counseling Parent-Child Problem (Unspecified)
- V61.21 Counseling for Victim of Child Abuse
- V61.21 Child Neglect and/or Physical Abuse of Child
- V61.11 Counseling for Victim of Spousal and Partner Abuse
- V61.12 Counseling for Perpetrator of Spousal and Partner Abuse
- V61.8 Other Specified Family Circumstances
- V61.9 Unspecified Family Circumstances
- V62.2 Other Occupational Circumstances of Maladjustments
- V62.4 Social Maladjustment
- V62.81 Interpersonal Problems Not Otherwise Specified
- V62.82 Bereavement Uncomplicated
- V62.89 Phase of Life Problem
- V71.02 Childhood or Adolescent Antisocial Behavior

Note: When billing these diagnosis codes, enter the complete V-code on the claim as written above to prevent errors.

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SUPPLEMENTAL V-CODES

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UNACCEPTABLE V-CODES

Unacceptable DSM supplemental V-codes include the following:

- V15.81 Noncompliance with Treatment
- V62.30 Academic Problems
- V62.89 Borderline Intellectual Functioning
- V65.20 Malingering
- V71.01 Adult Antisocial Behavior

RISK FACTORS

Risk factors for clients deemed "high risk" or "at risk" include but are not limited to the following:

- Evidence of substance use or abuse in the home environment
- Previous or current violence in the home
- Family history of AOD use, abuse, and/or dependence
- History of co-dependency and associated maladaptive behaviors
- Antisocial behavior in a child or adolescent that is not due to any other mental disorder

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UNACCEPTABLE V-CODES

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V-CODE DIAGNOSIS

An ITP for a V-code diagnosis should be based on an assessment of the client and should include at a minimum:

- Identification of the appropriate risk factors for at-risk behavior
- Short-term and long-term goals for reducing or eliminating at-risk behavior
- Objectives which must be outcome-oriented, measurable, and individual
- Types of interventions to be utilized, the planned frequency for the interventions, and the estimated duration of the treatment
- Signatures of the staff developing the ITP along with their titles and the date

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V-CODE DIAGNOSIS

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TREATMENT

Therapeutic interventions should stress the importance of promoting the "real life" behavior changes that eliminate or reduce the risk factors leading to substance use or abuse. Appropriate therapeutic interventions must be designed to meet the needs of the client and his or her family and should be based on the expertise of the clinician. The clinician should assist the client and his or her family in developing the appropriate skills and resources needed to increase their ability to cope with daily life circumstances that result in at-risk behavior. The clinician is responsible for justifying the use and clinical value of therapeutic interventions through clinical documentation in the client's record.

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DOCUMENTATION REQUIREMENTS

REQUIREMENTS

Medicaid reimbursement is directly related to the delivery of therapeutic services. All alcohol and other drug abuse treatment services provided to Medicaid clients shall be documented on a clinical service note (CSN) or other specified form. Each client's record must contain pertinent clinical documentation to support the therapeutic service rendered. Documentation must support the client's need for AOD services when diagnosed as at-risk or high-risk for substance abuse or dependency. Subsequent clinical documentation must reflect the patient's response to the treatment protocol (*e.g.,* indication of risk reduction) based on the initial or revised diagnosis as it relates to the treatment goals.

Providers must meet the requirements for a standardized documentation system, as approved by SCDAODAS in accordance with Medicaid requirements.

Clinical documentation must include the following:

- The specific service rendered, including the name of the service or its approved abbreviation
- The treatment plan showing the specific planned frequency for the service
- The service date and length of time
- Signature and credential title of staff that renders and documents the service

Staff responsible for the provision of services must ensure that services are provided in accordance with appropriate licensing, credentialing, certification, or privileging standards.

For Level III.2D, the staff that renders these services shall document the service and sign the service note.

For Level II.5 through Level III.7D, the client's primary clinician may prepare the summary of the day's activities and sign the CSN.

CSN documentation shall also address the following items in order to provide a pertinent clinical description and to ensure that the service conforms to the service description and authenticates the charges:

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DOCUMENTATION REQUIREMENTS

REQUIREMENTS (CONT'D.)

- The content of the service shall be outlined including identifying relapse triggers, breaking through denial, and improving communication skills. For example, "What is the focus of today's session?" It is not necessary to list every video, worksheet, or activity provided to the client.
- The client's involvement in the service shall be documented, including the client's reaction and arrival condition. For example:
  - Client Reaction—"What is the client's reaction or response to treatment?" "Is the client involved and participating?" "What is the behavior?"
  - Arrival Condition—"What is the client's mood?" "How does this affect his or her general appearance or physical condition?"
- Evidence of staff activity in the provision of the service is required and shall be documented. For example, "What did the clinician do to facilitate the client's treatment during this session?" "What was the clinician's role?" "How did the clinician intervene, confront, support, etc.?"
- The client's progress shall be included in the documentation. For example, "What is the client's progress with relationship to the treatment goals?" Please note that the treatment goals need to be specific according to the services provided.
- Planning and/or clinical consideration for future service provision shall be documented. This includes justification for continuing care. For example, "What are the plans and/or clinical considerations for future service provision?"
- Staff responsible for the provisions of services must ensure that services are provided in accordance with applicable service standards.
- Documentation of therapies provided must be completed within three working days for outpatient or inpatient services. Documentation must be filed in the client's record within three working days from the date of service.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

REQUIREMENTS (CONT'D.)

- Therapeutic Behavioral Services may be documented with weekly notes. Documentation for TBS must be filed in the client's record within five working days of the last date of service. The weekly service note must address the dates of service and the number of hours the client participated in the service.
- Treatment plans should be reviewed at each scheduled clinical contact. Any changes to the treatment plan should include the client's input.

MAINTENANCE OF RECORDS

All documentation must be typed or legibly handwritten using only black or blue ink, and filed in the client's record in chronological order. All records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order such that the records can be easily and clearly reviewed, copied, and audited. Photocopies are acceptable if completely legible. Originals must be available if needed.

All entries must be dated (with month, day and year) and legibly signed by the appropriate staff. The service provider must maintain a signature sheet that identifies all names, signatures, and initials.

Only the approved abbreviations and symbols of services may be used. Each service provider shall maintain a list of any abbreviations and symbols used in the record, so as to leave no doubt as to the meaning of the documentation.

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

- Clearly draw one line through the error and write "error" to the side in parenthesis, make the correct entry, and sign or initial and date.
- Errors must not be totally marked through, as the information in error must remain legible.
- If an explanation is necessary to clarify the correction, one should be entered. In extreme circumstances, it maybe prudent to have a correction and/or explanation witnessed and/or cosigned.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

MAINTENANCE OF RECORDS (CONT'D.)

- No correction fluid, tape, or erasable ink may be used.

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in the documentation. Late entries should be rarely used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

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

Medical records shall be retained for a period of three years after the last payment date. If litigations, claims, or other actions involving the records have been initiated prior to the expiration of the three year period, the records shall be retained until completion of the action/resolution of all issues which arise from it or until the end of the three year period, whichever is later.

Ambulatory Detox without Extended On-Site Monitoring and Ambulatory Detox with Extended On-Site Monitoring

Documentation must include medication use history and medical notes regarding any medical activity during the current stay.

PRIOR AUTHORIZATION

Process

Prior authorization is the process of obtaining prior approval as to the appropriateness of a service. For inpatient hospital services requiring prior authorization, the Severity of Illness/Intensity of Service (SIIS) criteria will be utilized. The SIIS criteria are used by Medicaid to

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Process (Cont'd)

ensure that inpatient hospital services are medically appropriate. Providers are responsible for obtaining prior authorization for services they will provide.

To obtain prior authorization for services, providers should call (800) 374-1390 or (803) 896-5988 (for calls within the Columbia area). Telephone coverage will be provided 24 hours per day, seven days per week.

The utilization review case manager (URCM) of SCDAODAS will screen the medical and/or clinical information provided using the appropriate American Society of Addiction Medicine *Patient Placement Criteria (ASAM-PPC).* If the criteria are met, the services will be approved by SCDAODAS.

If the reviewer disagrees with the treatment option requested by the provider, the reviewer and the provider will discuss the request in a collaborative manner utilizing the appropriate resources in an effort to establish the most appropriate treatment option.

AOD abuse treatment services rendered by Medicaid-enrolled AOD providers and inpatient hospitals for Diagnostic Related Groups 433 and 521-523 will require prior authorization from SCDAODAS.

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

The following services must be authorized through the prior authorization process to be eligible for reimbursement:

Code	Service	Unit Time	Maximum Units
90801	Psychiatric Medical Assessment (PMA)	15 minutes	6/day
96101	Psychological Testing (PT)	1 hour	8/day – 24/year
H0008	Subacute Detox (III.2-D)	day	1/day
H0008-HA	Subacute Detox — Adolescent (III.2-D)	day	1/day
H0011	Acute Detox (III.7-D)	day	1/day
H0012	Subacute Detox — Residential Addiction — Outpatient - (DT)	day	1/day
H0015	Intensive Outpatient (IOP)	30 minutes	12/day
H0018	Behavioral Health Short-Term Residential (III.7R)	day	1/day
H0018-HA	Behavioral Health Short-Term Residential — Adolescent (III.7)	day	1/day
H0019	Behavioral Health Long-Term Residential (III.5)	day	1/day
H0046	Mental Health Services Not Otherwise Specified (MHS-NOS)	15 minutes	48/day
H2012	Day Treatment (DT)	hour	6/day
S9475	AMB Setting Subacute Tx/Detox (AMB W)	day	1/day
*	Level IV-D — Hospital Detox	*	*
*	Level IV-R — Hospital Rehabilitation	*	*

*** South Carolina Medicaid reimburses these services through the Diagnostic Related Group (DRG) payment system when provided in an acute care general hospital.**

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

The following services **do not require** prior authorization:

Code	Service	Units	Frequency
H0001	Assessment (AS)	30 minutes	6/day
H0004	Behavioral Health Counseling & Therapy (IC)	15 minutes	12/day
H0005	Group Counseling by Clinician (GC)	30 minutes	15/day
H0006	Case Management (CM)	15 minutes	16/day
H0007	Crisis Intervention OP (CI)	15 minutes	4/day
H0016	Medical Somatic (MS)	15 minutes	3/day
H2017	Caregiver Services (CS)	15 minutes	24/day
H2019**	Therapeutic Behavioral Services (TBS)	15 minutes	16/day
H2020-HA**	Therapeutic Behavioral Services — Adolescent (TBS-A)	per visit	1/week
H2034	Abuse Halfway House (III.1R)	day	n/a
T1015	Clinic Visit — All-Inclusive Physical Examination (PE)	per exam	n/a
T1017	Targeted Case Management (TCM)	15 minutes	16/day

****When filing a claim for these services, a number beginning with "XU" must be entered in the prior authorization field.**

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM CONTENT

LEVELS OF CARE

Medicaid reimbursement is available for the following levels of care as defined by the American Society of Addiction Medicine's *Patient Placement Criteria* (ASAM-PPC) *for the Treatment of Substance-Related Disorders*. Providers shall refer to the ASAM-PPC as the basis for client placement in the appropriate level of care.

Level I: Outpatient Treatment

Outpatient Treatment level of care encompasses organized outpatient treatment services that can be rendered in a wide variety of settings. For these services, addiction treatment staff, including addiction-credentialed physicians, provides professionally directed evaluation, treatment, and recovery services to Medicaid-eligible individuals.

Level I-D: Ambulatory Subacute Tx/Detox

Formerly Ambulatory Detox without Extended On-Site Monitoring

Subacute Treatment and/or Detoxification level of care is an organized outpatient service that can be rendered in an office practice, health care or addiction treatment facility. Services are rendered by trained clinicians who provide medically supervised evaluation, detoxification, and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. Subacute Treatment and/or Detoxification must be delivered under a defined set of policies and procedures or medical protocols. Outpatient services must be designed to treat the client's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the client's transition into ongoing treatment and recovery. There must be 24-hour access to emergency medical services. Service providers should be able to provide or assist in accessing transportation services for clients who are unable to drive safely for legal or medical reasons, or who otherwise lack transportation.

Level II.1: Intensive Outpatient Services

Intensive Outpatient services are designed to provide clients who are in need of more than traditional outpatient

SECTION 2 POLICIES AND PROCEDURES

PROGRAM CONTENT

Level II.1: Intensive Outpatient Services (Cont'd.)

treatment services, or who are in need of an alternative to inpatient treatment. Treatment on an outpatient basis allows for a valid assessment of environmental, cognitive, and emotional antecedents to substance abuse or dependency. In addition, it allows the client the opportunity to test new coping strategies while still in a supportive treatment relationship. These conditions will lead to generalization of what was learned in treatment in the client's natural environment.

Intensive Outpatient level of care may be composed of a number of services such as group, individual, family unit, multi-family group, or parent-child interrelation training skills groups that, when combined, meet a minimum of nine hours of skilled treatment provided over at least three days per week. The amount, frequency and intensity of the services must reflect the needs of the client and must address the objectives of the client's treatment plan. Each provider is encouraged to develop a schedule of Intensive Outpatient services but is reminded that the needs of the client supersede the schedule.

Intensive Outpatient services are all-inclusive. Providers cannot bill separately for services utilized to make up this level of care (*e.g.,* individual, group counseling, family unit, multi-family, etc.). The following services are exceptions and may be billed separately: initial assessment, crisis management, and concurrent case management. The services that comprise an Intensive Outpatient level of care will be billed at the same rate. For example, if a provider renders an individual counseling session as part of the eligible client's care, it must be billed at the intensive outpatient rate, not the rate for an individual counseling session.

Level II.5: Day Treatment

Day Treatment services provide 20 or more hours of clinically intensive programming at least four days per week based on the client's ITP. Day Treatment involves a structured treatment program that provides essential education and treatment components while allowing clients to apply their newly acquired skills within "real world" environments. This service is for clients who are in need of more than traditional outpatient treatment services or as an alternative to inpatient treatment. Programs offering this service shall provide comprehensive bio-psycho-social

SECTION 2 POLICIES AND PROCEDURES

PROGRAM CONTENT

Level II.5: Day Treatment (Cont'd.)

assessments and individual treatment, and allow for a valid assessment of environmental, cognitive, and emotional antecedents to substance abuse or dependency. In addition, programs offering this service shall have active affiliations with other levels of care and can assist in accessing clinically necessary "wraparound" support services. Programs offering this service shall have ready access to psychiatric, medical, and laboratory services. Day Treatment is also an all-inclusive service, and the same billing criterion applies as in the intensive outpatient example.

Level II-D: AMB Setting Subacute Tx/Detox

Formerly Ambulatory Detox with Extended On-Site Monitoring

Subacute Treatment and Detoxification level of care is an organized outpatient service that can be delivered in an office practice, health care or addiction treatment facility by trained clinicians. Clinicians provide medically supervised evaluation, detoxification, and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. Services are delivered under a defined set of policies and procedures or medical protocols defined by the state plan. Outpatient services must be designed to treat the client's level of clinical severity, achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol), and effectively facilitate the client's transition into ongoing treatment and recovery.

Essential to this level of care is the availability of appropriately credentialed and licensed nurses (registered nurses and a licensed practical nurse, respectively) for monitoring of clients over a period of several hours each day of service. There must be 24-hour access to emergency medical services. Service providers must be able to provide or assist in accessing transportation services for clients who are unable to drive safely for legal or medical reasons, or who otherwise lack transportation.

Level III.1: Abuse Halfway House

Formerly Clinically Managed Low-Intensity Residential Services

Providers of this level of care offer treatment directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal

SECTION 2 POLICIES AND PROCEDURES

PROGRAM CONTENT

Level III.1: Abuse Halfway House (Cont'd.)

responsibility, and reintegrating the client into the work, education, and family life environments. The services provided may include individual, group, and family therapy; medication management; and education. Mutual and/or self-help meetings usually are available on-site. Providers should refer to the American Society of Addiction Medicine's (ASAM) *Patient Placement Criteria for the Treatment of Substance-Related Disorders* as the basis for client placement in this level of care.

Level III.2-D: Subacute Detox — Residential Addiction — Outpatient

Formerly Clinically Managed Residential Detox

Subacute Detoxification Residential Addiction level of care is an organized service that can be delivered by appropriately trained staff that provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. This level of care is characterized by its emphasis on peer and social support. Services are for clients whose intoxication and/or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. However, the full resources of a hospital detoxification service are not necessary. Some programs at this level are staffed to supervise self-administered medications for the management of withdrawal. All programs at this level rely on established clinical protocols to identify clients who are in need of medical services beyond the capacity of the facility and to transfer such clients to more appropriate levels of care.

Level III.5: Behavioral Health Long-Term Residential

Formerly Clinically Managed High-Intensity Residential Services

For the **Behavioral Health Long-Term Residential** level of care, providers must:

- Provide physician monitoring and nursing care and observation as needed, based on clinical judgment
- Have professional staff (*e.g.,* professional addictions counselor, registered nurse, physician, physician assistant [PA], certified nurse practitioner [CNP], clinical nurse specialist [CNP]) who are authorized by the South Carolina Board of Nursing to function in the extended role with prescriptive authority, and a child-care specialist who meets the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM CONTENT

Level III.5: Behavioral Health Long-Term Residential (Cont'd.)

criteria for TBS Lead Clinical Staff (LCS) who provide fifty hours of clinical services per week. These hours consist of eight hours a day, Monday through Friday, and five hours a day, Saturday and Sunday. Residential staff will provide coverage during the rest of each day.

- If applicable, providers may bill TCM services as a separate service.

Level III.7: Behavioral Health Short-Term Residential

Formerly Medically Monitored Intensive Inpatient Treatment

For **Behavioral Health Short-Term Residential** level of care, SCDHHS will expect providers to have available:

- A physician to assess the client face-to-face within 24 hours of admission and provide face-to-face evaluations at least once a week. **(All clients must be discharged from this level of care by the physician, or the client's record must be reviewed by the physician before a client is transferred to a lesser level of care within the same treatment system.) Note: This requirement must be met for <u>all</u> clients in this level of care, not just those receiving detoxification services or aversion therapy.**
- An alcohol- and/or drug-focused nursing assessment conducted by a registered nurse at the time of admission. **Note: This requirement must be met for <u>all</u> clients in this level of care, not just those receiving detoxification services or aversion therapy.**
- A registered nurse responsible for overseeing the monitoring of the client's progress and medication administration. **Note: This requirement must be met for <u>all</u> clients in this level of care, not just those receiving detoxification services or aversion therapy.**
- The ability to obtain laboratory and toxicology test results within two hours
- Concurrent Case Management services (can be billed separately)

Professional staff (*e.g.,* professional addictions counselor,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM CONTENT

Level III.7: Behavioral Health Short-Term Residential (Cont'd.)

registered nurse, physician assistant, certified nurse practitioner, or clinical nurse specialist who are authorized by the South Carolina Board of Nursing to function in the extended role with prescriptive authority, or child-care specialist who meets the criteria for TBS Lead Clinical Staff) shall provide 50 hours of clinical services per week. These hours consist of eight hours a day, Monday through Friday, and five hours a day, Saturday and Sunday. Residential staff provides coverage during the remainder of each day.

Level III.7-A: Behavioral Health Short-Term Residential — Adolescent

Formerly Medically Monitored Intensive Inpatient Treatment — Adolescent

Behavioral Health Short-Term Residential — Adolescent level of care is a level of care designed to address severe biomedical and emotional behavioral problems that meet the ASAM PPC adolescent criteria for residential inpatient treatment. This level of care encompasses organized services staffed by designated addiction treatment personnel who provide a planned regimen for the client's care in a 24-hour live-in setting. Adolescents are housed in permanent facilities that are staffed 24 hours a day where they can reside safely. The program serves clients in need of a safe and stable living environment to develop sufficient recovery skills. Adolescent services require emphasis on inclusion of the family in the therapeutic process whenever possible, and intensive case management to connect the client and family with community support resources. The length of service always depends on the time required for adolescent's ability to acquire basic living skills and master the application and demonstration of recovery skills.

For this level of care, SCDHHS expects providers to have the following available:

- A physician to assess the adolescent (face-to-face) within 24 hours of admission and provide evaluations at least once a week. (Clients must be discharged from the Behavioral Health Short-Term Residential level of care by the physician, or the client's record must be reviewed by the physician before the client is transferred to a lower level of care within the same treatment system.)

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PROGRAM CONTENT

Level III.7-A: Behavioral Health Short-Term Residential — Adolescent (Cont'd.)

- An alcohol- and/or drug-focused nursing assessment conducted by a registered nurse at the time of admission
- A registered nurse available for overseeing the monitoring of the adolescent's medically related progress and medication administration
- The ability to get laboratory and toxicology test results within two hours
- Case Management services (can be billed separately)

Level III.7-D: Acute Detox

Formerly Medically Monitored Inpatient Detox

Acute Detoxification level of care is an organized service delivered by medical and nursing professionals that provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to clients with withdrawal signs and symptoms sufficiently severe to require 24-hour inpatient care, but not severe enough to warrant placement in an acute general hospital.

Level IV-D: Hospital Detox

Formerly Medically Monitored Intensive Inpatient Detox

Detoxification services must be provided in a hospital setting staffed by medical professionals who are available 24 hours per day. Counselors must be available 24 hours per day/seven days per week and on-site 12 hours per day/seven days per week to administer planned interventions according the needs of the client.

Level IV-R: Hospital Rehabilitation

Formerly Medically Monitored Intensive Inpatient

Rehabilitation services for this level of care are provided in a hospital setting. Medical professionals and counselors must be available 24 hours per day/seven days per week and on-site 12 hours per day, seven days per week. Providers should refer to the American Society of Addiction Medicine's (ASAM) *Patient Placement Criteria for the Treatment of Substance-Related Disorders* as the basis for client placement in this level of care.

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PROGRAM CONTENT

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PROGRAM SERVICES

ASSESSMENT

Definition

An assessment is the evaluation of a client's strengths, weaknesses, problems, and needs. It involves a professional determination of problems with respect to substance abuse or dependency. The assessment is the mechanism used to determine if the patient meets the diagnostic criteria for substance-related disorders, as defined by the *American Psychiatric Association of Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or other standardized and widely accepted criteria as well as dimensional criteria for admission. The assessment is a component of the process to establish medical necessity for AOD treatment services. Updates to the assessment may be performed as needed based upon clinical judgment.

The assessment shall include the following:

- Diagnosis (all five axes)
- Master problem list
- Interpretive summary
- Presenting problem
- Health, medical, and developmental history
- Family and/or social interaction
- Psychoactive substance use
- Information related to special population groups
- Psychological information
- Educational and/or vocational
- Client's abilities, strengths, needs and preferences
- Other pertinent information, and sources of information other than the client

Short-term programs, such as detoxification, may not require all of the above items to perform an assessment.

An assessment shall be updated and documented when

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Definition (Cont'd.)

there is a change in the client's level of care or a change in the client's treatment needs.

A client's medical necessity must be certified by the physician or a LPHA. The LPHA will certify the client for services by checking and signing beneath the ***Admitted to Service*** block on the Clinical Assessment Summary (DAODAS Form CAS). The signature must include the LPHA's credentials and must be signed within three days of completing the assessment. Physicians will continue to use the Physical Exam form (DAODAS FORM PE) for physicals and annotate medical necessity in block seven. (See Section 5 for an example of this form.)

When certifying services, the LPHA should review the client's medical history to determine if a physical exam should be recommended prior to beginning treatment.

PHYSICAL EXAMINATION

Definition

A physical examination (PE) is a face-to-face interaction between a qualified professional and the client to assess the client's status and provide diagnostic evaluation and screening. The physical examination is one mechanism to provide referral for AOD rehabilitative services. The physical examination may include a tuberculosis test, as deemed necessary by the physician.

The PE form must be completed and signed by a qualified professional within the appropriate time frame for the client's level of care. See Section 5 for an example of this form.

The provider will ensure that physical examinations are conducted by qualified professionals. Qualified professsionals include physicians, physician assistants (PA), certified nurse practitioners (CNP), or clinical nurse specialists (CNS) who are authorized by the South Carolina Board of Nursing to function in the extended role with prescriptive authority.

Program Content

Physical examinations are performed to:

- Determine the medical necessity for initiating alcohol and other drug rehabilitation services
- Provide a specialized medical assessment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Content (Cont'd.)

- Assess the need for referral to other health care providers

Physical examinations must include the following:

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

The physical examination may be a component of the process that establishes the medical necessity for the provision of specific AOD services. These specific services, level of care, and the time frame for completing the physical examination (if the physical examination is used to order services) are listed below:

- Level I
  Outpatient Treatment

  If indicated, the physical examination must be completed within 21 calendar days of the initial service or prior to the fifth service date, whichever occurs first.

- Level I-D
  Ambulatory Subacute Tx/Detox

  If indicated, the physical examination must be completed within 21 calendar days of the initial

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Content (Cont'd.)

service or prior to the fifth service date, whichever occurs first.

- Level II.1
  Intensive Outpatient

  If indicated, the physical examination must be completed within 21 calendar days of the initial service or prior to the fifth service date, whichever occurs first.

- Level II.5
  Day Treatment

  The physical examination must be completed within 21 calendar days of the initial service or prior to the fifth service date, whichever occurs first.

- Level II-D
  AMB Setting Subacute Tx/Detox

  The physical examination must be completed within 21 calendar days of the initial service or prior to the fifth service date, whichever occurs first.

- Level III.1
  Abuse Halfway House

  A physical examination that is not over 30 days old can be accepted; otherwise, a new physical examination must be done within 72 hours of admission.

- Level III.2-D
  Subacute Detox — Residential Addiction — Outpatient

  An MD, a PA, a RN, or a CNP will complete a medical screening to include Clinical Institute Withdrawal Assessment of Alcohol, Revised (CIWA-Ar) Scale or an appropriate scale for drugs within 24 hours of admission. A physical examination will be done if appropriate.

- Level III.5
  Behavioral Health Long-Term Residential

  A physical examination must be completed within 24 hours of admission.

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PROGRAM SERVICES

Program Content (Cont'd.)

- Level III.7
  Behavioral Health Short-Term Residential

  A physical examination must be completed within 24 hours of admission.

- Level III.7-A
  Behavioral Health Short-Term Residential — Adolescent

  A physical examination must be completed within 24 hours of admission.

- Level III.7-D
  Acute Detox

  A physical examination must be completed within 24 hours of admission.

- Level IV-D
  Hospital — Detox

  A physical examination must be completed within 24 hours of admission.

- Level IV-R
  Hospital — Rehabilitation

  A physical examination must be completed within 24 hours of admission.

The Physical Examination form must be placed in the client's file within seven days of the examination.

Documentation

The Physical Examination (PE) form should be completed as follows:

- Block seven, which is used to order AOD treatment, must be checked, signed, and dated by the physician, PA, CNP, or CNS. The provider is responsible for ensuring that block seven is completed by the physician, PA, CNP, or CNS. Completion of this form confirms the medical necessity for services.
- The counselors may complete the non-medical sections to ensure the physician, PA, CNP, or CNS has sufficient information about the client to make an appropriate AOD treatment referral. The original PE form must be placed in the client's record.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Documentation (Cont'd.)

- A physician, PA, CNP, or CNS may document his or her assessment on any History and Physical form as long as the history and physical include all the information required in the physical examination. Each provider should be responsible for ensuring that the History and Physical forms are adequate in meeting this requirement.
- The physician, PA, CNP, or CNS must still complete block seven, sign, and date the PE form. The PE and other relevant historical data are retained in the client's medical history records.
- A physical examination completed by another provider agency, physician, PA, CNP, or CNS that contains the required information may be used by the physician, PA, CNP, or CNS ordering services from the provider. The information must be attached to the required PE form for AOD services with block seven checked and the physician, PA, CNP, or CNS's signature and date noted.

PSYCHIATRIC MEDICAL ASSESSMENT (PMA)

Definition

A Psychiatric Medical Assessment (PMA) is the face-to-face interaction between a qualified professional (physician or an advanced practice registered nurse [APRN]) and an eligible client to assess and monitor the client's psychiatric and/or physiological status. The scope of issues addressed in this service is based on client need.

Staff Qualifications

A Psychiatric Medical Assessment (PMA) must be rendered by a physician licensed to practice medicine within the state of South Carolina or by an APRN licensed to practice within the state of South Carolina who is recognized by the State Board of Nursing and has national certification. The APRN is allowed to render a subsequent PMA after a physician has performed the initial PMA.

Program Content

PMAs are designed to:

- Assess mental status and provide psychiatric diagnostic evaluations
- Provide specialized medical and/or psychiatric assessments

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Content (Cont'd.)

- Assess the appropriateness of initiating or continuing the use of medications, and prescribe medications or other treatment as indicated.
- Provide or review information on which to base a psychiatric evaluation
- Assess or monitor the client's status in relation to treatment
- Assess the need for referral to other health care and/or social service providers
- Diagnose, treat, and monitor chronic and/or acute health problems, which may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays

The following pertain to PMAs:

- A client receiving psychotropic medication is strongly encouraged to receive a PMA at a minimum of every six months.
- A PMA may be provided to a Medicaid client, as indicated, based on the initial clinical assessment.
- The provider may obtain a copy of a PMA performed by another provider for the purpose of the initial PMA requirement, provided that there are no clinical indications that necessitate another PMA. In these cases, under all circumstances, the receiving provider is responsible for ensuring that the client receives PMAs as clinically necessary and, for Medicaid billing purposes, in accordance with Medicaid requirements.
- Clients who have not had face-to-face treatment services during a six-month period will require a new PMA completed by a physician or an APRN.
- If a PMA has not been rendered during a retroactively covered period, a PMA conducted by a physician or an APRN must occur within 90 days from the date the client is determined eligible for Medicaid.
- A physician or a PRN may render a PMA to assess

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Content (Cont'd.)

the need for continued treatment and for treatment planning purposes.

Documentation

Documentation requirements for PMAs are listed below:

- A PMA must be entered on the ITP as the service rendered and may be listed as an PRN frequency.
- A PMA must be entered on the CSN as the service rendered. Enter "PMA" on the form.
- The date each service is rendered must be entered on the CSN.
- The start of the service will be the actual time the service is commenced and when combined with the billed time must represent the duration of the service.
- The physician or the APRN who renders the service must include a properly completed Physician Medical Order form in the record. The physician or PRN must sign and date the Physician Medical Order. A CSN must be entered in the record that references the Physician Medical Order.
- The place of service must be entered on the billing record.
- The place of service code for a PMA is one of the following:

  11 — Office
  12 — Home
  99 — Other unlisted facility

- The relationship of a PMA to the remainder of the services on the ITP is that all services can be rendered on the same day as the PMA.
- The documentation must provide a pertinent clinical description, ensure the service conforms to the service description, and authenticate the charges.
- The CSN and the Physician Medical Order must be placed in the client's record within 72 hours from the date of service.

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PROGRAM SERVICES

PSYCHOLOGICAL TESTING (PT)

Definition

Psychological Testing (PT) is the face-to-face interaction between the psychologist and the client for the purpose of evaluating the client's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics as well as utilization of other experimental methods of evaluation. PT is confined to the administering and interpretation of PT with a written interpretation completed and placed in the record within 72 hours from the date of service. The procedure is reimbursed per half-hour. The appropriate unit per half-hour must be recorded in the Units column of the claim form.

Staff Qualifications

Psychological Testing may be rendered by a licensed clinical psychologist or a licensed psychometrician.

Supervision

Psychological Testing may also be provided under the direct supervision of a licensed psychologist. For Medicaid billing purposes, direct supervision means that the supervising psychologist is accessible when the services being billed are provided; and the supervising psychologist is responsible for all services rendered, fees charged, and reimbursement received. The supervising psychologist must cosign all session notes indicating he or she accepts responsibility for the service rendered. In addition, the following conditions must be met:

- Supervision must be provided in accordance with standards and requirements as established by the South Carolina Board of Examiners in Psychology (SCBEP).
- SCBEP's Report of Supervised Persons field must be completed by the supervising psychologist and submitted to SCBEP prior to the initiation of the supervision and each year that the supervisor's license is renewed. Providers must have this report available and accessible for review.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Unlicensed Persons Providing Psychological Services

The guidelines for the Employment of Supervision of Unlicensed Persons Providing Psychological Services, as established by SCBEP, are:

- The supervising psychologist shall be licensed for the practice of psychology and have adequate training, knowledge, and skill to render competently any psychological services which his or her supervisee undertakes. The supervising psychologist shall supervise the provision of psychological services only in the specialty area(s) licensed by SCBEP.
- The unlicensed service provider must have background, training, and experience appropriate to the functions performed. The licensed supervising psychologist is responsible, subject to SCBEP review, for determining the adequacy of preparation of the unlicensed service provider and the designation of his or her title in accordance with the Code of Laws of South Carolina.

Conditions for utilization of unlicensed persons providing psychological services include:

- The licensed psychologist must register the following information, and any other information deemed necessary by SCBEP, with SCBEP at the time of annual license renewal:
  - The name of the unlicensed person rendering the psychological services
  - The nature of the psychological services rendered
  - The qualifying academic training and experience of the unlicensed person
  - The nature of the continuing supervision provided by the licensed psychologist
- The unlicensed person providing psychological services must be under the direct, administrative, and professional supervision of a licensed psychologist.
- The licensed psychologist must be vested with administrative control over the functioning of the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Unlicensed Persons Providing Psychological Services (Cont'd.)

unlicensed person to maintain ultimate responsibility for the welfare of every client. If the licensed psychologist is not the employer, then he or she should still have direct input into administrative matters.

- The licensed psychologist shall have sufficient knowledge of all clients, including face-to-face contact when necessary, in order to plan effective service delivery procedures. The progress of the work is monitored to ensure that full legal and professional responsibility can be accepted by the supervising psychologist. The supervising psychologist shall also be available for emergency consultation and intervention.
- The work assignments shall be commensurate with the skills of the unlicensed person. All procedures shall be planned in consultation with the supervising psychologist.
- The unlicensed employee shall work in the same physical setting as the supervising psychologist, unless other individual arrangements have been approved in advance by SCBEP.
- The public announcement of services, fees, and contact with the lay or professional community shall be offered only in the name of the supervising licensed psychologist. The title of the unlicensed person must clearly indicate his or her supervisory status.
- The client that utilizes the unlicensed person's services shall be informed of his or her status.
- The client shall be informed of the possibility of periodic meetings with the supervising psychologist at their or the supervising psychologist's request.
- The setting and receipt of payment shall remain the sole domain of the employing agency or supervising psychologist.
- The supervising psychologist shall establish and maintain a level of supervisory contact consistent with established professional standards and shall be fully accountable in the event that professional, ethical, or legal issues are raised.

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PROGRAM SERVICES

Unlicensed Persons Providing Psychological Services (Cont'd.)

- No more than three full-time unlicensed persons may be registered for any one supervising licensed psychologist.

It is recognized that the variability in preparation for the practice of all personnel will require individually tailored supervision. The range and content of supervision is arranged between the individual supervising psychologist and the unlicensed person. A detailed job description of which functions are designed at varying levels of difficulty, requiring increased levels of training, skill, and experience, should be available. This job description shall be made available to SCBEP and to clients upon request and shall maintain the following guidelines:

- Employment of a person who provides psychological services and who is not licensed by SCBEP requires the supervision of a licensed psychologist.
- The licensed psychologist may not be in the employment of the unlicensed person.
- The supervising psychologist is responsible for the planning course and outcome of the psychological services performed by the unlicensed employee. The conduct of supervision shall ensure the professional, ethical, and legal protection of the client and of the unlicensed person.
- An ongoing record of supervision shall be maintained that details the types of activities in which the unlicensed person is engaged, the level of competence in each activity, and the outcome of all procedures.
- All written reports and communications shall be reviewed, approved, and countersigned by the supervising licensed psychologist.

For copies of the SCBEP's requirements, or if you have questions regarding the supervision requirements, write or call:

South Carolina Board of Examiners in Psychology
Post Office Box 11329
Columbia, SC 29211-1329
(803) 896-4664

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PROGRAM SERVICES

Documentation

Psychological Testing must be identified on the ITP as the service to be rendered and may be listed as a PRN frequency.

TARGETED CASE MANAGEMENT (TCM) AND CASE MANAGEMENT (CM)

Definition

Targeted Case Management is responsible for locating, coordinating, and monitoring necessary and appropriate services for clients. TCM services are provided to help individuals gain access to appropriate medical, social, treatment, educational, and other needed services. Additionally, TCM services encourage the use of cost effective medical care by referrals to appropriate providers.

Services for AOD abusers will enable clients to have timely access to the services and programs that can best deal with their needs. Services will also ensure follow-up on placements and services to ensure that children and adults are in programs that are best suited to meet their needs.

TCM services can only be provided by the provider who has primary case management responsibility.

Service Description

Allowable activities are those that include assistance in accessing a medical or other necessary service, but do not include the direct delivery of the underlying service. Allowable activities for TCM services are:

The assessment component includes activities that focus on needs identification. Activities under this component include assessment of an eligible individual to determine the need for any medical, educational, social, and/or other services. Specific assessment activities include taking client history, identifying the needs of the individual, and completing related documentation. It also includes gathering information, if necessary, from other sources such as family members, medical providers, and educators to form a complete assessment of the client.

The care planning component builds on the information collected through the assessment phase. Activities under this component include ensuring the active participation of clients, working with individuals and others to develop

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

goals, and identifying a course of action to respond to the assessed needs of clients. The goals and actions in the POC should address medical, social, educational, and other services needed by the client.

The referral and linkage component includes activities that help link clients with medical, social, educational, and/or other providers, programs, and services that are capable of providing the assessed needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered case management.

The monitoring or follow-up component includes activities and contacts that are necessary to ensure the POC is implemented effectively and is adequately addressing the needs of the client. The activities and contacts may be with the client, family members, outside service providers, or other entities. These may be as frequent as necessary to help determine whether services are being furnished in accordance with client's POC, the adequacy of the services in the POC, and changes in the needs or status of clients. This function includes making necessary adjustments in the treatment plan and service arrangements with outside service providers.

TCM components may also include the following:

- Assisting clients in obtaining required educational, treatment, residential, medical, social, or other support services by accessing available services or advocating for service provision
- Contacting social, health, and rehabilitation service providers, either via telephone or face-to-face, in order to promote access to and the appropriate use of services by clients. Additionally, services by multiple providers may be coordinated.
- Monitoring clients' progress through the services and performing periodic reviews and reassessment of treatment needs
    - When assessing an individual's need for services includes a physical, psychological, or mental status examination or evaluation, billing for the examination or evaluation must be under the appropriate medical service category. Referral for such services may be considered a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

component of TCM services, but the actual provision of the service does not constitute TCM.

- When an assessment indicates the need for medical treatment, referral or arrangements for such treatment may be included as TCM services, but the actual treatment may not be.

- Arranging and monitoring a client's access to primary health care providers (non-center physicians) including written correspondence sent to a primary health care provider (non-center), which gives a synopsis of the treatment the client is receiving
- Coordinating and monitoring other health care needs of a client by arranging appointments for non-center medical services with follow-up and documentation
- Staffing meetings related to receiving consultation and supervision on a specific case to facilitate optimal case management. This includes recommending and facilitating a client's movement from one program to another or from one agency to another.
- Contacts with a client that deal with specific and identifiable problems of service access and require the case manager to guide or advise the client in the solution of the problem. (Interventions to monitor a client's general condition must be face-to-face.)
- Contacts with family, representatives of human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized service plan, which describes a client's problems and corresponding needs and details services to be accessed or procured to meet those needs.
- Preparation of a written report which details a client's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for physicians, other service providers, or agencies

TCM services may be provided for up to 15 business days

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

prior to assessment and/or treatment services. This service may also be provided by the agency for up to one year after the client is discharged from treatment. TCM services may be provided as a stand-alone service when treatment services are not deemed necessary by the bio-psycho-social assessment process. When used as a stand-alone service, a TCM treatment plan must be developed.

Case Management

Case Management services are rendered to clients for whom another provider has been designated as the primary case manager. The concurrent care provider renders different and distinct types of services. When concurrent care service is provided, the service is documented as Concurrent Case Management on the ITP.

Staff Qualifications

Case managers serving this population must, at a minimum, be credentialed by DAODAAS as a clinical counselor or intervention specialist; or, hold a master's degree in a social science or related discipline; or, hold a bachelors degree in the above mentioned disciplines and one year experience in service provision to alcohol and drug abuse or mental health clients; or, hold a master's or bachelor's degree in any discipline, and within nine months from the initiation of service provision demonstrate successful completion of the case management training curriculum developed and provided by SCDAODAS and approved by SCDHHS.

The required credentials for a case manger assistant will include no less than a high school diploma or GED, and the skills or competencies sufficient to perform assigned tasks, or the capacity to acquire those skills or competencies.

Case Manager Responsibilities

Case manager activities include:

- Coordinating access to all services available to Medicaid clients and any other necessary services within a community
- Arranging needed family support services indicated in the client's plan of care
- Arranging and monitoring the client's access to primary health care providers (physicians)
- Coordinating services from multiple agencies that are required to meet the client's needs

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Case Manager Responsibilities (Cont'd.)

- Attending public school meetings, community support meetings, and meetings with any other organization on behalf of the client
- Serving as the client's advocate in ensuring access to a wide range of services (Medicaid and non-Medicaid)

  The case manager will ensure that the client's freedom of choice of providers is maintained in accessing these services. The freedom of choice will be maintained at all times, including the freedom of the client to receive AOD services from a program other than the one that employs the case manager, if available. The case manager will coordinate the access to primary care physicians, local Department of Social Services (DSS) programs, county health departments, and other local service providers. The case manager will coordinate services within local AOD programs as indicated by the client's plan of service.
- Providing ongoing supervision of the plan of care documenting the client's activity. The receipt of TCM services must be at the option of the client and/or the client's family and/or guardian.
- Providing assistance in crisis intervention
- Documenting services that are needed by or recommended for the client but do not exist within the client's local community

  The case manager will also track the client to verify his or her arrival at recommended programs and will work to ensure that the client actually makes contact with these programs or is provided access to recommended programs. The case manager will work to remove barriers, if necessary, and ensure that appropriate services are available.
- Participating in staff meetings held at AOD programs or elsewhere
- Meeting the client's supplemental treatment service needs and supervises the activities of the assistant case manager
- The case manager's primary responsibility is the

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PROGRAM SERVICES

Case Manager Responsibilities (Cont'd.)

client's case management plan and all Case Management services rendered.

The case manager supervisor must meet staff qualifications to provide assessment services in accordance with the Staff Qualifications chart described earlier in this section.

Assistant Case Manager Responsibilities

Assistant case managers provide support to the case manager by assisting the case manager with the following:

- Identifying resources that meet the client's needs
- Coordinating information and referral requests for each client
- Assisting each client in gaining access to needed community-based services
- Following up on client referrals to ensure appointments are kept and ensuring the appropriateness of the services
- Monitoring service delivery on an ongoing basis to ensure services continue to meet the needs of each client.
- Providing specified tracking interventions to reinforce client compliance with service plan goals
- Coordinating the health care and/or service needs of each client with the case manager on a regular basis
- Assisting clients in coordinating transportation to medical appointments or other Medicaid-reimbursed services
- Completing required Medicaid documentation and ensuring the case manager reviews and signs all documentation before it is entered into the client's Medicaid file

By completing these functions, assistant case managers allow case managers to focus more on assessment, service planning, and other decision-making responsibilities.

Non-Reimbursable TCM Activities

The following is a list of activities that are **not** reimbursed by Medicaid as components of TCM. This list is intended as a guide and does not list all non-reimbursable activities:

- Verification of Medicaid numbers

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PROGRAM SERVICES

Non-Reimbursable TCM Activities (Cont'd.)

- Transportation of clients
- Attempted phone calls
- Attempted home visits
- Attempted face-to-face contacts
- Case management record reviews of own agency files
- Completion of any special requested information regarding clients for the provider, public agencies, or other private entities for administration purposes
- Participation in recreation or socialization activities with a client and/or his or her family
- Case Management rendered to clients in institutional placements such as jails, prisons, detention centers, or evaluation centers (formerly known as Reception and Evaluation Centers, Intermediate Care Facilities [ICF] or Intermediate Care Facilities for Mental Retardation [ICF-MR] nursing homes, etc.)
- Documentation of service notes
- Completion of MIS reports and monthly statistical reports, etc.
- Administrative duties such as copying, filing, mailing reports, etc.
- Activities rendered (S.C. Family Court, general sessions, or federal court) which are convened to address criminal charges by the client
- Services rendered on behalf of a client after death
- Internal agency staffing (*e.g.,* case manager and assistant case manager staffing)

Documentation

Clinical Service Note (CSN)

The clinical service note (CSN) should be completed as follows:

- The specific service rendered should be listed as "TCM" for Targeted Case Management or "CM" for concurrent Case Management. TCM or CM

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Clinical Service Note (CSN) (Cont'd.)

services must be listed on the ITP as the service to be rendered and may be listed as a PRN frequency.

- The date and the length of time the service is rendered should be entered on the CSN as "client time" only when the client is present. Face-to-face or non-face-to-face contact with another service provider or others on behalf of the client should be entered on the CSN.
- The staff member who renders the service shall document the service and sign the CSN as the person responsible for the provision of the service. The staff member shall ensure that services were provided in accordance with these standards.
- A case management note must recorded on the CSN and include the following:
  - The nature, content, and extent of the service and the person or provider and agency contacted
  - Evidence of staff activity in the provision of the service
  - The outcome and/or results of the contact

Clients who receive primary TCM services from another agency may **only** receive Case Management services, and, with the exception of MHS-NOS and TBS, all other services can be rendered on the same day as TCM or CM.

Special Restrictions

Clients not participating in any waiver program that includes Case Management services will not be case-managed under this program.

Case managers will have caseloads that will facilitate assessment of and quick response to situations that need immediate attention. Case Management activities may be rendered to a client on the date of the client's discharge from a hospital, SNF, ICF, or ICF/MR facility.

Telephone contacts between case managers and clients are Medicaid reimbursable when:

- The contact is necessary to assist clients in accessing care from health care providers or community agencies and/or informing clients of actions they must take to successfully access these

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PROGRAM SERVICES

Special Restrictions (Cont'd.)

services. In these situations, the case manager must document the specific service-access actions clients were instructed to take, as well as any actions taken by the case manager to ensure this service access. This contact includes brief communication directing clients to Crisis Intervention or other medical care.

- The contact is necessary to follow up on specific service-access needs of clients. The access arrangements must have been previously planned for clients, and the contact must be designed to monitor the completion of the service by the disabled or the otherwise non-compliant individual.

Medicaid reimbursement for telephone contacts with clients is restricted to a maximum of two units per day.

Medicaid does not reimburse for brief conversations to apprise clients of appointment times or contacts for the purpose of monitoring a client's general condition.

Residential Treatment Facility

Medicaid reimbursement for Case Management services rendered to children birth to age 21, residing in a Residential Treatment Facility or Institution for Mental Disease also known as a "psychiatric hospital," is limited to the following:

- Assuring that a placement continues to be necessary and appropriate to meet a clients' needs
- Planning for future placement(s)

TCM Overlap and Hierarchy Guidelines

Some individuals who are dually diagnosed, or have complex social and/or medical problems, may require services from more than one case management provider or agency to be successfully managed and/or integrated into the community.

The needs and resources of each individual may change over time, as well as the need for TCM services from another provider. To ensure that a client's needs are adequately met and that there is no duplication of services and Medicaid payments, TCM providers must work closely and cooperatively. A system must exist within each case management program to ensure that service providers are communicating, coordinating care and services, and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

TCM Overlap and Hierarchy Guidelines (Cont'd.)

adequately meeting individual needs.

A primary case manager, as well as a secondary provider, for each overlapping situation has been determined. The primary care manager shall:

- Ensure access to services
- Arrange needed care and services
- Monitor the case on an on-going basis
- Provide crisis assessment and referral services
- Provide needed follow-up
- Communicate, telephonically or face-to-face, with other involved agencies/providers on a regular basis

The primary care manager has the primary responsibility of integrating information and recommendations from other providers for clients, to develop an integrated, person-centered plan for addressing the client's multiple needs.

Concurrent care shall be rendered to an individual for whom another provider has been designated the primary care manager. The concurrent care provider shall notify the primary care manager in a timely manner regarding the following:

- Changes in the client/family situation
- Needs, problems, or progress
- Required referrals
- Program planning meetings

The concurrent care provider will provide different, distinctive types of services from the primary care manager. Billing is restricted to specific activities allowable under this service.

Service providers may render TCM services to those clients receiving a primary care manager from another case management provider.

If overlap occurs, these guidelines shall be followed:

CCEDC/DMH Targeted: CCEDC primary case manager with DMH providing case management services

DDSN/DMH Targeted: DDSN primary case manager with DMH providing case management services

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TCM Overlap and Hierarchy Guidelines (Cont'd.)

CRS/DMH Targeted: CRS primary case manager with DMH providing Case Management services

DDSN Early Intervention/DMH Targeted: Overlap not anticipated

DMH Managed Care/DMH Targeted: Overlap not permissible

DMH Targeted/DAODAS: DMH primary case manager with SCCADA providing case management services for a client with a psychiatric disability and substance abuse problem. For other dually diagnosed clients, whichever agency is predominantly meeting treatment needs will be primary case manager.

DMH Targeted/TMCM: TMCM primary case manager with DMH providing Case Management services

DMH Targeted/Sickle Cell: Sickle Cell primary case manager with DMH providing Case Management services

DMH Targeted/SCSDB - Commission For Blind: SCSDB - Commission For Blind primary case manager with DMH providing Case Management services

DMH Targeted/CLTC: CLTC primary case manager with DMH providing Case Management services

DMH Targeted/DSS Foster Care: DSS primary case manager with DMH providing Case Management services

DMH Targeted/Baby Net: Overlap not anticipated

DMH Targeted/HSCI: HSCI primary care manager with DMH providing Case Management services

In the above list:

CCEDC = Continuum of Care for Emotionally Disturbed Children

DDSN = Department of Development Disabilities and Special Needs

DMH = Department of Mental Health

DSS = Department of Social Services

SCSDB = South Carolina School for the Deaf and Blind

CLTC = Community Long Term Care

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PROGRAM SERVICES

TCM Overlap and Hierarchy Guidelines (Cont'd.)

DAODAS = Department of Alcohol and Other Drug Abuse Service

CRS = DHEC's Children's Rehabilitation Services

TMCM = Targeted Maternal Case Management Program

HSCI = Head and Spinal Cord Injury

AOD service providers shall be responsible for all of the following:

- Attempting to identify during the intake process whether an applicant is already receiving Case Management services from another Medicaid provider
- Notifying any other involved Medicaid Case Management providers of an applicant's request for services
- Billing Medicaid according to Case Management Hierarchy guidelines for each client receiving Case Management services from another Medicaid provider
- Not denying needed services to an individual because another provider has been designated the primary case manager
- Notifying other involved agencies or providers if an individual in an overlapping situation terminates their services

Exceptions to TCM Overlap and Hierarchy Guidelines

Providers are encouraged to resolve any exceptions to the Case Management Hierarchy at the local level. When an exception exists, these guidelines must be followed:

- If the service provider is predominantly meeting the treatment and service needs of the client and if the primary care manager has failed to adequately coordinate care and services, the provider may initiate contact with the primary care manager at the local level to request a change in the primary care manager. A meeting should be set up between the two agencies to discuss the feasibility of a change in the primary care manager.

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PROGRAM SERVICES

Exceptions to TCM Overlap and Hierarchy Guidelines (Cont'd.)

- Contacts (telephone or face-to-face) between service providers and the primary care manager concerning a change in the primary care manager, as well as the final determination of a primary care manager, must be documented in each provider's case management record. Although documentation of these activities is required, the activities are administrative and are not reimbursable by Medicaid.
- If the local providers are unable to reach a determination of the most appropriate primary case manger, the case should be referred to the appropriate state agency levels or main office for review.
- If the state agency or main office administrators are unable to reach a determination of the most appropriate primary care manager, the case should be referred to SCDHHS for review.
- SCDHHS may make the determination of the most appropriate primary case manger or may request that a team of other agency representatives make the determination.

The involved Medicaid providers will be notified within 45 days after the case is received by SCDHHS whether a change in the primary case manager is warranted.

CRISIS INTERVENTION

Definition

Crisis Intervention is an intensive, time-limited service providing face-to-face or telephone contact with the client following abrupt, substantial changes in function and/or a marked increase in personal distress resulting in an emergency situation for the client or a significant change in the client's environment.

Face-to-face interventions are intended to:

- Stabilize the client
- Identify the precipitant or casual agents that triggered the crisis
- Reduce the immediate personal distress felt by the client

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PROGRAM SERVICES

Definition (Cont'd.)

- Reduce the chance of future crises through the implementation of preventive strategies

Telephonic interventions are provided either to the client or on behalf of the client. Telephonic interventions are intended to:

- Stabilize the client
- Prevent a negative outcome
- Link the necessary services to assist the client

MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED

Definition

Formerly Intensive Family Services

Mental Health Services Not Otherwise Specified (MHS-NOS) are time-limited clinical interventions predominantly provided within the home and community environment of the identified child. Services are designed to serve children and adolescents under the age of 21. MHS-NOS cannot be billed concurrently with Therapeutic Foster Care.

Mental Health Services Not Otherwise Specified is behavioral, psychological, and psychosocial in orientation. They are multi-faceted and include crisis management, individual and family counseling, skills training, and coordination and linkage with other necessary services, resources, and supports to prevent the use of more restrictive residential services. Services are child centered and have a family focus. Services have a holistic perspective and are designed to include the child's family, community, education setting, and peer group. Assessment of needs and treatment planning are strength based and involve a partnership with the child and his or her family.

Services are designed to defuse a crisis that threatens the child's stability within the home environment. The child, family members, and other key individuals in the child's environment learn to evaluate the nature of the crisis, as well as to anticipate and defuse crises and thus reduce the likelihood of recurrence. Planned interventions help the family develop relationships with naturally occurring community networks that support positive

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Definition (Cont'd.)

adaptation and facilitate the child's adjustment to schools, peers, and community activities.

Mental Health Services Not Otherwise Specified are intended to effect the following outcomes for the child and his or her family by:

1. Keeping families together by preventing the unnecessary placement of an identified child into the foster care system, juvenile justice system, or an out-of-home therapeutic placement (*e.g.*, psychiatric hospital, therapeutic foster care, or residential treatment facility)
2. Preventing a child who is at risk of coming in contact with or already involved in the juvenile justice system from further penetration into the system
3. Preventing disruption of the child's home environment
4. Promoting reunification of the child with his or her family
5. Ensuring the child's safety and protection within his or her home environment

The following activities are non-billable:

- Documentation time
- Travel time
- Supervision time
- No-shows
- Recreational activities

Medical Necessity and Prior Authorization

Mental Health Services Not Otherwise Specified (MHS-NOS) must be recommended by a physician or other Licensed Practitioner of the Healing Arts who will certify that the identified child **meets at least one** of the following medical necessity criteria:

1. The identified child will be removed from his or her home if MHS-NOS are not rendered. The severity of the child's difficulties and the level of family dysfunction are such that out-of-home placement of the child is imminent.

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PROGRAM SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

2. The identified child's return home is deemed to be unsuccessful if MHS-NOS are not rendered. The child and his or her family require this service in order to successfully return the child to his or her home environment following an out-of-home placement.
3. The identified child and/or his or her home environment are experiencing problems that threaten the child's safety and well-being or family stability.
4. The child is at risk of involvement or further penetration into the juvenile justice system.
5. An immediate family member of the client meets criteria for psychoactive substance abuse or dependency using the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the client meets one of the four criteria listed above.

The medical necessity for the child's placement in the service must be substantiated with a diagnosis from the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This includes the use of V-codes.

The medical necessity is documented by the completion of a Medical Necessity Statement. The designated referring agent must ensure that a physician or other Licensed Practitioner of the Healing Arts evaluates and recommends that the identified child meet the medical necessity criteria for MHS-NOS. The Medical Necessity Statement provides documentation and justification of the identified child's problem areas and/or needs that require MHS-NOS.

At the time of admission, the designated referring agency will provide the treatment provider with a copy of the Medical Necessity Statement. A faxed copy is acceptable. The original form must be sent to the treatment provider within 10 days of admission to the program. The Medical Necessity Statement must be placed in the child's clinical record with the child's initial treatment plan.

In order to be Medicaid reimbursable, the service must be authorized by a designated referring agent prior to service delivery. Authorization for services is accomplished

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

through the completion of the DHHS Referral Form/ Authorization for Services (DHHS Form 254), if applicable. (See Section 5 for a copy of this form.) The DHHS Form 254 is required when state agencies refer children to private treatment providers. The designated referring agent will provide the treatment provider with a copy of this form at the time of admission. A faxed copy is acceptable. The original form must be provided within 10 days from the date of admission.

Program Staff

Services shall be rendered by appropriately trained Lead Clinical Staff (LCS) and/or trained Non-LCS staff as identified in this manual and who work under the direct supervision of a Lead Clinical Staff member.

Lead Clinical Staff

All LCS shall meet the professional standards defined by SCDHHS. Prior to rendering the services, all 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. All LCS must receive 20 contact hours of training annually. 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 Mental Health Services Not Otherwise Specified, the following professionals may serve as Lead Clinical Staff *in addition* to those listed under **Clinical Staff**:

- 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 **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 or child development and has a minimum of one year of experience working with the population to be served.

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PROGRAM SERVICES

Lead Clinical Staff (Cont'd.)

- 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 an 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 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 an advanced practice certification and is practicing under a physician preceptor according to an 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 experience working with the population to be served.

Non-Lead Clinical Staff

Services may be provided by Non-Lead Clinical Staff who are supervised by an LCS. Non-LCS must be at least 21 years of age and be privileged by the program to render the service, and must receive supervision to ensure services are rendered in accordance with accepted clinical practice. If the Non-LCS is the primary service provider, the Non-LCS must also sign, title and date the Progress Summary Note as the service provider.

All Non-LCS must hold a bachelor's degree from an accredited university or college and have a minimum of one year of experience in working with children and families. Prior to rendering the 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 treatment of children's mental health problems.

All Non-LCS must receive 20 contact hours of training annually.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Supervision

Program Director

Each MHS-NOS program must have a designated Program Director and at least one designated Lead Clinical Staff (LCS) to function as a supervisor for clinical oversight of the program's LCS and Non-LCS. The same individual can perform the two roles.

Supervising Lead Clinical Director

The individual performing the role of Supervising LCS is responsible for the execution of the following duties:

- Provide direct involvement in evaluating, assessing, and treating children and families
- Develop and sign treatment plans
- Provide and/or supervise service delivery, and periodically confirm the medical necessity of continued treatment
- Ensure that services are provided in a safe, efficient manner in accordance with accepted standards of clinical practice
- Provide supervision to all staff. Supervision must be provided weekly. Periods of supervision may be scheduled incrementally as deemed appropriate. Supervision must include opportunities to discuss treatment plans and client progress. Documentation of supervision must be maintained. Case supervision and consultation do not supplant training requirements.
- Facilitate regular staffings, at a minimum of once a week, in which administrative and client treatment issues and progress are considered. The staffing shall consist of an overview of the services rendered; the identified child's and the family's response to services, progress or barriers toward achievement of goals; new problems/needs identified; and any needed changes or modifications to their treatment plan. The staffing must be documented in the Progress Summary Notes.
- Ensure that supervision shall be available to the staff 24 hours per day, seven days per week
- Cosign all Medicaid documentation of Non-LCS

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Supervision (Cont'd.)

- Provide and document weekly supervision to all LCS and Non-LCS in an individual or group setting. Regular supervision includes all of the following:
  - Formulation of treatment plans for new clients
  - Review of progress of identified clients toward completion of treatment goals
  - Revision of treatment plans if indicated
  - Individual training as an apprentice to the Supervising LCS in the treatment process as needed
  - Individual face-to-face sessions between the Supervising LCS and staff

Staff-to-Case Ratios

Clinical caseloads shall not exceed one full-time staff to five child/family units.

Referral and Intake

- The provider of MHS-NOS shall have a mechanism in place that allows for response 24 hours per day, seven days per week to initiate screening of a referred child/family.
- For children whose physical safety may be at risk and/or who are at risk of imminent removal, a prompt response (acceptance or rejection) regarding the appropriateness of the referral must be made within 72 hours.
- For children in need of services but not at risk of imminent removal, a prompt response (acceptance or rejection) regarding the appropriateness of the referral must be made within one week (seven calendar days).
- Notification will be sent to the referring agency, *if applicable,* of the acceptance or non-acceptance of the identified child/family for MHS-NOS, including a justification for a decision of non-acceptance.

At least one family member with whom the identified child is living or will be returning to live with must be willing to participate in MHS-NOS with the goal of keeping the child in the home, returning the child to the home, or

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PROGRAM SERVICES

Referral and Intake (Cont'd.)

strengthening the family unit when abuse/neglect is the reason for referral. The identified child must also be willing to participate in MHS-NOS.

Program Content

Mental either face-to-face or via telephone. The intent of this service is Health Services Not Otherwise Specified shall be provided for the identified child based on assessed needs. Services may be rendered face-to-face contact, but services may be provided by telephone under extenuating circumstances. Documentation must support extenuating circumstances that warrant services provided by telephone.

The purpose of these services is to reinforce and enhance an individual child's ability to function within the family and to enhance the total family's level of functioning through the use of a variety of interventions.

Clinical interventions shall be designed to do the following:

- Reinforce and enhance the identified child's ability to function within his or her home environment, and enhance the family's level of functioning
- Identify and assist the identified child and his or her family in resolving conflicts
- Coordinate efforts between the LCS, the child and family, and the designated referring agent
- Communicate and demonstrate methods of appropriate skills and/or behavior management techniques in order to help family members more effectively manage certain behaviors, or support and/or strengthen the identified child's home environment
- Promote the family's relations with a social network that supports positive and pro-social behavior
- Identify and address difficulties in the child's peer relations and school performance
- Encourage the family to promote the child's positive social relations and academic performance

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Clinical Interventions

Interventions are provided primarily in the settings that comprise the social environment of the identified child and/or family and will:

- Reflect an assertive strategy by the LCS in engaging and retaining the identified child, family, and significant others in a therapeutic alliance
- Reflect an assumption of responsibility by the program for coordinating services with the educational, social, criminal justice, and health/ mental health systems. These efforts should not duplicate or replace efforts of the child's designated case manager.
- Teach the family to interact with the identified child in ways that improve behavior and control while conveying acceptance and emotional support
- Address marital and family conflicts that undermine a family's capacity to collaborate with the program in achieving behavior change in the identified child
- Motivate the child to disassociate from deviant peer groups and coach the child in behaviors that lead to acceptance in pro-social peer groups
- Teach the identified child to recognize the associations between his or her problems and his or her behavior, set goals, evaluate the consequences of antisocial responses to conditions that impede the child from realizing goals, and develop and implement pro-social plans in their place
- Make, coordinate, and follow up on referrals for more specialized therapeutic interventions

Duration of Services

Services are available 24 hours per day, seven days per week. Services will not exceed 24 weeks in a single year (a 52-week period). The referring or authorizing agency is responsible for determining the number of weeks to be authorized at any one time. The 24 weeks do not have to run consecutively.

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PROGRAM SERVICES

Accessibility and Continuity

- Continuity of care must be ensured throughout the delivery of the program service.
- One staff member other than the primary service provider must be familiar with the dynamics of each case in the event that the primary service provider is unavailable.
- An LCS must be available 24 hours per day, seven days per week to initiate screening of a referred child/family or to respond to an urgent need of the enrolled children.

Documentation

Client Record

A client record is opened for each identified child referred to the program. The record contains, at a minimum, the essential elements outlined under **Clinical Records**. The MHS-NOS record shall also contain:

- A screening assessment completed by the MHS-NOS program
- A consent to treatment explaining the goal of treatment, the nature of the proposed treatment, the expected frequency of contact and duration of treatment, financial responsibility, and the rights and responsibilities of the identified child/family in the treatment process
- Standardized fact sheet containing:
  - Name, date of birth, sex, and educational level of the child; current address and family's addresses, if different; and the family's telephone number(s)
  - Names, relationships, addresses, and telephone numbers of other members of child's primary family/social network who are or may be engaged in services on behalf of the child
  - Names, addresses, and phone numbers of key professionals engaged in service for the identified child (*e.g.,* teacher, school counselor, attorney, and state agency personnel)
  - Directions to the client's home

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PROGRAM SERVICES

Client Record (Cont'd.)

- Ongoing assessments of the strengths and weaknesses/needs of the child, family, school, peers, neighborhood, community, and linkages between the systems. Assessments must be derived from interactions and interviews with the identified child/family/key informants conducted in the child's social environment. Assessments must address the following:
  - Family system
  - Peer relations
  - Home/school behavior
  - Academic achievement and ability
  - Developmental level
  - Cognitive, psychiatric, and substance abuse disorders
  - Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

Individual Treatment Plan

Initial Treatment Plan

The initial treatment plan must be developed within 10 days of admission to the program. If a treatment plan is not developed within 10 days, services rendered from the 11th day until the date of completion of the treatment plan are not Medicaid reimbursable.

The plan must be developed mutually by the identified child and/or the family along with the LCS after a thorough assessment of the child and family's strengths and needs and in collaboration with the referring agency's case manager. The plan must be signed/titled and dated on each page by the Supervising LCS and the primary LCS. The identified child and/or family members must sign the treatment plan, thereby indicating their commitment to the treatment process. If the client does not sign the treatment plan or if it is not considered appropriate for the client to sign the treatment plan, the reason the client did not sign must be documented in the clinical record.

Components of the Plan

The treatment plan shall address the following:

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Individual Treatment Plan (Cont'd.)

1. Specific problems or behaviors requiring MHS-NOS
2. A combination of factors in the family, home, school, peer group, neighborhood, and community that contribute to the child's referral problems
3. Intermediary goals to be accomplished — Goals should be realistic (*i.e.,* obtainable), measurable, individualized, and related to assessed problems and needs of the identified child. Goals should be outcome oriented and based on the child's current level of functioning.
4. Methods and frequencies of intervention — The ITP should include the responsibilities of the LCS, the identified child, and/or family members; time frames for goal achievement; and the frequency of services to be delivered.

Treatment Plan Review

The treatment plan for MHS-NOS must be reviewed whenever a significant event occurs that affects the course of treatment but not less often than four-week intervals. The purpose of the review is to assess the treatment progress and continued need for services and to ensure services and treatment goals continue to be appropriate to the identified child's needs. The LCS shall make any necessary revisions, as well as sign, title and date each page of the treatment plan at each review.

Progress Summary Notes

Services are to be documented in Progress Summary Notes that shall be:

- Completed each time service is rendered and whenever information is obtained that has bearing on the identified child's treatment
- Completed on dates of treatment plan reviews to provide a comprehensive summary of the services provided, the identified child's response to treatment, and the basis for changes to the treatment plan
- Signed/titled and dated by Lead Clinical Staff as the person responsible for the provision of services. The LCS's signature verifies that the services were

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Progress Summary Notes (Cont'd.)

provided in accordance with these standards. If the Non-LCS is the primary service provider, the Non-LCS must also sign, title and date the Progress Summary Note as the service provider.

Discharge Summary

Upon completion of MHS-NOS, a discharge summary shall be completed. The summary shall include the reason for the discharge, the problems addressed during the course of treatment, the status of the identified child/family concerning each treatment intervention undertaken, and recommendations for continuing treatment.

The provider should furnish a copy of the discharge summary to the referring agency, if applicable, within 10 days of discharge.

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 shall submit an annual report to the SCDHHS Behavioral Health Services program representative describing their progress in meeting the outcome criteria 90 days after the close of the state fiscal year. Programs will be expected to meet the following outcome criteria targets:

OC1: For a one-year period after planned discharge, a minimum of 80% of the children reside in the home of family or a consistent stable caregiver.

OC2: For a one-year period after planned discharge, a minimum of 80% of the children attend school or job training, or are employed.

OC3: For a one-year period after planned discharge, a minimum of 85% of the children are free from abuse and/or neglect.

OC4: For a one-year period after planned discharge, a minimum of 80% of the children avoid involvement with the criminal justice system.

OC5: For a one-year period after planned discharge, a minimum of 85% of the children do not return to MHS-NOS or a more restrictive level of service (for example, a residential placement).

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Program Evaluation and Outcome Criteria (Cont'd.)

OC6: At the time of planned discharge, a minimum of 90% of children will have achieved at least 75% of the goals/objectives on their individual treatment plans.

OC7: A minimum of 75% of family responses indicate satisfaction with services.

OC8: A minimum of 75% of referring agencies indicate satisfaction with services.

ALCOHOL AND/OR DRUG SERVICES — MEDICAL/SOMATIC

Definition

Medical/Somatic services provide face-to-face interactions between an approved provider (*e.g.,* a physician, a PA, a CNP, or a CNS who is authorized by the South Carolina State Board of Nursing to function in the extended role with prescriptive authority) and a client to reassess or monitor the client's medical status or response to treatment. All Medical/Somatic services are to be provided by medical staff as appropriate to their state license.

Program Content

Medical/Somatic services are designed to:

- Provide specialized medical assessment
- Assess or monitor the client's physical status
- Assess and monitor the client's response to treatment
- Provide medication management
- Assess the need for referral to other health care providers

Treatment

Medical/Somatic services must be included on the ITP for clients who the counselor, referring physician, PA, CNP, or CNS believes are in need of medical follow-up. A written treatment plan goal must be included on the ITP. This goal must be individualized, outcome-oriented, and measurable based on an assessment of the client's current needs and level of functioning.

Documentation

Documentation on the ITP should be completed as follows:

- The specific service rendered must be documented.

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PROGRAM SERVICES

Documentation (Cont'd.)

Medical/Somatic must be identified on the ITP as the service to be rendered and may be listed as a PRN frequency. This service must be identified as the service rendered on the Medical Services form as well.

- The date and actual length of time of the service must be included on the Medical Services form.
- The physician, PA, CNP, or CNS who rendered the service must document this service appropriately in the client's record.
- The documentation must provide a pertinent clinical description to ensure that the service conforms to the service description and authenticates the charges.

THERAPEUTIC BEHAVIORAL SERVICES (FORMERLY THERAPEUTIC CHILD TREATMENT)

Definition

Therapeutic Behavioral Services (TBS) is a psychosocial and developmental system of services for young children birth through age six. The goal of this service is to cultivate the psychological and emotional well-being of children and to promote their developing competencies.

The child will show significant problem indicators in any one or more of the following developmental areas: behavioral, emotional, social, cognitive, bonding, self-help, receptive and/or 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.

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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. The following list indicates the professional designations of those considered Licensed Practitioners of the Healing Arts:

- 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

Determination of medical necessity shall include a developmental and emotional screening tool that is clinically sound and age appropriate such as the Denver Developmental Screening Test II used in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings.

Medicaid-eligible children may be referred for Therapeutic Behavioral Services when one of the following issues is documented:

- The child is unable to succeed in regular child care due to substantiated developmental or behavioral problems.
- The child exhibits developmental or behavioral problems as a result of substantiated case(s) of abuse and/or neglect.
- The child is in imminent danger of being removed from the home due to substantiated developmental or behavioral problems.

The medical necessity for a child's placement in a TBS

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Medical Necessity and Prior Authorization (Cont'd.)

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 V-codes.

The Medical Necessity Statement authorizes the placement of the child in TBS. The Medical Necessity Statement must be signed by a physician or other Licensed Practitioner of the Healing Arts and accompanied by the developmental and emotional screening tool. The Medical Necessity Statement and the developmental and emotional screening tool shall be placed in the child's clinical record on or by the 15th day of service. (See Section 5 for a copy of the Medical Necessity Statement for Therapeutic Behavioral Services.)

The DHHS Referral Form/Authorization for Services (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. (See Section 5 for a copy of Form 254.)

If the child is re-entering this service, a new Medical Necessity Statement and an updated developmental and emotional screening tool must be completed using the medical necessity criteria listed above.

Program Staff

Supervising Lead Clinical Staff (LCS)

Qualifications

The Supervising LCS must meet the qualifications and professional standards outlined by the Department of Health and Human Services. Each program site must designate one LCS as the Supervising LCS with the following qualifications.

- The Supervising LCS shall complete a minimum of 20 contact hours of training per year.
- Prior to rendering TBS, all Supervising LCS must show documentation of 40 contact hours of training in child development and/or early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.

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PROGRAM SERVICES

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

Responsibilities

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

The Supervising LCS is responsible for providing supervision to all treatment 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 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 TBS program will be responsible for maintaining a written program description that includes the following:

- A developmentally appropriate curriculum with goals and expected outcomes
- 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 outlined by SCDHHS. 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 and function within the scope of their practice under state law. The following professionals qualify as LCS:

- A **Psychologist** holds a doctoral degree in psychology from an accredited university or college and is licensed by the appropriate State Board of Examiners in the clinical, school, or

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PROGRAM SERVICES

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

counseling areas. A minimum of one year of experience working with the population to be served is required.

- A **Registered Nurse** is a licensed RN who has a bachelor's degree from an accredited university or college and 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, is licensed by 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-psych-social sciences or to treatment of the mentally ill; or is a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement; or is a 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 which includes provision of supervised clinical services. A minimum of one year of experience working with the population to be served is required.
- A **Child Service Professional** holds a bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development, or a related field

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PROGRAM SERVICES

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

including but not limited to criminal justice, rehabilitative counseling, elementary or secondary education; or holds a bachelor's 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, or 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 bachelor's 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 bachelor's degree from an accredited university or college and 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. A minimum of three years of experience working with the population to be served is required.

For the purposes of Therapeutic Behavioral Services, the following professionals may also serve as Lead Clinical Staff (LCS):

- 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 and/or child development and has a minimum of one year of experience working with the population to be served.

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PROGRAM SERVICES

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

- An **Advanced Practice Registered Nurse** 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. A minimum of one year of experience working with the population to be served is required.
- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist 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

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

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

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,

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

participation in the planning and implementation of the child's Individual Treatment Plan (ITP), treatment plan reviews, annual treatment plan reformulation, and the development of the Weekly Progress Summary Notes.

- The 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 directly supervised by an LCS in order to assure that services are being rendered in accordance with accepted clinical practice. Non-LCS staff must be 21 years of age or older and meet one of the following standards:

- Possess a bachelor's degree from an accredited university or college and have a minimum of one year of experience in working with young children.
- Possess an associate's degree or technical college diploma in early childhood education and/or child development or the equivalent and have a minimum of one year of experience in working with young children.
- Have a high school diploma or GED and a Child Development Associate (CDA) credential and one year of experience in working with young children.
- 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 either obtain a Child Development Associate (CDA) credential (or other nationally recognized credential) or have a plan for completing 60 hours of training approved by the SCDHHS within two years of the employee beginning the Non-LCS position. 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, all Non-LCS must show documentation of 40 contact hours of training in

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

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

A staff assistant (SA) must be 18 years of age or older with a high school diploma or a GED. Under the supervision of a LCS, an SA assists in carrying out program activities. An SA must receive the equivalent of 25 hours of training annually.

Responsibilities

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

Program 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 services listed below are the components of TBS.

Assessment

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 and/or 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 the child, caregiver, and caregiver-child interactions must be documented. Ongoing assessments should be conducted as needed.

Treatment

A general treatment milieu will consist of direct interventions with the child and with the caregiver,

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Treatment (Cont'd.)

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.

Group Therapy

Programs are encouraged to offer group therapy to families. Group sessions 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 classes, but these 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Treatment (Cont'd.)

Family Therapy

Family therapy is part of the treatment milieu provided by the treatment staff. These modalities are employed both in the center and in the child's home. The 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

A home visit is defined as 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 or setting where the child and family reside, thereby enabling the primary caregiver(s) the ability 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.

In order for the TBS home visit to be reimbursed by Medicaid, the following must apply:

- The home visit must be conducted by a Supervising LCS or LCS.
- The home visit must be conducted in the home or other appropriate setting. During the visit, caregiver(s)/child interactions can be monitored and appropriate interventions implemented in accordance with the child's ITP.

In situations where it is not deemed clinically appropriate to conduct the visit in the child's home, the provider must document this in the clinical record and indicate where the visit(s) will be conducted.

Mainstreaming

The child may be mainstreamed in a classroom or regular

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Treatment (Cont'd.)

daycare setting where appropriate. In accordance with the child's ITP, TBS staff will work in collaboration with the child's caregivers and other care staff to:

- Maintain current TBS skills
- Monitor behavior
- Initiate interventions

Mainstreaming activities must be documented in the Weekly Progress Summary Note.

Coordination and Linkage

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

Staff-to-Client Ratio for Center-Based Services

An LCS or Non-LCS treatment staff member must always be a part of staff-to-client ratio. When staff assistants are included in the ratio, an LCS or Non-LCS must also be a part of that ratio. For example, if there is a group consisting of eight children, 5 and 6 years of age, the ratio may be accomplished with either an LCS or a Non-LCS treatment staff and a staff assistant.

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 at all times:

- Birth through age two, one staff member to every three children
- Age three through age six, one staff member to every five children
- Mixed age group, one staff member to every three children

Length and Frequencies of Services

Center-Based

- A therapeutic schedule must be in place authenticating the activities that constitute the length of program day.

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PROGRAM SERVICES

Length and Frequencies of Services (Cont'd.)

- Treatment should be offered a minimum of five days per week (school districts shall operate programs based on the district calendar).
- The TBS program must be operational a minimum of 180 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

Each child's family unit is required to receive two face-to-face home visits every calendar month when the program is in session. 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 billable as home visits.

All home visits shall be documented in the Weekly Progress Summary Note. (See Weekly Progress Summary Notes later in this section.)

Service Duration

In most cases, it is anticipated that the TBS goals will be met within 18 months of initiation of the services. Services may be extended for an additional six months if clinically warranted and with the approval and authorization of the referring state agency. The clinical determination for the extension must be documented in the clinical record.

If a client is discharged from a TBS program but subsequently re-enters the service, this is counted as a separate episode of service.

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PROGRAM SERVICES

Length and Frequencies of Services (Cont'd.)

If a client reaches the age of 6 years old while in the TBS program, the provider may continue to serve the child but must discharge him or her prior to the child's 7th birthday.

Assessment

The assessment must be completed prior to the development of the child's ITP. Assessments should address the following:

- 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
- The presenting problem and the impacting issues

Additionally, the following information must be obtained during the assessment and placed in the clinical record:

- Name, date of birth, sex, and educational level of the child; current address and family's addresses, if different; and telephone number
- Names, relationships, addresses, and telephone numbers of other members of child's primary family/social network who are or may be engaged in services on behalf of the child
- Names, addresses and phone numbers of key professionals engaged in service to the identified child (*e.g.*, teacher, school counselor, attorney, and state agency personnel)
- Directions to the child's home

The assessment must be developed, signed with title, and dated by the LCS or the Supervising LCS. The Supervising LCS must sign with title and date the assessment form as the person responsible for the provision of service.

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PROGRAM SERVICES

Individual Treatment Plan

Initial Treatment Plan

An individual treatment plan (ITP) is a comprehensive plan of care developed by a multidisciplinary treatment team (which may include but is not limited to child's parent/caregivers, school personnel, case manager, representatives of other agencies involved in the case, and the child, when deemed appropriate) following review of the initial assessment and other pertinent clinical information. An ITP must be developed for every child by or before the 30th day of acceptance into the program and must be signed/titled and dated by the LCS. The signature/title and date of the Supervising Lead Clinical Staff are also required. The signature/title 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 seeing that this plan is implemented in a manner in accordance with the Medicaid standard for TBS. The child's family or caregiver should review and sign the ITP. If a child's family/caregiver's signature is not obtained, a reason should be documented in the clinical record.

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 frequencies of interventions
- Target dates for completion

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Individual Treatment Plan (Cont'd.)

Supervising LCS signature verifies that the ITP is designed for the child in accordance with the Medicaid standard for TBS. The ITP is a working document and may be modified at any time. Modifications must be signed/titled and dated by the LCS and the Supervising LCS. The child's primary caregiver should sign all treatment plan reviews. If a child's family/caregiver signature is not obtained, a reason should be documented on the treatment plan review form.

Treatment Plan Reformulation

A reformulated treatment plan must be developed every 12 months and signed/titled 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 new treatment plan must be developed, signed/titled, and dated by the LCS and the Supervising LCS. The child's primary caregiver should sign all treatment plan reformulations. If a child's family/caregiver signature is not obtained, a reason should be documented on the treatment plan review form.

Individual Treatment Plan Documentation

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

- A description of the child 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 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/setting), documentation in the child's treatment plan must show:

- The expected benefits the TBS child receives by being mainstreamed with non-TBS children
- The continued need for TBS
- The level of intensity of service (*e.g.*, two hours per day)

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PROGRAM SERVICES

Discharge Planning

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

- The reason for discharge
- 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

Clinical 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. Each TBS clinical record, at a minimum, shall contain the following information:

- Medical Necessity Statement
- Referral Form/Authorization for Services (DHHS Form 254), if appropriate
- A developmental and emotional screening tool that is clinically sound and age appropriate such as the Denver Developmental Screening Test II used in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings
- Signed/titled and dated assessment forms
- Signed/titled and dated Individual Treatment Plan(s)
- Signed/titled and dated Weekly Progress Summary Notes

Weekly Progress Summary Notes

The Weekly Progress Summary Notes summarize program participation of the child and family and must be documented weekly. Days present and absent in the program are included in the notes. The summary must be placed in the child's record within one week following the service rendered. The documentation addresses the following areas in order to provide a pertinent clinical

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Clinical Documentation (Cont'd.)

description and to assure that the service conforms to the service description:

- A general observation of the child's condition. This should include, but is not limited to, affect, attitude, health, and/or appearance.
- The child's and/or family's activity and participation in the treatment program
- The child's progress on treatment goals and response to treatment
- The involvement of the treatment staff in service provision
- When provided, documentation of group therapy that addresses attendance and reasons for lack of attendance
- Future plans for working with the child
- All home visits. The home visit documentation shall include the following:
  - The date, time, and place of the last visit and the next visit
  - Physical and emotional status of the caregiver and/or child
  - Environmental (health and safety) factors

The Supervising LCS shall sign/title 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 information for the Weekly Progress Summary Notes under the direction of the LCS/Supervising LCS, the signature/title of the Non-LCS and date is required on the Weekly Progress Summary Notes.

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 family's

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Evaluation (Cont'd.)

enhanced ability to meet the therapeutic needs of the child. (See Section 5 for a sample Consumer Satisfaction Survey.) Programs shall submit an annual report to the SCDHHS Behavior Health Services program representative describing their progress in meeting the outcome criteria 90 days after the close of the state fiscal year. Programs will be expected to meet the following outcome criteria targets.

OC1: After planned discharge, a minimum of 80% of the children who 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.

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

OC3: A minimum of 90% of caregivers indicate satisfaction with Therapeutic Behavioral Services.

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

BEHAVIORAL HEALTH COUNSELING AND THERAPY

Individual Counseling

Definition

Individual counseling includes face-to-face goal-oriented interactions between a client and a counselor. Individual counseling also includes family unit counseling (face-to-face interaction between a counselor and the client and family unit). Individual counseling may actively involve

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Definition (Cont'd.)

members of the identified client's immediate family, extended family, or significant others.

Caregiver Group

Definition

Caregiver group services include direct goal-oriented interactions between staff and persons serving in primary caregiver roles (*e.g.,* family members or significant others, non-paid professionals) of the clients. This service enables family members and significant others to serve as knowledgeable supportive members of the client's "treatment team." These direct services are designed to develop and/or improve the ability of the caregiver to care for clients and enhance the treatment process.

The service must be provided by clinical staff qualified to perform Medicaid assessments.

Program Content

Caregiver group services will identify and assist in meeting the client's needs, and enhance interactions among family members and significant others, and/or assist the client to understand the dynamics of their illness, including methods of dealing with the client's behavior. Caregiver group services focus entirely on the client's needs and the caregiver's capacity to serve those needs. Interactions shall include information on such items as education on the addiction process, dynamics of addiction, codependency, enabling the relapse process, and recovery needs of the client. It is recommended that sessions include information that will assist the client in accessing the appropriate services by multiple providers and allow the appropriate monitoring of the client's condition. These groups are psycho-education groups in nature, and are limited to a maximum of 12 clients.

Caregiver group services are rendered to caregivers or family members of the identified client as long as the identified client is the focus of the session. Both caregiver and staff must be actively involved in the group during the time to be billed.

Special Restriction

This service does not include educational interventions that do not include psychotherapeutic process interactions or experimental therapy not recognized by the profession.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Length and Frequencies of Services

A maximum of 24 15-minute units per day may be billed. Because of the comprehensive nature of MHS-NOS, behavioral health counseling and therapy may not be rendered on the same day as MHS-NOS.

Documentation

The service must be included in the client's ITP and documentation of the service should meet the standards for the clinical nurse specialist.

GROUP COUNSELING

Definition

Group counseling includes face-to-face goal-oriented interaction between staff and a group of clients. Group counseling also includes family group counseling (face-to-face interaction between a counselor and multiple client and family units).

Staff-to-Client Ratio

Services provided in groups for the purpose of counseling or therapy must be limited in size to no more than 12 clients, except multiple family group therapy that is limited to 12 billable clients. Educational groups are not subject to group size limitation.