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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

GENERAL REQUIREMENTS

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency in South Carolina responsible for the administration of a program of medical assistance under Title XIX of the Social Security Act known as the Medicaid Program. The United States Department of Health and Human Services allocated funds under Title XIX to SCDHHS for the provision of medical services for eligible persons in accordance with the South Carolina State Plan for Medical Assistance.

Under Title XIX, some services are mandated to be covered under the Medicaid State Plan while other services may be offered at the state's option. Children's Behavioral Health Services are defined as Rehabilitative Services in the State Plan and include both community-based and residential programs.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), the names of several Children's Behavioral Health Services have been changed to match national procedure code descriptions. For providers' convenience, we continue to refer to the former service names in some cases.

The Community-Based Service standards include:

- **Mental Health Services Not Otherwise Specified** (formerly Intensive Family Services [IFS])
- **Therapeutic Behavioral Services** (formerly Therapeutic Child Treatment [TCT])
- **Psychosocial Rehabilitation Services** (formerly Clinical Day Programming [CDP])

The Residential Service standards include:

- **Therapeutic Foster Care —** Levels I, II, and III
- **Therapeutic Behavioral Services** (formerly Moderate Management Rehabilitative Services, High Management Rehabilitative Services, and Supervised Independent Living)
- **Sexual Offender Treatment Services** (formerly Specialized Treatment Services for Sexual Offenders)

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PROGRAM OVERVIEW

GENERAL REQUIREMENTS (CONT'D.)

For the purpose of Medicaid reimbursement for these services, a child must first meet established medical necessity criteria. Services rendered by private providers must be pre-authorized by a designated referring agent before the child may be referred for treatment.

Providers must conduct an assessment of each child and use that assessment to identify problems and needs, develop goals and objectives, and determine appropriate rehabilitative services and methods of intervention. This comprehensive plan of care will be outlined in an individual treatment plan. While there may be certain treatment methodologies commonly utilized within a particular service, providers must ensure that services are tailored to the individual needs of each child and that service delivery reflects knowledge of the particular treatment issues involved.

Children's Behavioral Health Services were developed to accommodate the growing need for children's rehabilitative services. The purpose of these programs is to provide a system of care that assists children who are experiencing emotional or behavioral problems and/or have been abused and/or neglected to successfully live in a community setting. The goal of SCDHHS is to establish an array of Medicaid-reimbursable services in order to provide a full range of treatment alternatives for these children, and to maximize the effectiveness and cost efficiency of these services.

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PROGRAM REQUIREMENTS

BENEFICIARY REQUIREMENTS

Eligibility for Services

In order to be eligible for Children's Behavioral Health Services, a Medicaid-eligible individual must:

- Be under the age of 21
- Meet the medical necessity criteria for admission to the service
- Meet the diagnostic criteria for the particular level of care
- Have services pre-authorized by a designated referring agent if being referred to a private provider

A child's Medicaid eligibility may be confirmed by calling the Medicaid Interactive Voice Response System at 1-888-809-3040. Providers may also use the South Carolina Medicaid Web-based Claims Submission Tool. The referring state agency is responsible for ensuring that the child's eligibility is current and for furnishing the provider with the correct Medicaid number and the child's plastic Medicaid card.

Children residing in therapeutic residential treatment programs (group homes or Supervised Independent Living) cannot receive Community-Based Services with the exception of Psychosocial Rehabilitation Services. Facilities are given a daily rate as reimbursement for treatment services. There should be no duplication of any service component. Exceptions can be granted if there are extenuating circumstances related to the child's treatment needs. If this applies, there must be documentation provided in the client's record clearly indicating the need for specialized treatment that is beyond the scope of practice for the residential facility's staff.

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PROGRAM REQUIREMENTS

DOCUMENTATION REQUIREMENTS

Prior Authorization

Children's Behavioral Health Services must be authorized by a designated referring agent prior to service delivery in order for a private provider to be reimbursed by Medicaid. Upon recognizing a child's need for services, the designated referring agent will initiate the prior authorization process. The child will be referred to a treatment provider enrolled in the Medicaid program.

Referral for services is accomplished through the completion of a Referral Form/Authorization for Services (DHHS Form 254). An example of this form can be found in Section 5. When referring a child for services, 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 form will provide all of the information necessary for service delivery and most of the information required for billing.

The form will include the following:

- The child's Medicaid ID number
- The facility's Medicaid Provider ID number
- The Prior Authorization number assigned by the designated referring agent, which is **mandatory** for billing purposes
- The name of the designated referring agent (only state child-placing agencies are authorized to complete the DHHS Form 254)
- The authorization (beginning) date and the expiration (ending) date, which establish the period during which services are authorized to be provided
- The type of service authorized to be provided, *i.e.*, level of care

Medical Necessity Statement

Medical necessity is defined as the need for treatment services that are necessary in order to diagnose, treat, cure, or prevent an illness, or which may reasonably be expected to relieve pain, improve and preserve health, or be essential to life.

A child must meet specific medical necessity criteria in order to be eligible for any of the Children's Behavioral

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PROGRAM REQUIREMENTS

Medical Necessity Statement (Cont'd.)

Health Services. A physician or other Licensed Practitioner of the Healing Arts must establish that the child meets the eligibility criteria for a particular service before the child is placed for treatment. A Medical Necessity Statement must be completed and signed by the physician or other Licensed Practitioner of the Healing Arts and submitted to the treatment provider each time that a child is admitted or readmitted for services.

The Medical Necessity Statement serves to:

- Establish the level of care the child requires
- Identify current problem areas that need to be addressed by the treatment provider
- Provide documentation that placement has been recommended by a physician or other Licensed Practitioner of the Healing Arts

At the time of admission, the designated referring agent 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 placement. The Medical Necessity Statement must be placed with the initial treatment plan.

Licensed Practitioners of the Healing Arts

The following list indicates the professional designations of those considered Licensed Practitioners of the Healing Arts for Children's Behavioral Health Services:

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

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PROGRAM REQUIREMENTS

Clinical Records

General Requirements

Each provider of Children's Behavioral Health Services shall maintain a clinical record for each Medicaid-eligible child that fully describes the extent of the treatment services rendered. The clinical record must contain documentation sufficient to justify Medicaid participation, and should allow an individual not familiar with the child to evaluate the course of treatment. The absence of appropriate and complete records may result in recoupment of previous payments by SCDHHS. Clinical records shall be arranged in a logical order such that the clinical information can be easily reviewed, audited, and copied. Each provider shall have the responsibility of maintaining accurate, complete, and timely records and should always adhere to procedures to ensure confidentiality of clinical data.

Clinical records shall be retained for a period of three years. If any litigation, claim, 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 and resolution of all issues that arise from it or until the end of the three-year period, whichever is later. In the event of program closure, providers must notify DHHS regarding medical records.

Clinical records must include the following:

1. Medical Necessity Statement
2. Referral Form/Authorization for Services (DHHS Form 254)
3. Signed/titled and dated Treatment Plan(s) — initial, reviews, and reformulations
4. Signed/titled and dated Progress Summary Notes
5. Court orders, if applicable
6. Signed releases and confidentiality assurances
7. Documentation that, at the time of admission, the provider oriented the client to rules, consequences, treatment to be received, rights of the clients, and the behavior management system. Documentation of compliance with this requirement must be in the form of a written statement from the client that verifies his or her receipt of an orientation and such

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PROGRAM REQUIREMENTS

General Requirements (Cont'd.)

materials as an orientation handbook or checklist.

8. Evidence that transition services are being provided
9. A copy of the Independent Living Assessment (required only by the Supervised Independent Living Program)
10. A discharge report that:
    - Documents the reason for the discharge
    - Documents treatment recommendations and outcomes
    - Lists records to be transferred
    - Specifies recommended after-care services
    - Is made available to the referring agency within ten days of discharge

In addition to the above, it is suggested that providers maintain the following materials in the child's record:

1. Psychosocial and/or psychological evaluation
2. Correspondence with agencies involved with the child
3. Copy of Medicaid card

Individual Treatment Plan

The individual treatment plan (ITP) is a comprehensive plan of care that is formulated by the Lead Clinical Staff (LCS) based on the individual needs of each child. The treatment plan validates the necessity and appropriateness of services, and outlines the service delivery needed to meet identified needs, reduce problem behaviors, and improve overall functioning.

The treatment plan shall be based upon an assessment of the child's problems and needs in the areas of emotional, behavioral, and skill development. The treatment plan must be individualized to the child.

Goals and objectives should be written in language that is clear and understandable. The treatment plan should distinguish long- and short-term goals and objectives, and should address discharge planning. The treatment plan should be in agreement with the child's permanency plan, if applicable, and the long-term discharge goal developed by the referring agency.

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PROGRAM REQUIREMENTS

Individual Treatment Plan (Cont'd.)

Treatment Plan Development

The provider must have written policies and procedures for developing, reviewing, and redeveloping/reformulating individualized treatment plans according to the standards for the level(s) of care to be rendered. The policy must require all treatment plans to include the following components:

- **Presenting Problems:** Presenting problem statements that outline the specific behavior(s) that require treatment (validate the need for and appropriateness of the designated level of care)
- **Long-Term/Discharge Goals:** Long-term or discharge goals addressing the discharge plan of the client. The long-term goal should match the long-term plan of the referring agency (the client's permanency plan). For every child aged 13 or older, the long-term/discharge goals must include independent living goals specific to that child.
- **Short-Term Objectives:** Short-term objectives that are stated in behavioral terms and written so that they are observable, measurable, individualized (specific to the client's problems/needs), and realistic
- **Interventions:** Interventions and specific methods the treatment team will use to meet the stated objectives. The frequency, or how often each intervention will take place, should be clearly stated.
- **Criteria for Achievement:** Criteria for achievement that outline how success for each objective will be shown. In the case of Supervised Independent Living programs, transition/discharge criteria, including transition/discharge plans, will also be shown. Criteria must be reasonable, attainable, and measurable, must include target dates, and must indicate a desired outcome to the treatment process.
- **Target Dates** that are individualized to the child and the objective

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PROGRAM REQUIREMENTS

Individual Treatment Plan (Cont'd.)

Participation in Treatment Planning

The Client: Clients must be encouraged to participate in the treatment planning process. Before a treatment plan is finalized, clients must be given the opportunity to have input. Treatment plans must be signed and dated by clients as evidence of their participation in the planning 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.

The Family: If reunification or avoidance of removing the child from the home is a goal of the referring agency's comprehensive plan, families must be encouraged to participate in the treatment planning process. Specific family reunification activities must be described in the treatment plan. Documentation of compliance with this requirement must be located in the client's record.

If the family will not be involved in the treatment planning process, the referring agency must provide justification to the provider. Evidence of this justification must be located in the client's record. Reasons for excluding the family may include:

- The referring agency has determined that contact between the client and his or her family is not desirable.
- A court order prohibits contact between the client and his or her family.
- Reunification is not a goal of the referring agency's comprehensive plan.
- The client's family refuses to participate in the process.
- There is another treatment-related reason that the family should not be involved in the process.

Coordination and Notification

There must be evidence in the record of coordination between the provider and the referring agency case manager regarding treatment planning for the client. (For more information, see the specific levels of care.)

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PROGRAM REQUIREMENTS

Individual Treatment Plan (Cont'd.)

Initial Treatment Plan

An initial treatment plan must be developed for every child admitted to services and must be placed in the child's clinical record. The completed Medical Necessity Statement should be placed with the initial treatment plan. Different services may have different time requirements regarding development of the initial treatment plan. Please refer to the specific service for definitive timelines.

Treatment Plan Review

The treatment plan shall be reviewed and updated according to the child's level of functioning. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the child's current needs and to assess the child's progress and continued need for rehabilitative services. For specific treatment plan review requirements, refer to the particular service standard. Different services may have different time requirements regarding treatment plan review and reformulation. Please refer to the specific service for definitive timelines.

Treatment Plan Reformulation

The treatment plan shall be reformulated on a regular basis as specified in the service standard. The reformulated treatment plan must address the current needs of the child and the services required to meet those needs. The treatment plan is considered a working document and should be continuously refined and revised as progress is made and/or new therapeutic issues arise.

Reformulation of Independent Living Goals

Providers must reformulate independent living goals at the same time they reformulate the treatment plan for the level of care in which the child is placed.

Required Signatures

The LCS must sign/title and date (with month, day, and year) each page of the initial treatment plan as well as any and all subsequent reviews and reformulations. The client must also sign the treatment plan, or an explanation must be included. **Photocopying a previous treatment plan is not acceptable.**

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Individual Treatment Plan (Cont'd.)

Any modifications made to either the initial treatment plan or the reformulated treatment plan prior to the plan's review date should be signed or initialed and dated by the LCS. There must be documentation that the client was advised of any revisions to the treatment plan.

Progress Summary Notes

Children's Behavioral Health Services shall be documented in Progress Summary Notes that are filed in the clinical record. The purpose of these notes is to record the nature of the child's treatment and to summarize the child's program participation and psychosocial/behavioral status. Progress Summary Notes should:

- Be individualized and specific to each child
- Document the treatment services provided to the child
- Document the child's response to treatment, *i.e.*, progress on long- and short-term goals and staff/caregiver interaction and involvement with the child
- Reflect delivery of structured and therapeutic treatment services. Services must relate to the child's treatment plan.
- Summarize progress and note changes with respect to the child's permanency plan and the intended discharge placement if different from the permanency plan
- Document contact between the child and his or her family that relates to their treatment plan goals
- Document that services correspond to billing by type of service, units of service, and dates of service (with month, day, and year)
- Be signed/titled and dated by the LCS responsible for service delivery (either through direct service provision or supervision)
- Be legible and kept in chronological order
- Be written, signed, and dated on or shortly after the last date of service that the notes document. Please refer to each individual service for more specific filing requirements.

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PROGRAM REQUIREMENTS

Progress Summary Notes (Cont'd.)

Progress Summary Notes must not be written or entered in the clinical record prior to delivery of the services. Billing should not occur until notes have been completed and filed in the clinical record.

Maintenance of Medical Records

1. All entries in clinical records shall be typed or handwritten using only black or dark blue ink. All entries must be legible and kept in chronological order. Photocopies are acceptable if completely legible. Originals must be available if needed.
2. All entries must be dated (with month, day, and year) and legibly signed or initialed (when applicable) by the appropriate LCS. The LCS's signature verifies that the services were provided in accordance with the appropriate standards. If someone other than the LCS completes the Progress Summary Note, this individual must also sign/title and date the Progress Summary Note. The treatment provider must maintain a signature sheet that identifies all LCS names, signatures, and initials.
3. Only approved abbreviations and symbols may be used. Each treatment provider should maintain a list of any abbreviations and symbols used in the records. This list must be clear as to the meaning of each abbreviation and symbol.
4. Individuals referenced in the Progress Summary Notes should be identified by full name, title, and agency or provider affiliation at least once in each note.
5. Clinical records are legal documents; judgment and caution should be used when altering a clinical record. When an error is made in a clinical record, the following guidelines must be used:
   a) If an entry contains an error, clearly draw one line through the error, write "error" to the side in parentheses, make the correct entry, and add initials and date. Errors must not be totally marked through, as information in error must remain legible.
   b) If an explanation is necessary to clarify the correction, one should be entered. In extreme circumstances, it may be prudent to have a

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PROGRAM REQUIREMENTS

Maintenance of Medical Records (Cont'd.)

correction and/or explanation witnessed.

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

6. 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:

   a) Identify the new entry as a "late entry."

   b) Enter the current date and time.

   c) Identify or refer to the date and incident for which late entry is written.

   d) If the late entry is used to document an omission, validate the source of additional information as much as possible.

   e) When using late entries, document as soon as possible.

7. The Referral Form/Authorization for Services (DHHS Form 254) maintained in the record must be fully completed, signed, and dated by the designated referring agent's representative. A new referral form is required under the following circumstances:

   a) For each admission or readmission

   b) When the child is to remain in treatment past the expiration date

   c) When there is a change in the designated referring agent authorizing services

   d) When a client transfers from one level of care to another within the same provider agency

8. The child's Medicaid number must be recorded in the clinical record. The presence of a Referral Form/Authorization for Services (DHHS Form 254) will suffice for recording the child's Medicaid number as well as for justifying the use of

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PROGRAM REQUIREMENTS

Maintenance of Medical Records (Cont'd.)

"Signature on File" in field 12 on the CMS-1500 claim form.

9. Each treatment provider should maintain an index that indicates the correct method for organizing and maintaining clinical records.

STAFF AND TREATMENT PARENT REQUIREMENTS

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

Providers must comply with all other applicable state and federal requirements.

Required Documentation of Qualifications

Providers will maintain and make available upon request appropriate records and documentation of such qualifications and investigations. If these records are kept in a central "corporate" office, the provider will be given a reasonable amount of time to retrieve the records for the agency that is requesting them.

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

- A copy of the individual's resume or a completed employment application form; official college transcripts; and applicable licenses
- A copy of the individual's criminal record check form from an appropriate law enforcement agency. The criminal record check must be updated annually or at the time the facility license is renewed.
- Verification from the child abuse registry that there are no findings of abuse or neglect against the individual. The child abuse registry verification must be updated annually or at the time the facility license is renewed.
- Verification from the state and national sex offender registries that there are no findings of sexual charges against the individual. This verification must be updated annually or at the time the facility license is renewed.

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Required Documentation of Qualifications (Cont'd.)

- If the employee's position description requires that he or she transport clients, a copy of the individual's current driver's license and official motor vehicle record (MVR). MVR checks must be updated every two years.

Crisis On-Call

The provider must coordinate and provide back-up for 24-hour, 7-day-a-week on-call crisis services for treatment parents (when applicable) and treatment staff.

Staff Development and Training

Training is defined as organized, planned, and evaluated activities that are designed to achieve specific learning objectives.

The following general training requirements apply:

- All providers must ensure treatment staff receive adequate orientation to the program.
- The content of the training must be directly related to the duties of the individual receiving the training.
- Instruction shall be carried out by individuals who are qualified to conduct such instruction.
- Documentation of training received and successfully completed shall be kept in the individual's training record.
- Documentation of the training shall consist of an outline of the training provided and the trainer's credentials.

For more information, see the specific levels of care.

Clinical Staff

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

Each provider of Children's Behavioral Health Services shall maintain a file for each LCS substantiating that each staff member meets LCS qualifications. This shall include employer verification of the LCS's certification, licensure,

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Clinical Staff (Cont'd.)

and work experience. A signature sheet that identifies all LCS names, signatures, and initials must be maintained by the treatment provider. 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 **must not exceed their licensed scope of practice under state law**. Individuals wishing to be designated as LCS must be able to document experience working with the population to be served. "Experience working with the population to be served" is defined as direct work experience with the type of children served in the applicable level of care (*i.e.*, children who have been diagnosed as having an emotional or behavioral disorder, children who are victims of child abuse and/or neglect, or children deemed to be "at risk" of developing an emotional or behavioral disorder because of life circumstances.) A "year of experience" is defined as paid and/or volunteer experience that is equivalent to 12 months of full time work experience. Practicum or internship placements as part of a degree program are acceptable as work experience.

The following professionals qualify as LCS:

- A **Psychologist** holds a doctoral degree in psychology from an accredited university or college, is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling areas, and has a minimum of one year of experience working with the population that is to be served.
- A **Registered Nurse** is a licensed registered nurse who has a bachelor's degree from an accredited university or college and a minimum of three years of experience working with the population that is 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 that is 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

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Clinical Staff (Cont'd.)

the population that is to be served.

- A **Mental Health Professional Master's Equivalent** holds a master's degree in a closely related field that is applicable to the bio/psycho/ social sciences or to treatment of the mentally ill; or 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 who has a minimum of one year of experience working with the population that is 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 that is to be served.
- A **Child Service Professional** has a minimum of three years of experience working with the population that is 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 not limited to criminal justice, rehabilitative counseling, or elementary or secondary education
  - 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, and conferences on issues related to child development and children's mental health issues and treatment) in one or more of the above disciplines
- 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 that is to be served.

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Clinical Staff (Cont'd.)

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

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

CRITICAL INCIDENTS

The program must have a policy on critical incidents. At a minimum, the following behaviors and situations will be considered critical incidents:

- Death of client
- Attempted suicide by a client
- An incident that requires off-site emergency medical treatment
- An incident that requires an off-site emergency assessment
- Absence without approval
- Possession of a weapon
- Possession of an illegal substance
- A report to or involvement of an outside regulatory agency, *e.g.*, law enforcement, DSS OHAN, the Office of Children's Affairs, etc.
- An emergency change of placement, *e.g.*, discharge, hospitalization, incarceration, internal transfer, etc.
- Removal from school including suspension, expulsion, and placement on Medical Homebound or Home-based
- Use of restraint or seclusion

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CRITICAL INCIDENTS (CONT'D.)

The policy must specify that the above-stated incidents require the provider to notify the referral agency within 24 hours.

In the event of attempted suicide by or the death of a client, the provider must notify OHAN, the SCDHHS program representative, and the case manager or case manager's supervisor within 24 hours. All other state and federal reporting requirements apply.

A Critical Incident Report that must be used by providers can be found in Section 5 of this manual. The following information is included on the form:

- A clear description of the events leading up to the behavioral situation
- Staff intervention (treatment parent, if applicable) into the behavioral situation
- Outcome and necessary follow-up to the behavioral situation
- Date and time of referral agency notification, who was notified, and who on the provider's staff made the notification
- Date and time provider staff were notified, name and title of provider staff who were notified, and who on provider staff made the notification as identified by the provider's policy requirements
- Dated signatures of the person completing the incident report and the person(s) completing the clinical and administrative review as identified by the provider's policy requirements

The Critical Incident Report forms must be kept in the client's clinical record or some other location at which they are readily available for review by staff of the referring agency, monitoring entities (including the SCDHHS designee), law enforcement personnel, medical personnel, and other authorized personnel.

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EMERGENCY SAFETY INTERVENTIONS (SECLUSION AND RESTRAINT)

Pertaining to the below Emergency Safety Interventions section:

- All providers of Therapeutic Behavioral Services (High and Moderate Management), and Supervised Independent Living are responsible for adhering to all of the requirements in this section. This includes providers that have policies prohibiting the use of such interventions but who may have an emergency situation requiring staff intervention.
- All Therapeutic Foster Care and Community-Based providers are responsible for adhering to all of the requirements in this section, if they intend to employ the use of restraint and/or seclusion in their program.

For the purposes of this manual, "restraint" is defined as any type of physical intervention (including mechanical restraints and therapeutic holds) that reduces or restricts an individual's freedom of movement and is administered without the individual's permission.

Restraint and seclusion shall be used only to ensure the immediate safety of the individual or others when no less restrictive intervention has been or is likely to be effective in averting danger. Restraint and seclusion shall never be used for coercion, retaliation, humiliation, as a threat or form of punishment, in lieu of adequate staffing, as a replacement for active treatment, for staff convenience, or for property damage not involving imminent danger.

All providers must ensure that all staff involved in the direct care of a child successfully completes a course from a certified trainer in the use of restraints and seclusion. Training should be aimed at minimizing the use of such measures, as well as ensuring client safety. For more information on selecting training models, see Section 7 of the Project REST *Manual of Recommended Practice,* available at **www.frcdsn.org/rest.html.**

Staff must successfully complete all required training in Emergency Safety Interventions prior to ordering or participating in any form of restraint. 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. Providers must adhere to all state licensing laws and regulations regarding the use of seclusion and restraint.

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Ordering and Initiation

Each program will develop and implement a comprehensive written policy that governs the circumstances in which these practices are used. The policy shall identify the following:

- The threshold for initiating restraint and seclusion, such that the use of restraint or seclusion will be permitted only after other less-restrictive methods to prevent immediate and substantial bodily injury to the individual or others have been attempted and have failed. An exception may be warranted in the event of an emergency situation where there is a threat of harm to staff or clients. (Please see the documentation section for further information.)
- Forms of restraint identified for use
- Specific criteria for the use of restraint and seclusion
- Staff members authorized to approve the use of restraint and seclusion. Only staff members who have a master's degree and are licensed in their field can order the use of restraints and seclusion.
- Staff members authorized and qualified to administer or apply restraint and seclusion
- Approved procedures for application of each form of restraint and seclusion
- Procedures for monitoring any individuals placed in restraint and seclusion
- Limitations on the use of restraint and seclusion, including any applicable time limitations
- Procedures for immediate and continuous review of restraint and seclusion incidents to include reducing the likelihood of reoccurrence
- Procedures for comprehensive recordkeeping concerning all incidents of restraint and seclusion
- Procedures for reporting critical incidents resulting from the use of seclusion and restraint

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Notification of Rights, Policies, and Procedures at Admission

Each program must have written policies regarding notification of rights, policies, and procedures at admission. At admission, the facility will inform the incoming individual and, in the case of a minor, the parents or legal guardians of the policy regarding use of restraint and seclusion during emergency safety situations that may occur while the individual is in the program. The explanation will include the program's behavioral expectations and requirements. It will also include:

- Who can implement an emergency safety intervention
- The actions staff members must first take to defuse the situation and avoid an emergency safety intervention
- The situations in which an emergency safety intervention may be used
- A description of the emergency safety intervention procedures used
- When the use of emergency safety intervention will end
- What action the individual must exhibit to be released from the emergency safety intervention
- The grievance procedure to report an inappropriate restraint or seclusion
- The opportunity to view time-out and quiet and seclusion rooms or areas

Communication shall take place in a language that the individual and his or her parents or legal guardians understand; when necessary, the program must provide interpreters or translators. The program will obtain an acknowledgment in writing from the individual and his or her parents or legal guardians that they have been informed of the program's policy regarding the use of restraint or seclusion. The program will also obtain written consent from the individual's parents or guardians (unless otherwise ordered by the court) regarding permission to use restraint and seclusion in the event of an emergency crisis situation. A staff member must file the acknowledgment and consent forms in the individual's record and will provide copies to both the individual and his or her parents or legal guardian and the referring agency.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Documentation

Each program must document all emergency safety interventions. Documentation includes:

- A description of what happened
- The date and beginning and ending times of the incident
- Any precipitating incidents
- The age, height, weight, and gender of the client
- The exact methods of intervention used, the reasons for their use, and the duration of the intervention
- The names of all clients involved
- The names and titles of staff or others involved, and their relationship to the client
- Names of witnesses to the precipitating incident and subsequent restraint
- The name of the person making the report
- The names and titles of staff or others involved, and their relationship to the client
- Names of witnesses to the precipitating incident and subsequent restraint
- The name of the person making the report
- A detailed description of any injury to the client, including a body chart or photo
- The action taken by the provider as a result of the injury
- Preventive actions to be taken in the future
- A description of debriefing activities
- The follow-up required
- Documentation of supervisory and administrative reviews
- Description of notification efforts, including who was contacted, how and when they were contacted, and verification that contact was made

Staff must document the intervention in the client's record. For residential providers, the documentation must be completed by the end of the shift in which the intervention occurs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Monitoring/Termination

All providers must have a written log of each seclusion and/or restraint episode.

The staff member providing direct visual monitoring of the individual in seclusion or restraints must make a written annotation in the log at least once every fifteen minutes. The entry will describe the individual's behavior at that time and whether he or she needs continued seclusion or restraint. The program will have written procedures that outline the criteria for terminating a seclusion or restraint.

Programs must ensure that, when restraints or seclusion have been employed, the staff conducts regular internal oversight reviews.

Training Requirements

This remaining section on ESI pertains to all community-based and residential providers.

All community-based and residential providers must ensure that all staff involved in the direct care of clients successfully complete a course in the prevention and management of aggressive behaviors. Annual refresher courses must also be provided.

All staff members will be made aware of the program's written philosophy, rules, policies, procedures, intervention modalities, and the expectations for everyone who is working with clients. Each facility will describe in writing the program's plan for staff orientation, which must include but not be limited to:

- The characteristics of individuals served
- Symptoms and behavioral signs of emotional disturbance
- Symptoms of drug overdose, alcohol intoxication, and possible medical emergency
- The program's emergency and evacuation procedures
- Procedures for reporting suspected incidents of child abuse and neglect
- Orientation in first aid and CPR
- Training in universal precautions and infection control procedures

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Training Requirements (Cont'd.)

- The program's policies regarding medication, runaway individuals, and behavior support and intervention

No new staff member will be solely responsible for children in care until he or she has received the minimum orientation described above.

The facility must provide ongoing staff training programs appropriate to the size and nature of the program and staff involved. Each program will have a written plan for staff training, including the curriculum for behavior support and intervention training and refresher training as required by the program model.

MEDICATIONS

All residential treatment programs must ensure that prescribed medication is stored in a secure, double-locked location. "Double-locked location" means that one locked container is stored inside a second locked location, both of which can be opened by using a key, combination, or electric lock.

Program staff shall be informed of medication side effects/interactions and trained in proper administration and documentation of side effects.

The program must have a policy that specifies the method of administering medication, the documentation requirements including medication logs (see below for minimum requirements for medication logs), frequency of medication reviews, and process for obtaining informed consent, if applicable.

Medication logs must show the dates and times medications were administered and include the initials of the staff member who administered them each time medication is administered. (The log must also document any changes in medications.)

The program policy must include written procedures for documenting and communicating medication error(s).

The provider must make every effort to notify all medical personnel who will prescribe and/or administer medications to a child about any medications the child is currently taking, and of any changes in the child's medication since he or she was last seen by the medical caregiver.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

RIGHTS OF CHILDREN IN RESIDENTIAL CARE

The provider must have a written policy that outlines the rights of children in residential care.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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

REQUIREMENTS FOR PARTICIPATION IN COMMUNITY-BASED SERVICES

Potential providers of Mental Health Services Not Otherwise Specified, Therapeutic Behavioral Services, and Psychosocial Rehabilitation Services must complete the following steps in order to become enrolled Medicaid providers.

Step 1: The potential provider is to submit a detailed proposal describing the services to be rendered and the structure of the organization. Proposal pages must be numbered. The proposal must be submitted to the SCDHHS for review to determine compliance with minimum Medicaid Standards for the service. Incomplete proposals will be returned.

Please submit three copies of the proposal to:

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

The proposal needs to address, at a minimum, the following components:

1. A detailed program description outlining how the service is to be provided, including the following:
   a) Mission statement
   b) Organizational chart (if the enrolling entity currently provides any Medicaid-reimbursable services, this must be delineated on the chart)
   c) Program structure, days and hours of operation
   d) Treatment philosophy and model(s)
   e) Population to be served, including age, diagnosis, and problem profile of children eligible for program services

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

REQUIREMENTS FOR PARTICIPATION IN COMMUNITY-BASED SERVICES (CONT'D.)

f) Program policies

g) History and background of the provider

h) Assurance of financial viability. If an independent audit of the organization has been conducted within the past two years, enclose a copy of the Independent Auditor's Report Statement.

i) Copies of all provider-proposed personnel and program forms

2. A copy of the program's Standard Operating Policy and Procedures, to include crisis procedures, emergency safety procedures, and a copy of the Personnel Manual
3. Staff training plan, including completion of all pre-enrollment training
4. Provider's policy for ensuring staff meet appropriate qualifications
5. For PRS, a completed budget that outlines reasonable, anticipated costs and specifies the number of children to be served by the program**. No "start-up" funds can be provided**. (Contact Behavioral Health Services program staff.)
6. Information regarding licensing authority and a written description of corporate structure of the entity/organization
7. Letters of support from the referring agencies and any applicable Memoranda of Agreement with collaborative agencies

All providers of Mental Health Services Not Otherwise Specified, Therapeutic Behavioral Services, and Psychosocial Rehabilitation Services will be subject to applicable state licensure regulations. If not part of a school district program, a Therapeutic Behavioral Services provider must be licensed as a Daycare Center by the Department of Social Services. A provider must be a public or private entity that is governed by a Board of Directors and/or is part of an established entity/corporation that provides administrative oversight. Providers who are part of the Department of Mental Health (DMH) or the Department of

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

REQUIREMENTS FOR PARTICIPATION IN COMMUNITY-BASED SERVICES (CONT'D.)

Alcohol and Other Drug Abuse Services (DAODAS) or LEA network are referred to their own agencies' provider manuals for more specific enrollment requirements.

Potential providers should contact the Department of Behavioral Health Services for additional information.

Step 2: Upon receiving a completed proposal, BHS will initiate the review and approval process. During this process, providers may be contacted for additional information.

Once enrolled, providers are required to submit an **annual cost report** within 90 days following the end of their fiscal year for each Medicaid service they are enrolled to provide. The annual cost report should be sent to:

SCDHHS
Division of Ancillary Reimbursements
Post Office Box 8206
Columbia, SC 29202

Program Expansion

Providers of Therapeutic Behavioral Services and Psychosocial Rehabilitation Services wishing to expand the scope of their services, thus increasing the number of children served, must obtain approval from the appropriate BHS program representative prior to expansion. Providers will be required to submit, at a minimum, an updated program description and any changes in policies and procedures since initial approval, and may be required to submit a new budget.

Unit of Service

Children's Community-Based Behavioral Health Services must be billed in units as defined in the service standard.

For the purpose of the **Mental Health Services Not Otherwise Specified** programs, a billable unit is defined as a 30-minute block of time during which the child receives Medicaid-reimbursable treatment services from a treatment provider.

For the purpose of **Therapeutic Behavioral Services** programs, a billable unit is defined as a 15-minute block of time during which the child received Medicaid-reimbursable treatment services from a treatment provider. Medicaid may be billed for a unit of service only if the child received some treatment services during that time period. Therapeutic Behavioral Services programs may be

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Unit of Service (Cont'd.)

reimbursed for home visits.

For the purpose of **Psychosocial Rehabilitation Services**, a billable unit is defined as a day on which the child receives Medicaid-reimbursable treatment services from a treatment provider.

Providers must maintain adequate documentation to support the number of units billed. For Psychosocial Rehabilitation Services, the LCS should place a "P" in the appropriate blocks on the Progress Summary Note for each day the child received treatment. An "A" should be used for each absent day. The date of discharge should be annotated with a "D." Psychosocial Rehabilitation Services "Transition" days should be documented with a "T." Treatment services are billable from the date of admission.

Training Requirements

All Community-Based Service providers must ensure that staff members working directly with clients successfully complete a course from a certified trainer in the prevention and management of aggressive behavior with an emphasis on de-escalation skills. In addition, annual refresher courses must be provided. For more information, refer to the subsection on Emergency Safety Interventions.

MENTAL HEALTH SERVICES NOT OTHERWISE SPECIFIED

Definition

Mental Health Services Not Otherwise Specified (MHS-NOS) (formerly Intensive Family Services) 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 are 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Definition (Cont'd.)

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 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 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:

1. Keep 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. Prevent 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. Prevent disruption of the child's home environment
4. Promote reunification of the child with his or her family
5. Ensure the child's safety and protection within his or her home environment

The following activities are non-billable:

1. Documentation time
2. Travel time
3. Supervision time
4. No-shows
5. Recreational activities

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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.
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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

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 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Lead Clinical Staff (Cont'd.)

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.
- An **Advanced Practice Registered Nurse** is licensed to practice as a registered nurse with advanced practice certification, is practicing under a physician preceptor according to a mutually agreed-upon protocol, and has a minimum of one year of experience working with the population to be served.
- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist 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 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 assure services are rendered in accordance with accepted clinical practice. If the Non-LCS is the primary service provider, the Non-LCS

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Non-Lead Clinical Staff (Cont'd.)

must also sign/title and date the Progress Summary Note as the service provider.

All Non-LCS must have 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.

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
- Assure 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Supervision (Cont'd.)

- 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.
- Assure that supervision shall be available to the staff 24 hours per day, seven days per week
- Co-sign all Medicaid documentation of Non-LCS
- 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 Mental Health Services Not Otherwise Specified 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Referral and Intake (Cont'd.)

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 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 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 Health Services Not Otherwise Specified shall be provided for the identified child based on assessed needs. Services may be rendered either face-to-face or via telephone. The intent of this service is 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Content (Cont'd.)

- Communicate and demonstrate methods of appropriate skills and/or behavior management techniques in order to help family members more effectively manage certain behaviors; or supporting/strengthening 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

Clinical Interventions

Interventions are provided primarily in the settings that comprise the social environment of the identified child/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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Clinical Interventions (Cont'd.)

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 a day, seven days a 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.

Accessibility and Continuity

- Continuity of care must be assured 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.
- A Lead Clinical Staff (LCS) must be available (on call) 24 hours per day, seven days per week to initiate screening of a referred child/family or to respond to an urgent need of 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)

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Client Record (Cont'd.)

- 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 client's home

- 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Individual Treatment Plan (Cont'd.)

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:

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 — The 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 — This 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 at 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:

1. Completed each time service is rendered and whenever information is obtained that has bearing on the identified child's treatment

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Progress Summary Notes (Cont'd.)

2. 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
3. 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 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 in regard to 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, at a minimum 80% of the children reside in the home of family or a consistent stable caregiver.

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

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Evaluation and Outcome Criteria (Cont'd.)

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

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

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

OC7: At a minimum, 75% of family responses indicate satisfaction with services.

OC8: At a minimum, 75% of referring agencies indicate satisfaction with services.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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.

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

- 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 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.)

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

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.

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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

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 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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

- 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 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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

- 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.
- 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-

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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

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, 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:

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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

- 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 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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, 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Treatment (Cont'd.)

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.

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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Treatment (Cont'd.)

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 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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.
- 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Length and Frequencies of Services (Cont'd.)

- 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.

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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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.

Individual Treatment Plan (ITP)

Initial Treatment Plan

An Individual Treatment Plan (ITP) is a comprehensive plan of care developed by a multidisciplinary treatment team (may include but is not limited to child's parent/caregivers, school personnel, case manager,

Individual Treatment Plan (ITP) (Cont'd.)

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 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Individual Treatment Plan (ITP) (Cont'd.)

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 Planning (ITP) 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)

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Discharge Planning (Cont'd.)

- 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 should 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 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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Clinical Documentation (Cont'd.)

- 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 should be documented in the Weekly Progress Summary Notes. 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 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 BHS 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.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Evaluation (Cont'd.)

OC1: After planned discharge, at a minimum 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, at a minimum 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, at a minimum 80% of the children will not return to TBS or a higher level of care within a one-year period.

OC3: At a minimum, 90% of caregivers indicate satisfaction with Therapeutic Behavioral Services.

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

PSYCHOSOCIAL REHABILITATION SERVICES (FORMERLY CLINICAL DAY PROGRAMMING)

Definition

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

Psychosocial Rehabilitation Services must be provided in coordination with the local school district for children ages 6 to 21. Treatment is provided within a psychosocial context involving programming that integrates therapeutic interventions in an educational setting crafted to provide a more effective response to the individual needs of children and their families.

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

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

- Biological parent(s)

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Definition (Cont'd.)

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

When a child is in an out-of-home placement, and the plan is for the child to return home, the family must be an integral part of the implementation of the child's treatment plan.

When a child is an out-of-home placement, and the child is not expected to return home, the primary significant other (case manager, residential services staff, etc.) must be an integral part of the implementation of the child's treatment plan.

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

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

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

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

1. Learn effective strategies for managing problem behaviors and interacting with their child

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Definition (Cont'd.)

2. Identify and develop a collaborative and supportive relationship with school personnel aimed at optimizing the child's academic and social functioning

Although an intensive service, Psychosocial Rehabilitation Services should be provided in a setting with a level of restrictiveness commensurate with the client's needs. This service is intended to be community-based and may be provided by public and private providers in both traditional and non-traditional educational settings. Such programming is to be regarded as a treatment service rather than a place, so that flexibility and individualization are a natural consequence. For continuity of care, services should be rendered five days per week.

All providers of PRS must adhere to all of the standards outlined under Emergency Safety Interventions (see ESI under Program Requirements).

Medical Necessity and Prior Authorization

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

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

The physician or other Licensed Practitioner of the Healing Arts will complete a Medical Necessity Statement (see Section 5) authorizing the service delivery. The Medical Necessity Statement must substantiate the need for the

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

Psychosocial Rehabilitation Services as evidenced by the above criteria. The Medical Necessity Statement must be received from the referring state agency/entity at the time of admission to the program (a faxed copy is acceptable) and placed in the client's record with the initial treatment plan. The original Medical Necessity Statement must be received from the referring state agency/entity within 10 days of admission to the program and placed in the client's record. If the child is readmitted to this service following a discharge, a new Medical Necessity Statement must be completed.

If applicable, services must be pre-authorized by a designated agent. This is accomplished through completion of the Referral Form/Authorization for Services (DHHS Form 254) (See Section 5), which is presented to the provider by the referring agent at time of admission. The Referral Form is required when state agencies refer to private treatment providers.

Program Staff

Program Director

Qualifications

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

- A **Psychiatrist** is an M.D. who has completed residency in psychiatry.
- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners.
- A **Licensed 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 counseling areas.
- A **Mental Health Counselor** holds a master's or doctoral degree from a program that is primarily

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Director (Cont'd.)

psychological in nature (*e.g.*, counseling, guidance, social science equivalent) from an accredited university or college.

- A **Mental Health Professional Master's Equivalent** holds a master's degree in a field that is closely related to the bio-psycho-social sciences or treatment of the mentally ill, or holds a master's degree in a reasonably related field that is augmented by graduate courses and experience in a closely related field. Also, appropriate Ph.D. candidates who have bypassed the master's degree but have more than enough hours to satisfy a master's requirement, as well as professionals who are credentialed as Licensed Professional Counselors or Marriage and Family Therapists, can be considered Mental Health Professional Master's Equivalents.
- A **Social Worker** holds a master's degree from an accredited college or university and is licensed by the appropriate State Board of Social Work Examiners.
- A **Clinical Chaplain** holds a Master of Divinity degree from an accredited theological seminary and has two years of pastoral experience and one year of Clinical Pastoral Education that includes provision of supervised clinical services.
- A **Psychiatric Nurse** is a registered nurse with a master's degree in psychiatric nursing.

Responsibilities

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

Lead Clinical Staff

Qualifications

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Lead Clinical Staff (Cont'd.)

- 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.
- An **Advanced Practice Registered Nurse** is licensed to practice as a registered nurse with advanced practice certification in the state in which he or she is rendering services, is practicing under a physician preceptor according to a mutually agreed-upon protocol, and has a minimum of one year of experience working with the population to be served.
- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist 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.

Prior to rendering the PRS, all Lead Clinical Staff (LCS) must show documentation of 40 contact hours of training

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Lead Clinical Staff (Cont'd.)

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

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

Responsibilities

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

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

Non-Lead Clinical Staff

Qualifications

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

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Non-Lead Clinical Staff (Cont'd.)

behavioral child and adolescent disturbances.

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

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

Responsibilities

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

Staff-to-Client Ratio

All of the following apply:

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

Program Content

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Content (Cont'd.)

The services listed below are the components of PRS.

Assessment and Evaluation

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

Group Interventions

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

Individual Interventions

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Content (Cont'd.)

Rehabilitative Psychosocial Therapy

Included are therapeutic activities designed to improve or preserve the child's level of functioning. This component is designed to facilitate therapeutic interaction between staff, children, and community, as well as to provide children with reality orientation, minimize self-involvement, improve interpersonal skills, and improve concentration when participating in these goal-directed activities.

Coordination and Linkage

Psychosocial Rehabilitation Services include the provision of coordination and linkage with needed community services and resources. This involves 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**. Regular communication and collaboration with any or all disciplines involved in serving the child and his or her family should be incorporated within the structure of Psychosocial Rehabilitation Services. Treatment planning meetings and progress assessment staffings should encourage participation from all disciplines relative to the needs of the child.

Crisis Management

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

Family Involvement

Psychosocial Rehabilitation Services include planned interactions between staff, the child, and the child's family and/or significant others. Staff must be culturally competent and work with parents as partners in every way possible. The purpose of family involvement should be to identify and address any family-related barriers to the success of PRS and to mobilize family resources to support the treatment goals of PRS. Monthly family involvement is strongly encouraged. One home visit (*e.g.*, to the child's

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Content (Cont'd.)

current living arrangement) is required per school year. If extenuating circumstances prevent the program staff from completing the home visit, the reasons preventing the visit shall be documented in the child's clinical record.

Transitioning

The overriding goal of Psychosocial Rehabilitation Services is for the child to make sufficient progress so that he or she may be returned to a less restrictive school setting. When a child changes from a treatment setting that is highly structured, predictable, and interpersonally supportive to a less restrictive school setting that provides less support and guidance, it is very difficult for the child to transfer the skills gained in the treatment settings. In order to increase the likelihood of a successful transition, a clear plan for transition activities should be part of the child's treatment plan. The program should develop a schedule for the implementation of the child's transition, indicating when Transition Days are to be used.

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

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

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Length and Frequency of Service

The PRS program shall meet the following operational guidelines:

- The Psychosocial Rehabilitation Services day must last a minimum of four hours.
- A therapeutic schedule must be in place authenticating the activities that constitute the length of the program day.
- Treatment should be offered a minimum of five days per week.
- Treatment services delivered on the child's last day in the program are billable.
- The PRS program must be operational a minimum of 180 days during the year. This does not preclude the program offering PRS services during the summer.
- Wraparound Services **may not** be billed concurrently with PRS; *i.e.*, during PRS program hours.
- The PRS program must include a strong educational component reflecting coordination with the local school district.
- In order to prevent disruption of PRS therapeutically scheduled activities, services rendered by other providers during the PRS day must be coordinated by both entities. Documentation of coordination efforts must be reflected in the clinical service notes.

Documentation

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

The record contains, at a minimum, the essential elements outlined under **Clinical Records**.

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Individual Treatment Plan

Initial Treatment Plan

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

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

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

Treatment Plan Review

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

Treatment Plan Reformulation

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Progress Summary Notes

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

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

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

Program Evaluation

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 BHS 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, at a minimum 90% of the children that were enrolled in Psychosocial Rehabilitation Services will have achieved at least 75% of the objectives on their individual treatment plans.

OC2: At a minimum, 75% of children who have been successfully discharged are residing with a consistent, stable caregiver/family for at least three months following discharge. (See the definition of "family" at beginning of Psychosocial Rehabilitation Services.)

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

Program Evaluation (Cont'd.)

OC3: At a minimum, 75% of children and families indicate satisfaction with the PRS.

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

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

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

- Completion of their GED
- Vocational training
- Gainful employment

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

SECTION 2 POLICIES AND PROCEDURES

COMMUNITY-BASED SERVICES

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SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

OVERVIEW

Residential Children's Behavioral Health Services are designed for children who are unable to function successfully in a community environment and are in need of a structured therapeutic environment. The goal of these services is to restore the child to the highest level of functioning possible and return the child to the least restrictive living environment.

Requirements for Participation in Residential Services

In order to become eligible to provide Medicaid-reimbursable residential services, a provider must:

- Hold a valid and current license as follows:
  - In-state facilities must be licensed by the SC Department of Social Services (DSS). DSS is the agency that evaluates the need for licensed group homes and child caring institutions.
  - Out-of-state facilities must be licensed by that state's appropriate licensing authority.
- Have a facility with 16 or fewer beds (federal policy prohibits Medicaid payments to Institutions of Mental Disease [IMDs])
- Comply with the enrollment procedures listed below

Enrollment Procedures

The Department of Health and Human Services has established the following procedures and criteria to become enrolled as a provider of residential services. These procedures apply to providers located within the South Carolina Medical Service Area (SCMSA), which includes all of South Carolina, and regions of North Carolina and Georgia that are within 25 miles of the South Carolina border.

In order to become an enrolled Medicaid provider of residential services, a potential provider of Therapeutic Foster Care, Therapeutic Behavioral Services (High Management, Moderate Management, and Supervised Independent Living), and Sexual Offender Treatment Services must receive approval on the following steps:

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RESIDENTIAL SERVICES

Step 1

The potential provider is to submit a detailed proposal describing the services to be rendered and structure of the organization. Proposal pages must be numbered. The proposal must be submitted to SCDHHS for review to determine compliance with minimum Medicaid standards. Incomplete proposals will be returned.

Please submit three copies of the proposal to:

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

The proposal must address, at a minimum, the following components:

1. A copy of the current facility license. **No provider will be enrolled who has not received a "standard" license through the Department of Social Services.**
2. A detailed program description outlining how the service is to be provided, including the following:
   a) Mission statement
   b) Organizational chart (if the enrolling entity currently provides any Medicaid-reimbursable services, this must be delineated on the chart)
   c) Program structure, days and hours of operation
   d) Treatment philosophy and model(s)
   e) Population to be served, including age, diagnosis, and problem profiles of children eligible for services
   f) History and background of the provider
   g) Assurance of financial viability. If an independent audit of the organization has been conducted within the past two years, enclose a copy of the Independent Auditor's Report Statement.
   h) Copies of all provider-proposed forms
3. Information regarding licensing authority and a written description of corporate structure of the entity/organization

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Step 1 (Cont'd.)

4. A copy of the program's Standard Operating Policy and Procedures, including crisis procedures, emergency safety procedures, and a copy of the Personnel Manual
5. Staff training and policy for ensuring all staff receive training, including plan for completion of pre-enrollment training
6. A completed budget that outlines reasonable, anticipated costs and specifies the number of children to be served by the program**. No "start-up" funds can be provided**. All completed budgets must be submitted to:

   Department of Health and Human Services
   Division of Ancillary Reimbursements
   Post Office Box 8206
   Columbia, SC 29202-8206

DHHS and DSS must review and approve all fiscal documentation required for licensure and Medicaid rate setting to ensure agreement on the facility's fiscal viability and the integrity of the documentation. Both DHHS and DSS must agree on the integrity and viability of the fiscal documentation prior to licensure or Medicaid enrollment/ expansion.

An actual cost report (DHHS Financial and Statistical Report) shall be required after six months of operation. The rates may be adjusted based on review of the actual cost report. However, the rates may not exceed the cap established for the service. Please see Section 5 for a sample report.

Potential providers should contact the Department of Behavioral Health Services for additional information.

Step 2

Upon receiving a completed proposal, SCDHHS will initiate the review process.

Step 3

Once the proposal is approved, the third step involves the review of the Financial and Statistical Report. SCDHHS will determine the final unit cost, including treatment and room and board rates. **Medicaid funds are only used to reimburse for treatment costs. Medicaid does not pay for room and board. SCDHHS only determines the**

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Step 3 (Cont'd.)

room and board rate to be paid by the child-placing agency.

Once the program has successfully met all the requirements for enrollment, SCDHHS will notify the program that it has been **conditionally** enrolled as a Medicaid provider **contingent on successful completion of the post-certification evaluation process**. A provider number will be assigned, as well as the daily unit rate (including a breakdown of the treatment rate and the room and board rate).

Step 4

The final step in the process will consist of an on-site **post-certification evaluation** of the program. This will take place after the program has served Medicaid clients for at least 90 days. This evaluation will be conducted at the site where the program is operating. The evaluation will be conducted by SCDHHS or its designee to determine whether the provider has implemented policy and procedures consistent with the standards for the level of care being rendered.

Once a program has successfully met all the enrollment requirements, SCDHHS will notify the program of its enrollment as a Medicaid provider.

Program Expansion/ Modification

Facilities wishing to expand their Medicaid scope of service or bed size (regardless of current bed size) must obtain prior written approval by DHHS (prior to expansion approval by DSS) to be eligible for Medicaid reimbursement.

Existing residential treatment providers must complete the following procedures in the event of program expansion. A provider requesting expansion (defined below) will be required to submit a written request to SCDHHS and may be required to complete the certification process. Current providers will be required to submit to SCDHHS in writing any changes and revisions to policies and procedures enacted since the provider was enrolled.

Providers requesting any expansion/modification to their program are required to notify SCDHHS or its designee in writing 60 days in advance and will be required to follow the procedures outlined here prior to implementation. Providers must receive written approval for program

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Expansion/ Modification (Cont'd.)

expansion/modification from SCDHHS or its designee prior to claiming Medicaid reimbursement.

Program expansion shall be defined by any of the following conditions:

- An existing provider intends to add the same service which is to be located at a different site.
- An existing provider intends to add the same service but to serve a different population; *e.g.,* age, gender, problem type/severity, etc.
- An existing provider intends to add a new or different level of care.
- An existing program is sold or ownership is transferred to a different entity.
- An existing provider intends to increase its bed capacity.

An existing residential program/provider may not increase its current bed capacity to more than 16 beds as a result of program expansion (not applicable to Therapeutic Foster Care).

Exceptions

Certain situations could delay or suspend approval of the expansion process. These would include but are not limited to the following:

- A provider is currently under a formal corrective action plan from SCDHHS or its designee and DSS-Licensing. If **any service** offered by the provider or affiliated entities is under a corrective action plan, expansion will be considered on a case-by-case basis. The expansion would be considered only after the corrective action plan is completed.
- The provider has experienced substantial recoupment as a result of a post-payment review by Medicaid Program Integrity within the last two years and has failed to show evidence of correcting compliance issues. If during the process to expand, a post-payment review occurs and preliminary results indicate problems, the process could be delayed.
- The provider does not demonstrate fiscal responsibility/accountability of its existing

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Exceptions (Cont'd.)

programs as evidenced by review of annual financial reports submitted to the Division of Ancillary Reimbursements.

- The provider has failed to maintain the facility's license.

Temporary Program Closings

The provider must notify the SCDHHS program representative concerning all programs that are temporarily closed.

Providers are required to inform SCDHHS in writing of program design and/or policy changes, contact information, and/or operational changes to their approved programs.

Programs that are closed for up to ninety days will need to meet the following conditions before children are admitted:

- Submit a statement that indicates the provider adheres to the program description, policy, and procedure that were approved through the enrollment process
- Submit a copy of current DSS license
- Submit a new organization chart noting new staff and insuring appropriate supervision and oversight
- Submit detailed staffing patterns
- Submit training plans for all new staff
- Submit verification of all required training

Programs that are temporarily closed beyond ninety days will need to be re-evaluated. Certain conditions must be met before clients are admitted to the program. This may include an on-site review to determine readiness. Providers must submit to SCDHHS a statement of purpose for closure and plan of how the program will adhere to the program description, policy, and procedure that have been approved through the enrollment process.

Disenrollment Procedures

Any of the following may lead to disenrollment:

1. The provider has received technical assistance from program representative and/or contracted entity during the enrollment process established by SCDHHS or its designee and has been unable to meet required standards.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Disenrollment Procedures (Cont'd.)

2. The provider has been under Corrective Action through SCDHHS or its designee and continues to fail program requirements.
3. The facility has been closed by a regulatory body.

The Department of Health and Human Services will determine whether provider termination is warranted and the effective date of termination. The provider will be notified by certified letter of the reason for termination and the effective date of termination.

Section 1 of this manual contains information on appeals.

Facilities Located Outside of the South Carolina Medical Service Area

SCDHHS may reimburse for covered services rendered to a South Carolina emotionally/behaviorally disturbed Medicaid beneficiary outside the South Carolina Medical Service Area (SCMSA). The service area includes all of South Carolina, and regions of North Carolina and Georgia that are within 25 miles of the South Carolina borders.

SCDHHS will enroll and reimburse TBS (High and Moderate Management) and Supervised Independent Living providers outside the SCMSA for services rendered to beneficiaries in the following situations:

- When a designated child-placing state agency certifies that needed services are not available within the SCMSA
- When a child resides closer to an out-of-state facility that is appropriate to meet the child's emotional/behavioral needs than to a facility within the SCMSA

Referrals can only be made by child-placing agencies to an out-of-state provider when the residential service is not available within the SCMSA or the distance of the in-state facility presents problems for the child-placing agency or family to be actively involved in the child's treatment regime. All available resources must have been considered by the child-placing agency and documented in the Referral Request for Out-of-State Residential Services Form (see Section 5). The child placing state agency must provide the out-of-state provider with the Referral Form at the time of the child's admission into the program. A faxed copy is acceptable. The original form must be provided to the out-of-state provider within 10 days of admission. The provider

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Facilities Located Outside of the South Carolina Medical Service Area (Cont'd.)

will be required to file it in the child's Medicaid record along with the Prior Authorization Form (DHHS Form 254).

The Referral Request for Out-of-State Residential Services Form must include the following information:

- Beneficiary's name and Medicaid number
- Child-placing state agency
- Name, address, and telephone number of out-of-state provider
- Justification as to why services must be rendered out-of-state instead of within the SCMSA
- Other resources utilized or considered
- The date the Children's Case Resolution System approved the placement if the placement is 50 or more miles outside of the South Carolina borders. For placements greater than 50 miles outside the South Carolina border, written approval is required from the Children's Case Resolution System in accordance with the South Carolina Code of Laws §20-7-5245.

An out-of-state provider must successfully complete the Medicaid pre-certification process and be enrolled as a South Carolina Medicaid provider of residential services prior to Medicaid reimbursing for the first South Carolina Medicaid beneficiary placed in the program. The provider must accept the treatment rate established and paid by the Medicaid program as payment in full for the treatment services rendered.

Unit of Service

Children's Residential Behavioral Health Services must be billed in units as defined in the service standard. For the purpose of the residential programs, a billable unit is defined as any day or portion of a day that the child receives Medicaid reimbursable treatment services from a treatment provider. Medicaid may be billed for a unit (day) of service only if one of the following applies:

1. The child received some treatment services during that day and has spent the night before or the night of the day in question. Treatment services area billable from the date of admission; however, the

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RESIDENTIAL SERVICES

Unit of Service (Cont'd.)

date of discharge may not be billed to Medicaid.

2. The guidelines covering Medicaid reimbursement for absentee days are met (see Absentee Day Policy below).

The cost of delivery of these treatment services can be divided into separate treatment and room and board costs. Medicaid will only reimburse the treatment portion. The state agency that pre-authorized the services and referred the child for treatment is responsible for the room and board portion of the cost.

Providers must maintain adequate documentation to support the number of units billed. Treatment services are billable from the date of admission; however, the date of discharge may not be billed to Medicaid.

Absentee Day Policy

The purpose of this policy is to provide clarification about Medicaid reimbursement when children are absent from Medicaid-reimbursable Therapeutic Foster Care and Therapeutic Behavioral Services programs. Medicaid absentee days should be documented in the body of the Progress Summary Note. The documentation shall illustrate the nature of the absence, providing the record reviewer with a clear understanding of the type of absentee day that has been reimbursed. Also required are the dates the child left and returned to the program, and a summary of the treatment benefit. Absentee days for both Out-of-Placement Medical Leave and Transition & Family Reunification Leave are per provider, per child, per year in treatment. If a child is discharged from one provider's program and admitted into a different provider's program, the days allocated under the Absentee Day Policy start over with the new provider's program. Per year in treatment varies from child to child and is counted from each child's date of admission into a program. Absentee days are only reimbursable if the child returns to the same program or, in the case of a TFC placement, the same home.

Out-of-Place Medical Care

The following criteria will apply when a child is temporarily absent from a program due to medical reasons requiring crisis stabilization, acute hospital care, inpatient psychiatric care, and/or residential substance abuse

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RESIDENTIAL SERVICES

Out-of-Place Medical Care (Cont'd.)

treatment:

1. Medicaid will reimburse for a maximum of 20 days of medical leave per year in treatment.
2. The child must return to the same program. For Therapeutic Foster Care (TFC), absentee days are only Medicaid reimbursable if the child returns to the same foster family.

If it is known that the child will not return to the program following the medical leave, the day the child leaves on medical leave will be the date of discharge. If the program expects the child to return, but during the course of medical treatment a decision is made for the child to be placed elsewhere, the day the child left on medical leave is a billable day. The day the program is notified that the child will not return is the date of discharge. The days in between are not reimbursable since the child did not return to the program.

Required Documentation

The provider must document the following in behavior-specific terminology in the Progress Summary Note:

- The incident leading up to medical leave
- The date the child left the program
- Where the child was placed
- That the referring agent was notified. The referring agent should execute any additional forms when required (Medical Necessity Statement and DHHS Form 254).
- Communication between the provider and the entity providing medical services
- The date the child returned to the program

Transition and Family Reunification

The following criteria will apply when a child is transitioning out of the program or for the purpose of family reunification:

1. Medicaid will reimburse for a maximum of five consecutive absentee days per period of leave, not to exceed 18 days per year in treatment.

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RESIDENTIAL SERVICES

Transition and Family Reunification (Cont'd.)

2. Periods of leave may not be used for program/facility closings.
3. Periods of leave may be used when a child attends camp or participates in an out-of-state trip if the focus of this transitional leave is therapeutic in nature and consistent with treatment plan goals. Absentee days are not reimbursable for non-therapeutic activities, for example, attending sports camps, educational camps, boy/girl scout camps, etc.

If it is known that the child will not return to the program following the transition/family reunification leave, the day the child leaves the program will be the date of discharge. If the program expects the child to return, but during the course of leave a decision is made for the child not to return to the program, the day the child left on leave is a billable day. The day the program is notified that the child will not return is the date of discharge. The days in between are not reimbursable since the child did not return to the program. If a child returns for portion of a day to collect personal belongings and/or meet with staff, **but does not stay overnight**, this is **not** a billable day.

Required Documentation: The need for transitional and family reunification leave must be reflected in the child's Individual Treatment Plan in behavior-specific terminology. The provider must also document the following in the Progress Summary Note:

- How the child was prepared for the leave
- What transpired during the leave
- How the child benefited from the leave
- The treatment goals the child was working toward
- The child's behavior during the leave
- The child's behavior upon return to the program

Unauthorized Leave

Medicaid will **not** reimburse for treatment days when a child is absent from a program due to "running away" or temporary incarceration. The absence should be annotated in the appropriate blocks on the Progress Summary Note with an "A."

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RESIDENTIAL SERVICES

Administrative Policy

The treatment provider must annotate the days the child was absent and present in the appropriate blocks provided on the Progress Summary Note, adhering to the following instructions:

1. If a child is present for any portion of a day on which a treatment service is rendered and has spent the night before or the night of the day in question, annotate the box with a "P."
2. If a child is absent but meets the Medicaid Absentee Day policy criteria, annotate the box with an "M".
3. If a child is absent from the program due to an unauthorized leave, annotate the box with an "A." These are **not** Medicaid reimbursable days.
4. If a child is absent from the program due to any of the following, annotate the box with an "A." These are **not** Medicaid reimbursable days:
   a) Reasons other than those in the Medicaid Absentee Day policy
   b) Program closings
   c) If the days absent exceed the allocated days in the Absentee Day Policy
5. If the child is discharged from the program — planned or unplanned — annotate the block with a "D". This is **not** a Medicaid reimbursable day.

Staff-to-Client Ratios

Staff-to-client ratio is determined based on what is considered the minimum standards for therapeutic efficacy. Each program (level of care) has a specific ratio requirement. The standard applies to all clients served by a program regardless of whether they are Medicaid eligible or non-Medicaid. Questions should be directed to your program representative.

Staff Development and Training

A minimum of 14 hours of training in the following areas must be received before a staff member begins work with the children:

- History, development, and current status of the service being provided; orientation to the agency's treatment philosophy; and specific agency policy and procedures

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RESIDENTIAL SERVICES

Staff Development and Training (Cont'd.)

- Skill training in specific treatment methods employed by the program
- Crisis management protocol and procedures employed by the program
- Recognizing signs of and reporting child abuse and neglect
- Recognizing and documenting side effects of medications commonly used with clients who are emotionally disturbed
- Working with children who have emotional and behavioral problems
- Working with children who have been abused and neglected

A staff member may meet these requirements if he or she can document that he or she received the training as a part of academic coursework, in a training workshop, or in another structured learning environment within the last five years. Acceptable documentation of such training will consist of course outlines, syllabi, certificates of attendance, academic transcripts, or other written descriptions of the training received.

Continuing Staff Education and Training

A minimum of 14 hours of continuing education and training in the following areas must be provided annually:

- Working with children who have emotional and behavioral problems
- Group dynamics
- Review of the agency's treatment philosophy
- Specific agency policies and procedures
- Treatment and care specific to the needs of the population served by the program
- Individualized education plans (Note that this requirement only applies to the LCS)

All providers must ensure that, prior to working with children, staff members successfully complete a course from a certified trainer in the prevention and management of aggressive behavior.

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RESIDENTIAL SERVICES

Continuing Staff Education and Training (Cont'd.)

Staff must maintain certification in first aid, CPR, universal precautions, and other topics that may be required by the regulatory agencies.

THERAPEUTIC FOSTER CARE

Definition

Therapeutic Foster Care (TFC) is an intensive treatment program for emotionally disturbed children that incorporates clinical treatment services provided within a supportive foster home setting. The goal of TFC is to enable a child to overcome emotional, behavioral or psychiatric problems in a highly supportive, individualized, and flexible residential placement, thereby helping the child to move to a less intensive foster or group care placement, or to return to the natural home or family setting.

TFC services are behavioral, psychological, and psychosocial in orientation. Therapeutic Foster Parents (TFPs) are specially recruited and trained in behavioral management and treatment interventions designed to meet the individual needs of the child. TFC provider agency clinical staff directly supervise and support the TFPs throughout the child's length of stay.

Services rendered to siblings who are placed in the same TFC home, and/or to the children of a minor parent placed in same TFC home for purposes of family unity, but who do not meet the medical necessity criteria for TFC, **are not** Medicaid reimbursable.

Levels of Care

TFC services may be offered in three levels of intensity depending upon the needs of the child. Specialized programming may also be provided appropriate to the needs of the child. This may include but is not limited to supervised independent living components.

Level I

Level I refers to the level of supervision and intensity of programming required to manage and treat children who **currently** present moderate emotional and/or behavioral management problems. Emotionally disturbed children receiving Level I typically display a moderate degree of "acting out" behavior, which may include aggressiveness

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RESIDENTIAL SERVICES

Levels of Care (Cont'd.)

toward inanimate objects, delinquent behavior such as truancy and running away, and/or drug or alcohol problems, along with other emotional or psychiatric problems that cannot be addressed in a less intensive treatment environment. The nature of the behavioral problems displayed prevents the child from living at home or in an unstructured foster care or group home setting.

Programming and interventions are tailored to the age and diagnosis of the child. A structured and supportive home environment is essential to the therapeutic process.

Level II

Level II refers to the level of supervision and intensity of programming required to manage and treat children who **currently** present moderate to more severe emotional and/or behavioral management problems than those children in Level I. Emotionally disturbed children receiving Level II typically display a high degree of impulsive and acting out behavior that is often characterized by verbal and physical aggression directed toward other persons. These behaviors, along with other more severe emotional or psychiatric problems, cannot be addressed in a less intensive treatment environment.

Programming and interventions are tailored to the age and diagnosis of the child. Level II is characterized by intense supervision of the child, greater structure within the therapeutic foster home, and increased clinical intervention from the TFPs and the provider agency staff. In addition, a licensed psychologist or psychiatrist must be involved in the child's care on an as-needed basis, but at a minimum every six months.

Level III

Level III refers to the level of supervision and intensity of programming required to manage and treat children who **currently** present severe emotional and behavioral management problems. Severely emotionally disturbed children receiving Level III services typically display multiple and severe psychiatric, emotional, and behavioral problems. They may have experienced recent and multiple psychiatric hospitalizations or other restrictive placements. These behaviors are often seen in combination with other behaviors typically associated with emotionally disturbed children. The range of behaviors and problems seen with

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Levels of Care (Cont'd.)

Level III children includes aggression toward animals, others, and/or self; sexual acting out; delinquent behavior; destruction of property; substance abuse; personality disorder; and/or suicidal behaviors or ideation.

Programming and interventions are tailored to the age and diagnosis of the child. Due to potential harm to self and/or others, these children require intense supervision from the TFPs. The frequency and intensity of contact between the TFPs, the child, and the professional staff provides a greater amount of structure, support, and clinical intervention than are offered at Levels I or II. In addition, a licensed psychologist or psychiatrist must be involved in the child's care on an as-needed basis, but at a minimum on a quarterly basis.

Medical Necessity and Prior Authorization

The child will be assessed by the referring state agency to determine the needed level of care. Both the need for and the level of TFC services must be recommended by a physician or other Licensed Practitioner of the Healing Arts who will certify that the child meets the medical necessity criteria outlined in this section. In addition, the level of TFC that meets the child's needs must be pre-authorized by a designated referring agent through their predetermined assessment process.

Level I — the child must currently meet at least one of the following criteria.

Level II — the child must currently meet at least two of the following criteria.

Level III — the child must currently meet at least three of the following criteria:

1. The child is diagnosed as having severe behavioral and emotional problems that, without TFC, would require admission to a psychiatric hospital, to the psychiatric unit of a general hospital, or to a residential treatment facility.
2. The child is a patient in a psychiatric hospital, or in the psychiatric unit of a general hospital, or in a residential treatment facility and, in the opinion of the professional staff involved, the child's condition has improved to the point that treatment in a less restrictive setting would be appropriate.

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Medical Necessity and Prior Authorization (Cont'd.)

3. The child exhibits maladaptive or disruptive behavior. The child may be displaying aggression through destruction of property or aggression toward animals, others, and/or self (through self-inflicted injuries or suicidal behaviors/ ideation). Other behaviors may include delinquency (*i.e.*, repeated episodes of running away, truancy, and incorrigibility), oppositional behavior, substance abuse, and sexual acting out.
4. The child exhibits an inability to perform activities of daily living due to psychiatric symptoms. The child may be extremely impulsive and demonstrate limited ability to delay gratification. The child's limited social and emotional capacity impairs decision-making and places him or her at risk in the community. Often the child is handicapped by psychiatric dysfunction and experience hallucinations and/or delusions leading to some bizarre behaviors. The constant attention of a caretaker is usually required.
5. The child has emotional problems because of sexual or physical abuse. The child avoids adult relationships and has become impersonal, detached, and preoccupied with sexual content. The child may act out as a perpetrator, practice prostitution, or become a submissive victim.
6. The child has emotional problems associated with a history of substance abuse and/or dependency. The child's physical and emotional well-being is at risk due to excessive use of drugs and/or alcohol, thus making a structured environment, close monitoring, frequent counseling, medical visits, and a well-coordinated network of support medically necessary.

The designated referring agent shall provide the TFC provider agency with both of the following forms for each child referred for services:

- A completed Medical Necessity Statement
- A completed Referral Form/Authorization for Services (DHHS Form 254)

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RESIDENTIAL SERVICES

Program Staff

TFC services shall be rendered by the Lead Clinical Staff (LCS) and by the TFPs under the supervision of the LCS.

Lead Clinical Staff

The LCS providing services to children or supervision of the TFPs shall have substantial training in provision of services to emotionally disturbed children. The provider agency shall ensure that all LCS meet the following guidelines for involvement at each level of TFC offered.

Level I — The LCS shall meet one of the professional qualifications as defined by SCDHHS (see Clinical Staff under Staff Requirements).

Levels II and III — The LCS shall meet the professional qualifications at the master's or doctoral level as defined by SCDHHS. Non-master's level LCS may also provide Levels II and III under the supervision of a master's or doctoral level LCS. (See Supervision for more information).

The LCS shall spend time individually with each child to allow the child to communicate concerns, assess the child's progress and to monitor health, safety, and the well-being of the child.

Therapeutic Foster Parents

The role of the TFPs is central to treatment in a TFC setting. TFPs are viewed as the primary treatment agents in the delivery of therapeutic services to the emotionally disturbed child. They are responsible for implementing services as developed in the child's individual treatment plan. TFPs shall be at least 21 years of age and must meet all applicable state standards for licensing. The TFC provider agency is responsible for ensuring TFPs meet the following training requirements when rendering services for a client in Level 2 or 3 TFC :

Level 1 – The TFPs shall meet the minimum training requirements.

Level 11- The TFPs shall have an additional five hours of client-specific training to include client diagnosis/special needs.

Level III – The TFPs shall have an additional seven hours of client-specific training to include client diagnosis/ special needs.

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RESIDENTIAL SERVICES

Staff Availability

The program must identify in each child's crisis/contingency plan who, from the program, will be available to meet the child's needs. The program and/or TFPs must be available to the child when needed. The LCS must be available 24 hours a day, seven days a week. The program staff and/or the TFPs must be available to handle crisis situations as outlined in the crisis/contingency plan that is developed by the treatment team. Crisis situations include but are not limited to situations at school (such as school meetings or supervision when a child has been expelled). It is expected that the program and treatment team will consider consistency and continuity of care when determining contingency plans.

Supervision

TFC services shall be directly supervised by the appropriate LCS. The LCS has dual responsibility for supervising the performance of the TFPs, and evaluating and assessing the children who are receiving services.

The provider agency shall ensure the appropriate involvement of the LCS in each child's care. Said involvement must include an intake assessment of the child's condition, the development and signing of the treatment plan, and periodic reconfirmation of the necessity for treatment and the appropriateness of care.

Level II and Level III guidelines do allow for a master's level LCS to supervise the services of a non-master's level LCS under the following conditions:

- The non-master's level LCS must have appropriate training and supervision to ensure that services are rendered in accordance with standards and acceptable clinical practice.
- The supervising master's level LCS must sign all Progress Summary Notes and treatment plans as the individual responsible for the provision of service. The signature of the master's level LCS verifies that services were provided in accordance with standards and acceptable clinical practice.
- Each child receiving services from a non-master's level LCS must be considered as part of the caseload of the supervising master's level LCS for purposes of caseload size limitations guidelines.

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RESIDENTIAL SERVICES

Caseload and Contact Requirements

Level I — The LCS caseload size shall not exceed 16 children.

Level II — The LCS caseload size shall not exceed 12 children.

Level III — The LCS caseload size shall not exceed eight children.

The LCS may carry a "weighted" caseload; *i.e.*, the caseload may be composed of children from each of the three levels of care. Each caseload cannot exceed 48 units. Each child will be assigned a certain number of units based on that child's level.

- Level I = three units (16 Level I clients would fill one caseload (16 x 3 = 48)
- Level II = four units (12 Level II clients would fill one caseload (12 x 4 = 48)
- Level III = six units (eight Level III clients would fill one caseload (8 x 6 = 48)

Any combination of Level I, II, and III clients that totals 48 units is allowed. For example, four Level III children and eight Level I children would be allowed: (4 children x 6 units) + (8 children x 3 units) = 48 caseload units.

The LCS shall be available for supervision and consultation 24 hours a day, seven days per week. The LCS must spend as much time in contact with the TFPs and with the child as is necessary to ensure that the child is receiving services in a safe, effective manner. There should be regular contact and face-to-face meetings with the TFPs to discuss specific needs of the child in order to monitor behavioral, psychological, and psychosocial development.

Level I — The LCS must contact the TFPs at least weekly to monitor the child's progress and discuss the treatment services provided in the home. There should be a meeting with the TFPs as often as needed, but there must be face-to-face contact at least once per month and telephone contact at least once per week.

Level II — The LCS must contact the TFPs at least twice weekly to monitor the child's progress and discuss the treatment services provided in the home. This should

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RESIDENTIAL SERVICES

Caseload and Contact Requirements (Cont'd.)

include at least one face-to-face meeting and one telephone contact. In addition, psychological or psychiatric consultation regarding a specific child's problems or needs must be provided to the TFPs and/or the LCS on an as-needed basis but at least every six months.

Level III — The LCS must contact the TFPs at least twice weekly to monitor the child's progress and discuss the treatment services provided in the home. This should include at least one face-to-face meeting and one telephone contact. In addition, psychological or psychiatric consultation regarding a specific child's problems or needs must be provided to the TFPs and/or the LCS on an as-needed basis but at least quarterly.

Program Content

The following services should be considered integral components of TFC and should be provided by the provider agency:

- Placement of a child with a TFP specifically matched to meet the child's individual needs
- Intake assessment, development of a treatment plan, and crisis/contingency plan
- Professional clinical or consultative services rendered by the LCS or psychologist/psychiatrist as required by the standards

The following services are considered integral components of TFC and should be provided by the Therapeutic Foster Parent:

- Twenty-four hour availability for supervision; TFPs are expected to fulfill all the roles normally filled by a child's parents. This includes assuming responsibility for the health, welfare, and safety of the child, and being responsible for the care of the child 24 hours per day, seven days per week. The LCS must identify in each child's crisis/ contingency plan who, from the program, will be available to meet the client's needs. The LCS and/or TFPs must be available to the client when needed. The LCS and/or TFPs must be available to handle crisis situations as outlined in the crisis/contingency plan that is developed by the treatment team. Crisis situations include, but are

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RESIDENTIAL SERVICES

Program Content (Cont'd.)

not limited to, situations at school (school meetings, supervision when a client has been expelled, etc.). It is expected that the program/treatment team will consider consistency and continuity of care when determining contingency plans.

- A high level of child care in a nurturing home setting with attention to the child's health, safety, and welfare
- Parenting skills appropriate to the level of TFC being provided, and adequate to deal with the needs of emotionally disturbed children in the areas of behavior management, crisis intervention, supportive counseling, and implementation of a treatment plan
- Structured/therapeutic daily activities
- Record keeping that documents the child's progress toward achievement of treatment plan goals and objective

Documentation

Medicaid reimbursement is directly related to the delivery of services. Each clinical record must contain adequate documentation to support the services rendered and billed. The record contains, at a minimum, the essential elements outlined under **Clinical Records**. Documentation of the treatment services provided to the child, the child's responsiveness to the treatment, and the interaction and involvement of the LCS with the child and the TFPs should justify and support the services billed to Medicaid.

In order for TFC services to be billed to Medicaid for any calendar day, services must have been rendered directly to the child during that day. Medicaid should not be billed for full days in which a child is absent or away from the delivery of TFC services, unless the guidelines covering Medicaid reimbursement for absentee days are met (see Absentee Day Policy).

Individual Treatment Plan

Initial Treatment Plan

A treatment plan must be developed for every child within 30 days of placement, and shall be written, signed, and dated on each page by the LCS. If a treatment plan is not developed within 30 days, services rendered from the 31st

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan (Cont'd.)

day until the date of completion of the treatment plan are **not Medicaid reimbursable**. The completed Medical Necessity Statement must be placed with the initial treatment plan in the treatment section in the client's file. The LCS shall work closely with the TFPs and other professionals to develop a treatment plan.

Treatment plans must be signed and dated by clients as evidence of their participation in the planning 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.

TFPs must be considered the primary treatment agents for the implementation of treatment plans and, as such, must attend all treatment planning meetings. The TFPs must sign all treatment plans. The child must participate in treatment planning to the maximum extent possible. The licensed psychologist or psychiatrist also must sign and date the initial treatment plan for any child in Level III placement within 30 days of the LCS's signature.

Treatment Plan Review

The treatment plan should be updated as needed. However, treatment plan reviews must be conducted at least every ninety days from the date of the initial treatment plan to ensure that services and treatment goals continue to be appropriate to the child's needs, and to assess the child's progress and continued need for services.

- **Level I —** The treatment plan review shall be signed/titled and dated on each page by the LCS. The TFP is encouraged to sign each review.
- **Levels II and III —** The treatment plan must include a written summary of each 90-day review, and must be signed/titled and dated by the LCS. For Level III placements, the licensed psychologist or psychiatrist must sign and date each treatment plan review within 30 days of the LCS's signature, as verification that services are appropriate to address the child's problems and meet the child's needs.

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RESIDENTIAL SERVICES

Individual Treatment Plan (Cont'd.)

Treatment Plan Reformulation

Treatment plans shall be reformulated on a regular basis. Treatment plans for Levels I and II shall be reformulated every 12 months or 365 days; Level III treatment plans shall be reformulated every six months or 180 days. The reformulated treatment plan must:

- Reflect the child's current problem areas, needs and, if appropriate, discharge plans
- Support the continued need for TFC services
- Be signed/titled and dated by the LCS
- Be signed and dated by the licensed psychologist or psychiatrist within 30 days of the LCS's signature (**Level III only**)
- Be signed by the TFP
- **Never** be a photocopy of a previous treatment plan

Progress Summary Notes

The LCS shall document a Progress Summary Note summarizing the child's current status, program participation, psychosocial/behavioral skills development, and the interaction and involvement of the LCS and TFPs. The LCS shall sign/title and date the Progress Summary Note as the person responsible for the provision of service. It must be dated on or shortly after the last day of service for that note and placed in the chart within 14 calendar days. Providers may not bill Medicaid for services before the Progress Summary Notes are placed in the chart. The Progress Summary Note should be co-signed by the TFPs. Signature by the LCS verifies that services were provided in accordance with these standards. Progress Summary Notes shall be written at the following frequency:

- **Level I —** The Progress Summary Note must be written every two weeks.
- **Levels II and III —** The Progress Summary Note must be written every week.

For further information on clinical documentation, please see Progress Summary Notes earlier in this section.

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RESIDENTIAL SERVICES

THERAPEUTIC BEHAVIORAL SERVICES (FORMERLY MODERATE MANAGEMENT REHABILITATIVE SERVICES)

Definition

Therapeutic Behavioral Services (Moderate Management) are highly structured therapeutic residential rehabilitative services with intensive staff supervision and programs for children who are experiencing relational or behavioral problems and/or have been abused and/or neglected and are therefore not able to function successfully in a community environment. The treatment program must be operational 24 hours per day, seven days per week, 365 days per year. **Temporary closings, except in emergency situations, are not allowed.**

The goal of these residential rehabilitative services is to enable children to overcome their problems to the degree that they may be safely stepped down to a less restrictive environment.

Moderate management refers to the level of supervision and intensity of programming required to manage and treat children who present less intensive problems than those treated in high management rehabilitative services. Structured therapeutic interventions such as individual and group therapy are provided several times per week.

Staff often supervise a greater number of children at a given time than might be supervised in a high management setting. In addition to the programming and structure, the children receive 24-hour supervision, during 16 hours of which staff members are awake.

As Medicaid reimbursement for this service is an all-inclusive rate, there should be no duplication of the components of the service array by any other entity unless extenuating circumstances are documented in the client record and prior approval is granted by SCDHHS.

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RESIDENTIAL SERVICES

Medical Necessity and Prior Authorization

TBS (Moderate Management) must be recommended by a physician or other Licensed Practitioner of the Healing Arts who will certify that the child meets the medical necessity criteria outlined in this section. These services must also be pre-authorized by a designated referring agent. Services may be recommended for a child who currently meets both the following criteria for this level of care:

- The child is not able to function successfully in a less restrictive environment.
- The child is experiencing relational or behavioral problems and/or has been abused and/or neglected, as reflected in a diagnosis from the most current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This includes the use of appropriate V-Codes for diagnostic purposes.

The designated referring agent shall supply the residential rehabilitative services provider with the following at the time of placement:

- A completed Medical Necessity Statement
- A completed Referral Form/Authorization for Services (DHHS Form 254)

A faxed copy is acceptable. The original form must be provided within 10 days of placement.

Program Staff

The residential rehabilitative services provider shall ensure appropriate involvement of the Lead Clinical Staff (LCS) in each child's care. This involvement shall include an assessment, development and signing of the treatment plan, and periodic reconfirmation of the necessity of treatment and the appropriateness of care.

Service components of each program shall be rendered by the Lead Clinical Staff (LCS) or by staff under the supervision of the LCS. The following standards must be met:

1. The LCS shall meet the professional standards as defined by SCDHHS (see Clinical Staff).
2. Non-LCS supervised by the LCS may render services. The Non-LCS must have the appropriate

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Staff (Cont'd.)

training to ensure that services are rendered in accordance with acceptable clinical practice.

3. The staff shall be engaged in client-centered activities during program hours.

Supervision

The residential rehabilitative services shall be provided by or directly supervised by the LCS. The LCS has dual responsibility for supervising the performance of the Non-LCS staff, and evaluating, assessing, and treating children who are receiving services.

The LCS shall be available for supervision and consultation to ensure that children are receiving services in a safe, efficient manner according to accepted standards of clinical practice. Those hours must normally be scheduled at a time the children are expected to be awake and out of school. The LCS must spend a portion of his or her time observing and interacting with the children.

The LCS shall meet at least every week with Non-LCS staff either individually or in groups to discuss specific children's cases in order to monitor the child's behavioral, psychological, and psychosocial development. This meeting must be documented in the weekly Progress Summary Notes.

LCS-to-Client Ratio

One LCS is required for each 16 children.

Staff-to-Client Ratio

- **Residential Rehabilitative Services:** The staff-to-client ratio shall be a minimum of one LCS or Non-LCS staff to eight children during program hours. Staff shall be physically available on-site at the program. There must be staff designated as "on-call" who are available for emergencies.

  During sleeping hours, **both** of the following conditions must be met:

  - A minimum of two LCS or Non-LCS staff must be present in **each** cottage/residence. On-call staff must be available for emergencies.
  - A minimum ratio of one LCS or Non-LCS staff to 10 children must be maintained during

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Supervision (Cont'd.)

sleeping hours in **each** cottage/residence.

- **Residential Rehabilitative Services provided in approved alternative settings:** During sleeping hours, all of the following shall apply:
  - There shall be a minimum of one staff member physically present in each campsite.
  - There shall be one awake staff member who rotates between campsites. This identified staff member shall conduct routine, random checks of each campsite throughout the night. The program must maintain documentation to show that such checks were conducted, including the status of the campsite at each check.
  - The minimum staff-to-client ratio in each campsite shall be one staff to every 10 children.
  - "On call" staff shall be available to respond to emergencies.
  - Administrators of these programs shall ensure that adequate safety and environmental issues are addressed.

Program Content

Each residential rehabilitative service must have a structure in place that clearly supports the development of desired behaviors, skills, and emotional growth through either a level system, or another specialized milieu or intervention approach. Structure within the residential rehabilitative service shall be demonstrated by a posted schedule of structured activities and treatment services provided within the program.

Services must be therapeutic and structured. The services must also be consistent with the child's diagnosis and treatment needs. The services listed below are components of TBS (Moderate Management):

- **Intake Assessment and Reassessments:** The systematic process of collecting and analyzing data pertinent to the child's mental health, behavior, strengths, and current problem(s)/need(s). This information can be obtained through interviews, observations, discussions with service providers, and/or the review of previous treatment records.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Content (Cont'd.)

- **Behavior Management:** Interventions used to change specific behaviors
- **Counseling/Therapy:** Face-to-face, goal-oriented intervention between the child and staff. The service can be therapeutic or supportive and used to assist the child in solving identified problems.
  - **Individual Counseling/Therapy:** Face-to-face interactions between a child and staff. The scope of the issues addressed is based on the child's need, as is the therapy modality employed by the staff. Individual counseling/ therapy shall occur at least one time per week.
  - **Family Counseling/Therapy:** Face-to-face interactions between staff and the child's family unit. The intended outcome is the management, reduction, or resolution of the identified problems, thereby allowing the child and his or her family to work on identified problems and thus strengthen the family unit. Although a specific frequency is not required, family counseling/therapy should be offered as needed.
  - **Group Counseling/Therapy:** Face-to-face interactions between staff and a group of children. Group counseling/therapy allows the staff to address the needs of several children at the same time. The group counseling/therapy process provides commonality of client therapy experience and utilizes a complex of client interaction. Group counseling/therapy shall occur at least one time per week.
- **Crisis Intervention:** An intensive, time-limited service provided by the staff face-to-face with the child following abrupt or substantial changes in the child's functioning and/or marked increase in personal distress. The interventions are often needed to prevent further decompensation or escalation.
- **Treatment Plan Formulation and Reviews:** A written individualized plan of care, or reviews of the plan of care, developed and signed by the LCS.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Content (Cont'd.)

The treatment plan should address the child's needs, reasons for placement, and treatment methods that will be used to obtain the identified goals/objectives.

- **Rehabilitative Psychosocial Therapy:** Therapeutic activities designed to improve or preserve the child's level of functioning. This component is designed to facilitate therapeutic interaction between staff, children, and peers as well as to provide children with reality orientation, minimize self-involvement, and improve concentration when participating in these structured, goal-directed activity therapy events.
- **Restorative Independent Living Skills:** Services provided individually or in groups to help facilitate the child's transition from residential rehabilitative services to more independent living. The service modality may be chosen by staff and may differ from child to child.

Services that are unstructured or non-therapeutic in nature are **not** Medicaid reimbursable. Medicaid reimbursement will only be made for the treatment component of the residential rehabilitative services program.

Documentation

Medicaid reimbursement is directly related to the delivery of services. Each clinical record must contain adequate documentation to support the services rendered and billed. The record contains, at a minimum, the essential elements outlined under Clinical Records. Documentation of the treatment services provided to the child, the child's responsiveness to the treatment, and the interaction and involvement of the staff with the child should justify and support the services billed to Medicaid.

In order for TBS (Moderate Management) to be billed to Medicaid for any calendar day, services must have been rendered directly to the child during that day. Medicaid should not be billed for full days in which a child is absent or away from the delivery of these services, unless the guidelines covering Medicaid reimbursement for absentee days are met.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan

Initial Treatment Plan

A treatment plan must be developed for every child within 30 days of placement, and shall be written, signed, and dated by the LCS. 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 completed Medical Necessity Statement should be placed with the initial treatment plan.

Treatment plans must be signed and dated by clients as evidence of their participation in the planning 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.

The treatment plan must be based on an assessment of the child's needs and should include the following: specific problems or behaviors requiring treatment; treatment goals and objectives; methods and frequency of intervention; criteria for achievement; target dates; and signatures with dates on each page.

If the child is 14 or older, the treatment plan must include independent living goals for transition.

Treatment Plan Review

Treatment plan reviews must include a written summary and shall be conducted every 90 days to ensure services and treatment goals continue to be appropriate to the child's needs and to assess the child's progress and continued need for services. The LCS shall sign/title and date the treatment plan at each treatment plan review.

Treatment Plan Reformulation

The treatment plan shall be reformulated every 180 days. The reformulated treatment plan must:

- Reflect the child's current problem areas, needs, and discharge goals
- Support the continued need for TBS (Moderate Management) to include specific problem behaviors that need to be reduced before the client can be safely stepped down to a less restrictive environment

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan (Cont'd.)

- Be signed/titled and dated by the LCS
- Never be a photocopy of a previous treatment plan

Progress Summary Notes

A Progress Summary Note summarizing the child's program participation and psychosocial/behavioral status and functioning must be documented weekly. The LCS shall sign/title and date the Progress Summary Note as the person responsible for the provision of service. The note must be dated on or shortly after the last day of service for that note and must be placed in the chart within 14 days. The provider may not bill Medicaid for services until the Progress Summary Note is placed in the chart. The documentation must address, at a minimum, the following items in order to provide a pertinent clinical description and ensure that the service conforms to the service description:

1. A general observation of the child's condition. This may include the child's mental status, behavior, health, and/or psychosocial skills.
2. The child's activity and participation in the treatment portion of the program. This must include the child's progress on treatment goals, as well as involvement in the structured program of the residential rehabilitative services and/or other appropriate activities.
3. Activities of counseling/therapy staff. The involvement of the staff in service provision is required and shall be documented.
4. Future plans for working with the child

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

THERAPEUTIC BEHAVIORAL SERVICES (FORMERLY HIGH MANAGEMENT REHABILITATIVE SERVICES)

Definition

Therapeutic Behavioral Services (High Management) are highly structured residential rehabilitative services having intensive staff supervision and programs for children who are experiencing relational or behavioral problems and/or have been abused and/or neglected and are not able to function successfully in a community environment. The treatment program must be operational 24 hours per day, seven days per week, 365 days per year. **Temporary closings, except in emergency situations, are not allowable**.

The goal of these residential rehabilitative services is to enable children to overcome their problems to the degree that they may be safely stepped down to a less restrictive environment.

High Management refers to the level of supervision and intensity of programming required to manage and treat children who present severe behavior management problems.

Programming and interventions are tailored to the age and diagnosis of the children served. Frequent **structured** therapeutic group and individual interventions along with specialized behavior management techniques are often offered several times per day. In addition to the intensive programming and structure, the children are provided with 24-hour awake supervision.

Medical Necessity and Prior Authorization

TBS (High Management) must be recommended by a physician or other Licensed Practitioner of the Healing Arts who will certify that the child meets the medical necessity criteria outlined in this section. These services must also be pre-authorized by a designated referring agent. Services may be recommended for a child who currently meets both the following criteria for this level of care:

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

- The child is not able to function successfully in a less restrictive environment.
- The child is experiencing relational or behavioral problems and/or has been abused and/or neglected as reflected in a diagnosis from the most current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. A client with a V-code as the primary diagnosis would not be appropriate for a High Management level of care.

The designated referring agent shall supply the residential rehabilitative services provider with both of the following at the time of placement:

- A completed Medical Necessity Statement
- A completed Referral Form/Authorization for Services (DHHS Form 254)

Faxed copies are acceptable. The original forms must be provided within 10 days of placement. For further information, please see Medical Necessity Statement and Prior Authorization earlier in this section.

Program Staff

The residential rehabilitative services provider shall ensure appropriate involvement of the Lead Clinical Staff (LCS) in each child's care. This involvement shall include an assessment, development and signing of the treatment plan, and periodic re-confirmation of the necessity of treatment and the appropriateness of care.

Service components of each program shall be rendered by the Lead Clinical Staff (LCS) or by staff under the supervision of the LCS. The following standards must be met:

- The LCS shall meet the professional standards as defined by SCDHHS (see Clinical Staff).
- Non-LCS supervised by the LCS may render services. The Non-LCS must have the appropriate training to ensure that services are rendered in accordance with acceptable clinical practice.
- The staff shall be engaged in client-centered activities during program hours.

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RESIDENTIAL SERVICES

Supervision

The residential rehabilitative services shall be provided by or directly supervised by the LCS. The LCS has dual responsibility for supervising the performance of the Non-LCS staff, and evaluating, assessing, and treating children who are receiving services.

The LCS shall be available for supervision and consultation during program hours to ensure that children are receiving services in a safe, efficient manner according to accepted standards of clinical practice. Those hours must normally be scheduled at a time the children are expected to be awake and out of school. The LCS must spend a portion of his or her time observing and interacting with the children.

The LCS shall meet at least weekly with Non-LCS staff either individually or in groups to discuss specific children's cases in order to monitor the child's behavioral, psychological, and psychosocial development. This meeting should be documented in the weekly Progress Summary Notes.

LCS-to-Client Ratio

One LCS is required for each 10 children.

Staff-to-Client Ratio

Residential Rehabilitative Services

The staff-to-client ratio shall be a minimum of one LCS or Non-LCS staff to five children during program hours. Staff shall be physically available on-site at the program. There must be staff designated as "on-call" who are available for emergencies.

During sleeping hours, **all** of the following conditions must be met:

- A minimum of two LCS or Non-LCS staff must be present in **each** cottage/residence. One staff member must be awake at all times. On-call staff must be available for emergencies.
- A minimum ratio of one LCS or Non-LCS staff to seven children must be maintained during sleeping hours in **each** cottage/residence.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

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

Residential Rehabilitative Services Provided In Approved Alternative Settings

During sleeping hours, **all** of the following shall apply:

- There shall be a minimum of two staff physically present in each campsite.
- There shall be one awake staff member who rotates between campsites. This identified staff shall conduct routine, random checks of each campsite throughout the night. The program must maintain documentation to show that such checks were conducted, including the status of the campsite at each check.
- The minimum staff-to-client ratio in each campsite shall be one staff to every seven children.
- "On-call" staff shall be available to respond to emergencies.
- Administrators of these programs shall ensure that safety and environmental issues are adequately addressed.

Program Content

Each residential rehabilitative service must have a structure in place that clearly supports the development of desired behaviors, skills, and emotional growth through either a level system or another specialized milieu or intervention approach.

Structure within the residential rehabilitative service shall be demonstrated by a posted schedule of structured activities and treatment services provided within the program.

Services must be therapeutic and identifiable as structured programming. The services must also be consistent with the child's diagnosis and treatment needs. The services listed below are components of TBS (High Management). Due to the severity of the problems of children served in TBS (High Management), services must be more intensive than those provided in TBS (Moderate Management).

- **Intake Assessment and Reassessments:** The systematic process of collecting and analyzing data pertinent to the child's mental health, behavior, strengths, and current problem(s)/need(s). This

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Content (Cont'd.)

information can be obtained through interviews, observations, discussions with service providers, and/or the review of previous treatment records.

- **Behavior Management:** Interventions used to change specific behaviors
- **Counseling/Therapy:** Face-to-face, goal-oriented intervention between the child and staff. The service can be therapeutic or supportive and used to assist the child in solving identified problems.
  - **Individual Counseling/Therapy:** Face-to-face interactions between a child and staff. The scope of the issues addressed is based on the child's need, as is the therapy modality employed by the staff. Individual counseling/ therapy shall be provided a minimum of two times per week.
  - **Family Counseling/Therapy:** Face-to-face interactions between staff and the child's family unit. The intended outcome is the management, reduction, or resolution of the identified problems thereby allowing the child and his or her family to work on identified problems and thus strengthen the family unit. Although a specific frequency is not required, family counseling/therapy should be offered as needed.
  - **Group Counseling/Therapy:** Face-to-face interactions between staff and a group of children. Group counseling/therapy allows the staff to address the needs of several children at the same time. The group counseling/therapy process provides commonality of client therapy experience and utilizes a complex of client interaction. Group counseling shall be provided a minimum of two times per week.
- **Crisis Intervention:** An intensive, time-limited service provided by the staff face-to-face with the child following abrupt or substantial changes in the child's functioning and/or marked increase in personal distress. The interventions are often needed to prevent further decompensation or escalation.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Content (Cont'd.)

- **Treatment Plan Formulation and Reviews:** A written individualized plan of care, or reviews of the plan of care, developed and signed by the LCS. The treatment plan should address the child's needs, reasons for placement, and treatment methods that will be used to obtain the identified goals/objectives.
- **Rehabilitative Psychosocial Therapy:** Therapeutic activities designed to improve or preserve the child's level of functioning. This component is designed to facilitate therapeutic interaction between staff, children, and peers as well as to provide children with reality orientation, minimize self-involvement, and improve concentration when participating in these structured, goal-directed activity therapy events.
- **Restorative Independent Living Skills:** Services provided individually or in groups to help facilitate the child's transition from residential rehabilitative services to more independent living. The service modality may be chosen by staff and may differ from child to child.

Services that are unstructured or non-therapeutic in nature are **not** Medicaid reimbursable. Medicaid reimbursement will only be made for the treatment component of the residential rehabilitative services program.

Documentation

Medicaid reimbursement is directly related to the delivery of services. Each clinical record must contain adequate documentation to support the services rendered and billed. The record contains, at a minimum, the essential elements outlined under **Clinical Records**. Documentation of the treatment services provided to the child, the child's responsiveness to the treatment, and the interaction and involvement of the staff with the child should justify and support the services billed to Medicaid.

In order for High Management Rehabilitative Services to be billed to Medicaid for any calendar day, services must have been rendered directly to the child during that day. Medicaid should not be billed for full days in which a child is absent or away from the delivery of these services, unless the guidelines covering Medicaid reimbursement for absentee days are met (see Absentee Day Policy).

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan

Initial Treatment Plan

A treatment plan shall be developed for every child within 30 days of placement, and shall be written, signed, and dated by the LCS. 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 completed Medical Necessity Statement should be placed with the initial treatment plan.

Treatment plans must be signed and dated by clients as evidence of their participation in the planning 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.

The treatment plan shall be based on an assessment of the child's needs and should include the following: specific problems or behaviors requiring treatment, treatment goals and objectives, methods and frequency of intervention, criteria for achievement; target dates, and signatures with dates on each page.

If the client is 14 or older, the treatment plan must include independent living goals for transition.

Treatment Plan Review

Treatment plan reviews shall be conducted every 90 days to ensure services and treatment goals continue to be appropriate to the child's needs and to assess the child's progress and continued need for services. The LCS shall sign/title and date the treatment plan at each treatment plan review. The treatment plan reviews must include a written summary of the above which is signed/titled and dated by the LCS.

Treatment Plan Reformulation

The treatment plan shall be reformulated every 180 days. The reformulated treatment plan must:

- Reflect the child's current problem areas, needs, and discharge goals
- Support the continued need for High Management Rehabilitative Services, to include specific

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan (Cont'd.)

problem behaviors that need to be reduced before the client can be stepped down to a less restrictive environment

- Be signed/titled and dated by the LCS
- Never be a photocopy of a previous treatment plan

For further information, please see Individual Treatment Plan under Documentation Requirements.

Progress Summary Notes

A Progress Summary Note that summarizes the child's program participation and psychosocial/behavioral status and functioning shall be completed weekly. The LCS shall sign/title and date the Progress Summary Note as the person responsible for the provision of service. The note must be dated on, or shortly after, the last day of service for that note and must be placed in the chart within 14 days. The documentation must address, at a minimum, the following items in order to provide a pertinent clinical description and ensure that the service conforms to the service description:

- A general observation of the child's condition. This may include the child's mental status, behavior, health, and/or psychosocial skills.
- The child's activity and participation in the treatment portion of the program. This must include the child's progress on treatment goals as well as involvement in the structured program of the residential rehabilitative service and/or other appropriate activities.
- Activities of counseling staff. The involvement of the staff in service provision is required and shall be documented
- Future plans for working with the child

For further information on clinical documentation, please see Progress Summary Notes under Documentation Requirements.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

SEXUAL OFFENDER TREATMENT SERVICES (FORMERLY SPECIALIZED TREATMENT SERVICES FOR SEXUAL OFFENDERS)

Definition

The **Sexual Offender Treatment Services** program involves specialized services provided in conjunction with Medicaid-enrolled high or moderate management residential rehabilitative services. These services have trained staff and programs designed for children who exhibit sexually aggressive behavior. These children are not able to function successfully in a community environment due to their history of sexual abuse of other children/adolescents, and the potential for recurrence of sexually offending behaviors.

This specialized treatment program is designed for sexual offenders under the age of 21, and must provide the structure, supervision, and array of services necessary to treat this special population. This program must be tailored to the age, diagnosis, and background (*i.e.*, history of sexually abusive behavior) of each child being served.

In order for placement in this program to be appropriate, the child must exhibit behaviors that place them at risk. Examples of behavior exhibited by sexual offenders may include: previous victimization, sexual assault, sexual deviance, violent aggression (severe physical acting out), fire setting, or abusive acts toward animals.

There must be either:

1. A court adjudication of guilt for a sex offense

OR

2. A court adjudication of guilt on a pled-down offense that was originally a sex offense, and
3. A significant and well-documented history (*i.e.*, self report, witness testimony, treatment history, assessment) of sexual aggression supported by an independent clinical psychosexual assessment by a qualified (by training and experience) child behavioral health professional that documents the

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Definition (Cont'd.)

existence of the sexual disorder.

Those youth not adjudicated for any offense, but who meet the criteria of #3, should be reviewed by the sponsoring state agency's designated child behavioral health professional for confirmation of need and benefit of specialized residential treatment services. Placement of such youth in a sex offender treatment program should only occur with the informed consent of the legal parent/guardian.

Medical Necessity Criteria and Prior Authorization

Sexual Offender Treatment Services must be recommended by a physician or other Licensed Practitioner of the Healing Arts. The child's current problem areas and current need for services shall be appropriately documented through the practitioner's completion of a Medical Necessity Statement. Sexual Offender Treatment Services must also be pre-authorized by the designated referring agent.

The designated referring agent shall supply the treatment provider with the following at the time of admission:

- A completed Medical Necessity Statement
- A completed Referral Form/Authorization for Services (DHHS Form 254)
- A completed Sex Offender Protocol Endorsement Sheet (See Section 5)

Faxed copies are acceptable. The original forms must be provided within 10 days of admission.

Note: If a beneficiary is to receive both TBS (High/Moderate Management) **and** Sexual Offender Treatment Services, authorization for both services can be provided by just one Medical Necessity Statement and one DHHS Form 254.

Program Staff

In addition to the involvement of the Lead Clinical Staff (LCS) required by the TBS (High/Moderate Management) programs, the Sexual Offender Treatment Services program requires that a Sexual Offender Treatment Specialist (SOTS) be involved in providing and supervising the treatment services. An SOTS is an LCS who has received a minimum of 45 hours of advanced training and certification in treatment of the adolescent

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Program Staff (Cont'd.)

sexual offender. An SOTS also must receive a minimum of 20 hours per year of ongoing training in this field.

The SOTS shall meet at least weekly with LCS and Non-LCS personnel, either individually or in groups, to discuss specific cases in order to monitor the children's participation in the program. This meeting must be documented in the weekly Progress Summary Notes. The LCS and SOTS shall spend as much time on site as is necessary to ensure that children are receiving treatment services in a safe, efficient manner according to accepted standards of clinical practice.

The residential rehabilitative service provider shall maintain a credentials file on each SOTS that documents his or her qualifications and training.

Program Content

In addition to the daily group and individual therapeutic interventions and specialized behavior management techniques provided under the TBS (High/Moderate Management) programs, the provider shall also provide a Sexual Offender Treatment Services component. These services must be specialized, structured, and consistent with the diagnoses and treatment needs of this special population.

As a condition of enrollment, the residential rehabilitative services provider shall submit documentation/justification to SCDHHS describing the sexual offender treatment component offered in residential rehabilitative service that will be billed to Medicaid. Emphasis should be placed on special group therapies, individual therapies, or therapeutic programming provided, and on the involvement of the SOTS in the treatment services. These services **must** be clearly distinguishable from, and in addition to, the TBS (High/Moderate Management) to be concurrently provided by the provider.

Documentation

Individual Treatment Plan

Initial Treatment Plan

An individual treatment plan shall be developed as soon as feasible, but no later than 30 days after admission. 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

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan (Cont'd.)

Medical Necessity Statement must be placed with the initial treatment plan. The treatment plan shall be based on the criteria set forth in the Medicaid standards for TBS (High/Moderate Management).

Treatment plans must be signed and dated by clients as evidence of their participation in the planning 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.

The treatment plan shall address the various components and interventions of both the TBS (High/Moderate Management) program and the Sexual Offender Treatment Services program. The LCS and an SOTS (or a clinician who is both) must sign/title and date each treatment plan.

If the client is 14 or older, the treatment plan must also include independent living goals for transition.

Treatment Plan Reviews

Treatment plan reviews shall be conducted every 90 days to ensure that the treatment goals continue to be appropriate to the child's needs, and to assess the child's progress and continued need for both TBS (High/Moderate Management) and Sexual Offender Treatment Services. The SOTS shall complete the written summary of each 90-day treatment plan review to be included in the child's clinical record. This written summary must be signed/titled and dated on each page by the LCS and an SOTS (or a clinician who is both).

Treatment Plan Reformulation

The treatment plan shall be reformulated every 180 days. The reformulated treatment plan must:

- Reflect the child's current problem areas, needs, and discharge goals
- Support the continued need for TBS (High/Moderate Management) and Sexual Offender Treatment Services, to include specific problem behaviors that need to be reduced before the client can safely be stepped down to a less restrictive environment

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Individual Treatment Plan (Cont'd.)

- Be signed/titled and dated on each page by the LCS and SOTS (or a clinician who is both)
- Never be a photocopy of a previous treatment plan

For further information, please see Individual Treatment Plan under Documentation Requirements.

Progress Summary Notes

A Progress Summary Note documenting the provision of Sexual Offender Treatment Services must be entered in the child's clinical record each week. Weekly Progress Summary Notes shall document the child's participation in the specialized treatment program and any staffing held or treatment plan reviews conducted.

The weekly Progress Summary Notes shall meet the same documentation criteria as set forth in the Medicaid standards for TBS (High/Moderate Management) and must be signed/titled and dated by the SOTS. However, Sexual Offender Treatment Services shall be documented separately from the TBS (High/Moderate Management) weekly Progress Summary Note entry. The SOTS shall sign/title and date the Progress Summary Note as the person responsible for the provision of service. The note must be dated on or shortly after the last day of service for that note and must be placed in the chart within 14 days. Providers may not bill Medicaid for services until the Progress Summary Notes are placed in the chart.

Medicaid Reimbursement

Sexual Offender Treatment Services may only be rendered in a high or moderate management residential rehabilitative services setting having a specialized program established for this population of children. In order to be eligible to receive Medicaid reimbursement for Sexual Offender Treatment Services, the residential rehabilitative service provider must meet the criteria set forth in the Medicaid standards for both TBS (High/Moderate Management) and Sexual Offender Treatment Services.

Sexual Offender Treatment Services may be billed only for days on which this specialized service was rendered to the child. Medicaid should not be billed when a child is absent or away from the delivery of these services for a full day, unless the guidelines covering Medicaid reimbursement for absentee days are met (see Absentee Day Policy).

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

THERAPEUTIC BEHAVIORAL SERVICES (FORMERLY SUPERVISED INDEPENDENT LIVING)

Definition

Therapeutic Behavioral Services (Supervised Independent Living) (SIL) involves a range of rehabilitative services provided to adolescents ages 16 to 21. Services are designed to improve the quality of life for adolescents by assisting them to assume responsibility over their lives and to function as actively and independently in the community as possible. SIL is designed to both strengthen the adolescent's skills and develop environmental supports necessary to enable them to function independently in the community.

SIL services are restricted to adolescents who have been assessed by the referring agency as being in need of treatment services in a therapeutic environment that offers independent living skills. The service is appropriate **only** for those adolescents who have demonstrated developmental and emotional readiness based on positive behaviors, personal skills and strengths, ability to develop independence, and for those adolescents requiring a continuing level of staff involvement/supervision while learning and developing independent living skills. SIL services are intended to enable the adolescent to transition to an independent living environment while encouraging the adolescent to maintain community tenure, obtain all necessary treatment services, access services from a variety of community programs, and improve the capacity for independent living. Services are provided in the context of a supportive, non-institutional environment in the community and should be offered in a manner that maximizes the adolescent's responsibility, control, and feelings of self worth, and encourages ownership in the rehabilitation process.

SIL programs are available to adolescents ages 16 to 21 who need independent living skills provided in a structured environment. Such adolescents may be aging out of a more restrictive placement, be in need of transitional services, or be returning to DSS custody after having left the system of care at the age of majority.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Definition (Cont'd.)

Services are provided in a designated cottage on a residential group care campus or a separate group care facility in conjunction with 24-hour monitoring by staff. Staff must be available to adolescents 24 hours per day, seven days per week.

The goals of SIL are to:

1. Reduce problem areas that prevent successful independent living
2. Develop and implement an independent living plan that will identify the skills necessary to function independently and be self-sufficient
3. Develop or increase skills in stress management, decision making, problem solving, and coping
4. Develop or increase basic life skills that contribute to successful independent living
5. Reduce barriers that impede the adolescent's ability to function independently within the community or independently with non-residential supports (*e.g.,* outpatient mental health services) by creating realistic opportunities for the adolescent to practice/apply the skills listed in goals 3 and 4
6. Develop a protected living environment for the adolescent requiring long-term protected care, which promotes development of his or her maximum possible independent living skills and abilities while providing the appropriate oversight and monitoring necessary for the adolescent to succeed

Medical Necessity and Prior Authorization

SIL services must be recommended by a physician or Licensed Practitioner of the Healing Arts who will certify that the identified adolescent meets the medical necessity criteria outlined in this section. The medical necessity is documented by the completion of a Medical Necessity Statement. 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 Medical Necessity Statement must be placed with the Independent Living Plan.

SECTION 2 POLICIES AND PROCEDURES

RESIDENTIAL SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

The original form must be sent to the treatment provider within 10 days of admission to the program.

In order to be eligible for services, the identified adolescent must meet all of the following medical necessity criteria:

- Psychiatric, emotional, or behavioral problems prevent or impede the adolescent from functioning independently in the community.
- The adolescent requires SIL services in order to be able to function independently at age of majority.
- The adolescent's problems **will** require outpatient services/assistance (*e.g.,* social work, mental health, or structured recreational services) from community agencies in order to maximize his or her level of independence in adult living.

In order for a provider to receive Medicaid reimbursement, SIL services must be authorized by a designated referring agent prior to service delivery. Prior authorization is accomplished through completion of the Referral Form/ Authorization for Services (DHHS Form 254).

Program Staff

Lead Clinical Staff

Credentials

The Lead Clinical Staff (LCS) shall meet the professional standards defined by SCDHHS (see Clinical Staff). The LCS's credentials should be made available to SCDHHS upon request.

Responsibilities

SIL services shall be rendered by or under the supervision of an LCS. In the provision of SIL services, regular contact and face-to-face meetings must occur with the adolescent in order to facilitate the development of independent living skills. SIL services shall ensure appropriate involvement of an LCS in each adolescent's care. An LCS shall be involved in the supervision of the SIL services, especially in the delivery of treatment services. The LCS work hours must normally be scheduled at a time the adolescents are expected to be

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Lead Clinical Staff (Cont'd.)

awake, and the LCS must spend a portion of his or her time observing and interacting with them.

The involvement of the LCS shall include: assessing the adolescent's current strengths, problem areas, and needed independent living skills; developing an individualized Independent Living Plan; coordinating and integrating services; providing and/or supervising service delivery and confirming the necessity of treatment; and consultation with appropriate outside entities.

Consultation services can be used by the LCS to communicate treatment outcomes, progress made toward independent living, and the adolescent's readiness for transitional and discharge planning. The LCS shall be responsible for formulating appropriate discharge plans to ensure the adolescent's successful and timely discharge to independent living.

Transitional services provided to an adolescent **after discharge** from the SIL program are **not Medicaid reimbursable**. Transitional services must be reflected in the Independent Living Plan and should be developed by the treatment team to include the provider, the referring agency case manager, and the adolescent.

LCS-to-Client Ratio

The LCS caseload shall not exceed one LCS to 16 adolescents.

Supervision

The LCS's responsibilities include supervising the performance of Non-LCS, assessing the adolescent's progress in accomplishing the treatment goals and toward reaching independent living, and supervising the quality and programming of services being rendered.

Supervision of Non-LCS by the LCS shall be held a minimum of every two weeks to discuss and monitor the adolescent's treatment issues and progress. The supervision shall consist of an overview of the independent living services rendered to each adolescent, the achievement of goals, identification of new problems/needs, and any necessary changes or modifications to his or her Independent Living Plan. The supervision must be documented in the Progress Summary Notes.

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Required Contacts

In the provision of SIL services, regular contact and face-to-face meetings must occur with the adolescent in order to facilitate the development of independent living skills. The amount of contact the LCS has with the adolescent should be based on the adolescent's assessed problems and needs. The LCS or appropriate staff under direct supervision of the LCS must have daily face-to-face contact with the adolescent as well as provide 24-hour monitoring, seven days per week.

Staff-to-Client Ratio

During program hours, one LCS or Non-LCS must be available for every eight adolescents. "Available" means identified staff must be in the facility, on the program grounds, or off the program grounds but able to respond to the adolescents within ten minutes or less. Every client must know how to and be able to contact available staff at all times. Although 24-hour supervision is not required, the program should individualize supervision through a level system or individual treatment plans.

At night, one LCS or Non-LCS must be available for every ten adolescents. "Available" means identified staff must be in the facility, on the program grounds, or off the grounds but able to respond to the adolescents within ten minutes or less. If a staff member is not physically in the facility, a staff member must conduct random nightly checks. The program must maintain documentation to show that such checks were conducted.

The provider must identify specific members for the SIL program to meet the staff-to-client ratio for program hours and at night. If a provider utilizes staff from other programs (TBS High or Moderate Management, etc.) to meet the SIL staff availability requirements, staff-to-client ratios must be met in all programs at all times. On-call staff must be available for emergencies.

Admissions

Admission of the adolescent to SIL services is contingent upon his or her identified need for the service through the medical necessity criteria. Because of the nature of the SIL services, all admissions must be planned and medically necessary. "Emergency" admissions are not acceptable.

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Admissions (Cont'd.)

Ongoing assessments of the adolescent's problems/needs should be conducted by the LCS as needed. Ongoing assessments are a component of the SIL service and should not be considered a separate service.

Independent Living Assessment

After admission of the adolescent into a SIL program, the provider's LCS must complete an Independent Living Assessment (ILA) within 30 days. The ILA must be completed before the treatment plan is developed, and it must include the name and birth date of the adolescent.

The ILA must be written, signed, and dated by the LCS. The adolescent must be given the opportunity and encouragement to participate in the assessment process unless there are documented reasons why his or her participation is not possible. If the adolescent does not participate in the ILA process, an explanation must be included in the adolescent's record.

The ILA must include an assessment by the LCS defining the adolescent's need for independent living services to include whether he or she feels the adolescent displays adequate self-control, ability, and judgment skills in most situations. Specific elements of this assessment must include all of the following:

- A description of the adolescent's strengths and needs, including issues that may impede the adolescent's ability to live and function independently
- A description of the adolescent's cognitive abilities and his or her emotional and psychological stability
- A description of the adolescent's education history and current status
- A list of both the independent living skills the adolescent has and those that need to be developed (including but not limited to money management, coping skills, dealing with authority figures, and personal hygiene)
- A description of the adolescent's previous placement history to include dates of placement and reasons for discharge

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Independent Living Assessment (Cont'd.)

- A description of the adolescent's communication skills to include telephone, written, and verbal
- A description of the adolescent's involvement with his or her family to include the effect this has on the adolescent
- A description of the adolescent's commitment to learning independent living skills and his or her participation in their future planning

Independent Living Plans

An Independent Living Plan (ILP) must be based on the ILA and must be developed with the adolescent within 30 days of the date SIL services are initiated. If an ILP 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 ILP must be written, signed/titled, and dated on each page by the LCS and the adolescent. The completed Medicaid Necessity Statement and ILA must be placed with the initial ILP.

Independent Living Plan Development

The written ILP must be developed mutually and signed by the adolescent and the LCS. The designated referring agent is encouraged to participate in the development of the plan. The ILP shall address the following:

1. Specific problems or behaviors requiring SIL services. This information must be based on the adolescent's assessed strengths, problems, and/or needs as outlined in the ILA.
2. Long- and short-term treatment goals that are based on the adolescent's current level of functioning and desired outcome. Goals shall be realistic, individualized and relate to the adolescent's problems/needs, especially basic life skills needed to maximize his or her potential for successful independent living. At least one treatment goal must pertain to education or employment.
3. Methods and frequencies of intervention
4. Transitional/discharge criteria, which should include transitional/discharge plans and the related time frames for the adolescent living independently

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Independent Living Plan Reviews

The ILP shall be reviewed a minimum of every 90 days. The review(s) help to ensure services and treatment goals continue to be appropriate to the adolescent's needs and to assess the treatment progress and continued need for services. The LCS and the adolescent shall sign and date each page of the ILP at each review.

Independent Living Plan Redevelopment

The ILP must be redeveloped every 180 days. The LCS and the adolescent shall develop, sign, and date each page of the re-developed ILP.

Program Content

SIL services shall be provided for each adolescent based on his or her assessed needs. The purpose of SIL is to provide treatment, strengthen the adolescent's skills, and develop environmental supports necessary to enable him or her to function independently within the community. A SIL program must include and be able to provide all components in the service content array. The LCS shall render the appropriate components within the array of services to the adolescent depending on his or her assessed needs; the provision of only one component (continually) to an adolescent does not constitute the full array of SIL services. **In order to be Medicaid reimbursable,** SIL services must include, at a minimum, the following components:

Assessment

Assessment Services

Assessments must include but not be limited to the evaluation of possible life options and goals as well as the development of plans to achieve those goals. Assessments should take into account the adolescent's developmental readiness and stages of independence, not his or her chronological age. Ongoing assessments of the adolescent's problems/needs should be conducted by the LCS as needed.

Treatment

Counseling/Therapy Services

Counseling/therapy involves face-to-face, goal-oriented interventions between the adolescent and LCS. The services must be therapeutic and supportive and used to assist the adolescent to solve identified problems or to remove psychological, emotional, and behavioral barriers to living independently. These services shall teach

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RESIDENTIAL SERVICES

Treatment (Cont'd.)

interpersonal conflict resolution, and reinforce learned skills. Counseling/therapy services effect personal standards, reality orientation, self-concept development, stress reduction, and coping skills. Counseling/therapy services shall occur, at a minimum, one time per week. Documentation of the counseling/therapy shall be included in the adolescent's Progress Summary Notes.

Rehabilitative Psychosocial Therapy

These services provide structured, goal-directed, therapeutic activities designed to improve the adolescent's level of functioning. This component is designed to facilitate therapeutic interaction between staff, adolescents, and peers as well as to provide the adolescent with reality orientation, minimize self-involvement, and improve concentration. The rehabilitative psychosocial therapy must meet the following requirements:

- The therapy must be structured, goal-directed, and designed to improve the adolescent's level of functioning.
- Rehabilitative psychosocial therapy shall take place, at a minimum, once per week.

Documentation of the rehabilitative psychosocial therapy shall be included in the adolescent's progress notes.

Case Management/Linkage and Transportation

These services are aimed at providing the support and assistance needed for the adolescent to acquire the educational and/or vocational skills to live independently. Some examples include linking the adolescent with a vocational skills program, transporting him or her to a job in the community, or assisting with the financial aid process so the adolescent can pursue his or her educational goals.

Skill Development

These services are aimed at enhancing the adolescent's ability to develop and demonstrate skills necessary to live independently. These services should focus on reducing psychological, emotional, and behavioral barriers to skill development in activities of daily living. These services can be provided in group or individual sessions based on the needs of the individual adolescent. Skill development

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Treatment (Cont'd.)

services include but are not limited to both Abstract and Concrete Skills. Based on the results of the ILA, skill development should be provided in the following areas:

- **Abstract Skills** may include: stress management; dealing with authority figures; developing daily living skills; personal decision-making; family planning issues; problem solving; and understanding and coping appropriately with anger, loss, and rejections, including circumstances that led to out-of-home care.
- **Concrete Skills** may include: personal hygiene and grooming; effective management of living space, including housekeeping, meal preparation, retail purchasing, shopping, and laundry; developing the skills necessary to secure gainful employment and/or self-sufficiency; managing money within income limits; using community resources such as transportation, social services, medical services, etc; and locating, financing, and maintaining decent, safe, and affordable living arrangements.

Structured System

The program uses a structured system that illustrates how adolescents progress through the program and acquire skills needed for independent living.

Community Services

Community Services are planned and appropriately utilized for assessment, direct service, consultation, and/or crisis intervention, as needed.

Documentation

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

A case record will be established by the program for each identified adolescent. The record contains, at a minimum, the essential elements outlined under **Clinical Records**.

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Documentation (Cont'd.)

The SIL record will also contain the ILA, the ILP, and other pertinent clinical information.

In order for SIL to be reimbursed by Medicaid for any calendar day, services must have been rendered directly to the adolescent during that day. Medicaid should not be billed for full days in which the adolescent is absent or away from the delivery of these services, unless the guidelines covering Medicaid reimbursement for absentee days are met (see Absentee Day Policy).

Progress Summary Notes

SIL services must be documented weekly in the Progress Summary Notes. The LCS shall sign/title and date the Progress Summary Note as the person responsible for the provision of service. The note must be dated on or shortly after the last day of service for that note and must be placed in the chart within 14 days. Providers may not bill Medicaid for services before the Progress Summary Notes are placed in the chart. Progress on the adolescent's ILP should be monitored and recorded through written weekly progress notes.

The Progress Summary Notes must contain, at a minimum, **all** of the following information in order to provide a pertinent clinical description, assure that services conform to the service description, and support and justify the amount of time billed to Medicaid:

- A description of the treatment services provided to the adolescent
- The adolescent's response to services
- The LCS's interaction and involvement, supervision results, and future plans for working with the adolescent
- Documentation of the counseling/therapy received by the adolescent
- Documentation of the rehabilitative psychosocial therapy received by the adolescent