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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

COMMUNITY MENTAL HEALTH SERVICES OVERVIEW

The purpose of this manual is to provide pertinent information to community mental health service providers for successful participation in the South Carolina Medicaid program. This manual provides a comprehensive overview of the program, standards, policies and procedures for Medicaid compliance. Updates and revisions to this manual will be made by the South Carolina Department of Health and Human Services (DHHS) and will be made in writing to all providers.

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

Community mental health service providers shall provide clinic and rehabilitative services as defined in federal regulations 42 CFR 440.90 and 440.130.d., respectively. This section describes these services, legal authorities, and the characteristics of the providers of services.

Community mental health services are provided to adults and children diagnosed with a mental illness as defined by the current edition of the Diagnostic Statistical Manual (DSM).

Clinic Services

Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that meet **all** of the following criteria:

- Services provided to outpatients
- Services provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients
- Services furnished by or under the direction of a physician

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Rehabilitative Services

Rehabilitative services include any medical or remedial services recommended by a physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under state law for the maximum reduction of physical or mental disability and the restoration of clients to their best possible functional level.

General Definitions

- **DHHS –** South Carolina Department of Health and Human Services
- **DMH** – South Carolina Department of Mental Health
- **DSM** – Current edition of the Diagnostic and Statistical Manual of Mental Disorders
- **ICF/MR** – Intermediate Care Facility for People with Mental Retardation
- **IMD** – Institutions for Mental Diseases
- **MUSC** – Medical University of South Carolina
- **SNF** – Skilled Nursing Facility
- **Client** – Any Medicaid beneficiary who is receiving services from the service provider
- **Community Mental Health Center (CMHC)** – A free-standing facility of the Department of Mental Health or Medical University of South Carolina having as its primary function the diagnosis, treatment, counseling, and/or rehabilitation involving mental, emotional, and behavioral problems, disturbances or dysfunction (Services are provided to clients on an outpatient basis.)
- **Collaterals** – Persons who are significant others or members of the client's family or household, academic or workplace setting who regularly interact with clients and are directly affected by, or have the capability of affecting, their conditions and are identified in the client's Plan of Care (POC) as having a role in treatment and/or are identified as being necessary for participation in the evaluation and assessment of the client prior to admission
- **Contact –** A face-to-face interaction between a staff member and a client or collateral

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PHYSICIAN DIRECTION AND SUPERVISION FOR CLINIC SERVICES

Clinic services require that services be provided to clients under the direction of a physician, whether or not the clinic itself is administered by the physician. That is, the physician must at least be affiliated with the clinic in accordance with Section 1908(a) of Title XIX of the Social Security Act.

Although the physician does not have to be on the premises when his or her client is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate and that clients are getting services in a safe, efficient manner in accordance with accepted standards of medical practice.

PHYSICIAN RESPONSIBILITIES

To comply with the above requirements, the physician/psychiatrist must see all Medicaid clients within the first 90 days from the date of admission to a Community Mental Health Center (CMHC) or earlier, based on the individual client's needs. Physicians should prescribe the type of care to be provided and periodically review the need for continued care.

Physicians must include a properly completed Physician Medical Order (PMO) form in the medical record to confirm the initial contact with the client.

The physician/psychiatrist's signature is required on the client's Plan of Care (POC) to confirm diagnosis, medical necessity of the treatment, the appropriateness of care, and authorization of all services that are required to be listed on the POC. Refer to the heading "Plan of Care (POC)" in this section of the manual for more detail.

The physician/psychiatrist must evaluate all clients' needs for continued service at least once every 12 months. This evaluation will be confirmed by the physician/psychiatrist's signature and date on the POC.

Exception: For services rendered to children in School-Based, Family Preservation and Truancy Diversion programs, the physician/psychiatrist must see the child whenever a clear indication of need exists after the staff

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PHYSICIAN RESPONSIBILITIES (CONT'D.)

involved in treating the child has reviewed the POC. The physician/psychiatrist is continually required to review and sign each child's POC no later than nine months from the date of admission to the CMHC. If the child continues to need treatment nine months after the date of admission, the child is required to see a physician/psychiatrist.

STAFF-TO-CLIENT RATIO

Staff-to-client ratios must be met and maintained at all times during hours of operation. Ratios must be maintained in accordance with each individual service standard. Staff involved in the treatment delivery must have direct contact with clients; staff present but not involved in the treatment delivery cannot be included in the ratio.

If at any time during the delivery of a service, the staff-to-client ratio is not in accordance with the service standard, billing for clients in excess of the required ratio should be discontinued. Appropriately credentialed staff must be substituted or group sizes must be adjusted to meet the service standard requirements before billing may resume.

MEDICAL NECESSITY

All services are required to meet medical necessity. A service is medically necessary when it meets **all** of the following conditions:

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

COORDINATION OF CARE

Coordination of care must occur for clients who are being served by multiple agencies/providers. During the intake process, each provider is responsible for attempting to identify whether a client is already receiving treatment from another Medicaid provider and notifying any other involved Medicaid providers of the client's need for

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COORDINATION OF CARE (CONT'D.)

services. Needed services should never be denied to an individual because another provider has been identified as the service provider. Each provider should also notify other involved agencies or providers immediately if an individual in an overlapping situation discontinues his or her services.

OUT-OF-HOME PLACEMENT SERVICES

Some children in out-of-home placements have specific treatment needs that cannot be adequately addressed by the out-of-home placement provider's staff. If a child requires therapeutic interventions beyond the clinical scope of the out-of-home placement providers' treatment capacity, the out-of-home placement provider may seek the services of an outside provider.

Community mental health service providers may provide services to children of which there is no duplication of services with the out-of-home placement provider. Community mental health services may provide the following services where there is clearly no duplication of services: Psychiatric Medical Assessment, Injectable Medication Administration, and Nursing Services.

Since there is no way to address all of the possibilities that may arise, each situation must be judged on its own merit. Those most clinically knowledgeable of the child's treatment needs and/or direct care staff, as well as the Case Manager from the state agency that placed the child, should discern the appropriateness for the need of an outside provider. Emergency situations do not require approval from the child-placing agency.

Services must be documented in the child's clinical record, in accordance with the requirements of this manual, and must clearly show no duplication of services.

It is NEVER appropriate for an out-of-home placement provider to seek the service of an outside provider to replace his or her required treatment services.

Regardless of the special needs of any one child, it is inappropriate for the out-of-home placement provider to rely on an outside provider to render most or all of the treatment service to any child.

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PROVIDER QUALIFICATIONS

The community mental health service provider may bill for only those services rendered by clinical staff who hold the credentials required by each covered, billable service. The community mental health service provider is responsible for the appropriate billing for services administered by staff members who possess the credentials required by each covered, billable service.

The CMHC shall have a credentials folder on file for each clinician that includes **all** of the following:

- Curriculum vitae or resume
- Copy of diploma or transcripts representing the highest degree attained
- Copy of licenses or certification, including current renewals or required training

Each community mental health service provider shall also maintain a file that lists the clinical staff, their professional titles, and the services each staff member is privileged to render.

General Staff Requirements

The following information describes the credentialing requirements for staff delivering services in community mental health service programs. Prior to delivery of services, each staff member should be appropriately credentialed and privileged by the authorizing community mental health service provider. Each community mental health center shall adhere to the standards of qualification of service provider credentials as defined below.

Mental Health Professionals (MHP)

Community mental health services must be rendered by, or under the supervision of, a Mental Health Professional (MHP) as outlined in the individual service standard. The following are considered to be MHPs:

- A **Psychiatrist** must be a licensed Doctor of Medicine or Doctor of Osteopathy who has completed a residency in psychiatry and who is licensed to practice medicine in South Carolina.
- A **Psychiatric Nurse** must be a registered nurse licensed in South Carolina with a minimum of one year of experience in the mental health field.
- A **Physician** must be licensed to practice medicine in South Carolina.

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Mental Health Professionals (MHP) (Cont'd.)

- A **Nurse Practitioner** or **Advanced Practice Registered Nurse** must be a registered nurse, licensed in South Carolina, with a minimum of a master's degree in nursing.
- A **Psychologist** must possess a doctoral degree from an accredited university or college, and be licensed in the state of South Carolina in the clinical, school, or counseling areas.
- A **Social Worker** must possess a master's degree in social work from an accredited university or college and be licensed by the State Board of Social Work Examiners.
- A **Clinical Chaplain** must possess a Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister, or rabbi and one year of Clinical Pastoral Education that includes a provision for supervised clinical services.
- A **Mental Health Counselor (MHC)** must possess a master's or doctoral degree from a program that is primarily psychological in nature from an accredited university or college (*e.g.*, counseling, guidance, or social science equivalent).
- A **Mental Health Professional with a Master's Equivalent** must possess a master's degree in a closely related field that is applicable to the bio-psycho-social treatment of the mentally ill. Alternatively, they may possess a master's degree in a reasonably related field that is augmented by graduate courses and experience in that field. Also included in this category are those appropriate Ph.D. candidates who have bypassed the master's degree but have more than enough hours to satisfy a master's requirement.

Non-Mental Health Professionals (Non-MHP)

Non-Mental Health Professionals (Non-MHPs) must possess a bachelor's degree in psychology, social work, or a related field from an accredited university or college; or must have three years direct care experience in a health care setting for the chronically mentally ill. They must also have completed a training program as specified by the authorizing community mental health service provider.

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PROGRAM REQUIREMENTS

Targeted Case Manager

A Targeted Case Manager must possess, at a minimum, a Ph.D.; Master of Social Work (MSW) degree; master's degree in psychology, counseling, or a closely related field; or a bachelor's degree in the above mentioned fields; or be licensed as a registered nurse.

Targeted Case Manager Assistant

A Targeted Case Manager Assistant must possess a high school diploma or GED; and skills/competencies sufficient to perform assigned tasks, or the capacity to acquire those skills/competencies.

Peer Support Specialist

A Peer Support Specialist must possess, at a minimum, a high school degree or GED equivalent, and complete and pass a certification-training program approved by DHHS. He or she must also be a current or former consumer of services as defined by the authorizing CMH service provider and meet at least one of the following criteria:

- Have had a serious mental illness which meets the federal definition and received treatment for it
- Self-identify as a current or former consumer
- Self-identify as having had a serious mental illness, as well as a substance use disorder and be in dual recovery

The Peer Support Specialist will also have the following experiences and abilities:

- The ability to demonstrate recovery expertise including knowledge of approaches to support others in recovery and dual recovery, as well as the ability to demonstrate his or her own efforts at self-directed recovery; and/or
- One year of active participation in a local or national mental health consumer movement, which is evidenced by previous volunteer or work experience

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

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Lead Clinical Staff (LCS)

Community-Based Wrap Around Services (WRAPS) and/or Mental Health Services Not Otherwise Specified (MHS-NOS) must be rendered by a 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 these services. The LCS must spend as much time as is necessary to ensure that children are receiving services according to accepted standards of clinical practice in a safe, efficient manner.

Each provider of WRAPS and/or MHS-NOS shall maintain a credentials file for each LCS member substantiating that they meet the required qualifications. This shall include employer verification of the LCS member's credentials and work experience. The treatment provider must maintain a signature sheet, which identifies all LCS member's names, signatures, and initials. Individuals wishing to be designated in one of the categories requiring a professional license must be licensed to practice in the state in which they are employed.

Individuals wishing to be designated as LCS must be able to document experience working with the population to be served. "Experience working with the population to be served" is defined as direct work experience with the type of children served at 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). DHHS defines a "year of experience" 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 list describes professionals qualified to serve as an LCS:

- **Physician:** A Doctor of Medicine currently licensed by the appropriate State Board of Medical Examiners who has one year of experience working with the population to be served

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PROGRAM REQUIREMENTS

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

- **Psychiatrist:** A licensed Medical Doctor who has completed residency in psychiatry and who has a minimum of one year of experience working with the population to be served
- **Psychologist:** A holder of a doctoral degree in psychology from an accredited university or college who is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling area with a minimum of one year of experience working with the population that is to be served
- **Registered Nurse:** 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
- **Mental Health Counselor:** A holder of 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) with a minimum of one year of experience working with the population that is to be served
- **Social Worker:** A holder of a master's degree from an accredited university or college and licensed by the State Board of Social Work Examiners who has a minimum of one year of experience working with the population that is to be served
- **Mental Health Professional Master's Equivalent:** A holder of a master's degree in a closely related field that is applicable to the bio/psycho/social sciences or to the treatment of the mentally ill; or a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirements; or a professional who is credentialed as a Licensed Professional Counselor with a minimum of one year of experience working with the population that is to be served

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

- **Clinical Chaplain:** A holder of a Master of Divinity degree from an accredited theological seminary with one year of Clinical Pastoral Education that includes provision of supervised clinical services and a minimum of one year of experience working with the population that is to be served
- **Child Service Professional:** A holder of a bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development, or a related field; which includes, but is not limited to, criminal justice, rehabilitative counseling, and elementary or secondary education; or a bachelor's degree in another field with 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 of the above disciplines

  A minimum of three years of experience working with the population that is to be served is required for the Child Service Professional.
- **Licensed Baccalaureate Social Worker:** A holder of a bachelor's degree from an accredited university or college who is 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
- **Certified Addictions Counselor** A holder of a bachelor's degree from an accredited university or college who is credentialed by the Certification Commission of the South Carolina Association of Alcoholism and Drug Abuse Counselors, the NAADAC – The Association for Addiction 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 that is to be served

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

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

All LCS and Non-LCS who are providers of WRAPS and/or MHS-NOS must show documentation of 40 hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems before rendering services.

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DOCUMENTATION REQUIREMENTS

MEDICAL RECORDS

Each client shall have a medical record that includes sufficient documentation to justify Medicaid participation and permit a clinician not familiar with the client to evaluate the course of treatment.

The client's medical record should contain the following:

- A written comprehensive bio-psychosocial examination or initial clinical assessment conducted by an MHP
- A Psychiatric Medical Assessment
- All plans of care, reviews, and addenda
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered)
- Clinical Service Notes
- Copies of any testing performed on the client
- Copies of all written reports
- Consents and eligibility information, and any other documents relevant to the care and treatment of the client

The medical record must be arranged in a logical order to facilitate the review, copy, and audit of the clinical information and course of treatment.

Medical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and safeguarded as outlined in Section 1.

CONSENT TO EXAMINATIONS AND TREATMENT

A "Consent to Examinations and Treatment" form [hereinafter referenced as "Consent form"], dated and signed by the client or representative, must be obtained at the onset of treatment from all clients except in the circumstances indicated below.

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DOCUMENTATION REQUIREMENTS

CONSENT TO EXAMINATIONS AND TREATMENT (CONT'D.)

If the client cannot sign the Consent form due to a crisis, and is accompanied by a next of kin or responsible party, that individual may sign the Consent form. If the client is alone and unable to sign, a statement such as "client unable to sign and requires emergency treatment" should be noted on the Consent form and must be signed by the physician or MHP and one other staff member. The client should sign the Consent form as soon as circumstances permit.

A new Consent form should be signed and dated each time a client is readmitted to the system after discharge.

Consent forms are not necessary to conduct designated examinations ordered by probate court. However, a copy of the probate court order must be kept in the medical record.

ABBREVIATIONS AND SYMBOLS

Community mental health service abbreviations on the Plan of Care (POC) and/or Clinical Service Notes (CSNs) must use only the approved abbreviation for services. Approved abbreviations for services can be found in the "Medicaid Billable Services" chart in Section 4 of this manual. Service providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation.

LEGIBILITY

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

Original legible signature and credential (*e.g.*, Registered Nurse) or functional title (*e.g.*, MHP) of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service and/or co-signature, when required, are not acceptable.

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ERROR CORRECTION

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

- Draw one line through the error, and write "error," "ER," "mistaken entry," or "ME" to the side of the error in parenthesis. Enter the correction, sign or initial, and date it.
- Errors cannot be totally marked through; the information in error must remain legible.
- No correction fluid may be used.

LATE ENTRIES

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

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

RECORD RETENTION

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

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

INITIAL CLINICAL ASSESSMENT

An MHP shall perform an initial clinical assessment or comprehensive bio-psychosocial examination for each client at the onset of treatment.

Initial Clinical Assessments or bio-psychosocial examinations are provided to evaluate a client's mental condition, establish medical necessity, and, based on their diagnosis, determine the appropriate treatment. The initial assessment or comprehensive bio-psychosocial examination must be completed within the first three non-emergency visits and shall include, at least, the following areas:

- Presenting problem/history
- Psychiatric history/care
- Integrated Substance Abuse Disorder Assessment (as appropriate)
- Medical history/care/current medications
- Personal history/developmental/family/social/ occupational
- Mental status examination
- Diagnosis

PLAN OF CARE (POC)

The Plan of Care (POC) is an individualized comprehensive plan of care to improve the client's condition developed in collaboration with a client and/or significant other(s).

POC Due Date

The initial POC must be formulated, signed, and dated by the MHP and the reviewing physician within 90 calendar days from the day a client enters services at the mental health center.

For beneficiaries receiving retroactive coverage, and for whom a PMA has not been rendered during a retroactively covered period, the PMA must occur within 90 days from the date that a client is determined Medicaid eligible. The initial POC must be developed, signed, and dated by the MHP and reviewing physician/psychiatrist within 90 calendar days from the day the client becomes retroactively eligible. A note indicating the date the client became retroactively eligible should be placed in the medical record.

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DOCUMENTATION REQUIREMENTS

Duration of the POC

The maximum duration of a POC is 12 months from the date of the physician/psychiatrist's signature on the POC. If the POC is reformulated prior to its expiration, the maximum duration is 12 months from the reviewing physician's signature.

POC Requirements

The POC must be in writing or print and include the following:

1. The client's name and Medicaid ID number
2. The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the Diagnostic Statistical Manual (DSM)

   For individuals who have more than one diagnosis regarding mental health, substance use, and/or medical conditions, all diagnoses should be recorded.
3. Justification for treatment, frequency of services, and continuation of treatment statement based on the diagnosis and needs of the client

   For individuals who have concurrent substance abuse disorders, the other diagnoses should be integrated into the POC. A list of specific goals and objectives, and as appropriate, interventions coordinated with substance abuse service providers, should also be included.
4. Authorized treatment process including the following:
   - Goals (stated by the client as possible) that are relevant to treatment
   - Objectives that are outcome oriented and individualized
   - Clinical interventions that are appropriate to achieve the objectives
   - Services necessary to meet each objective

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

POC Requirements (Cont'd.)

- The appropriate frequency of the services that are required in the POC

  The frequency of services must be listed on the POC. Each service should be listed by its name or approved abbreviation with either a planned frequency or, if allowable, PRN (as necessary for client needs). Services cannot be listed as both. Services which may be listed as PRN are PMA, MH Assessment by Non-Physician, Injectable Medication Administration, Nursing Services, Crisis Intervention Services, Peer Support Services, MH Service Plan Development by Non-Physician, Targeted Case Management, and WRAPS.

- Expected dates to meet each objective, which should not exceed the duration of the POC
- The type of staff who will be rendering the service and professional title (MD, MHP, RN, etc.)

5. Client signature (if the client refuses to sign the POC, document the reason the client did not want to sign it.)

6. The signature(s) and title(s) of the MHP that developed the POC

7. The physician/psychiatrist's signature and date is required to confirm the medical necessity and appropriateness of care.

Services Required to be Listed on the POC

The following services must be listed in the POC to receive reimbursement:

- Behavioral Health Day Treatment
- Behavioral Health Prevention Education
- Community-Based Wraparound Services
- Comprehensive Community Support Service
- Crisis Intervention MHS
- Family Therapy
- Group Therapy
- Individual Therapy

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Services Required to be Listed on the POC (Cont'd.)

- Mental Health Services NOS
- Peer Support Service
- Psychosocial Rehabilitation Services
- Skills Training and Development

The following services may be listed in the POC, but are not required. However, when a combination of these services are to be provided due to the medical needs of a client it is recommended that these services be included on the POC to maintain the integrity of the plan of care.

- Targeted Case Management (TCM)
- Injectable Medication Administration
- MH Assessment by Non-Physician
- Psychiatric Medical Assessment
- Crisis Intervention Services
- MH Service Plan Development by Non-Physician
- Nursing Services

POC Additions or Changes

Services added or frequencies of services changed in an existing POC must be signed or initialed and dated by the reviewing physician except for WRAPS and MHS-NOS, which can be authorized by either the physician or a Licensed Practitioner of the Healing Arts (LPHA). Clients are not required to have face-to-face contact with physicians/psychiatrists for the addition of services or changes in service frequency. All additions to the POC should be listed in chronological order.

When additions or changes are authorized without face-to-face contact with the physician, the contact should be documented in the record and should be signed and/or initialed by the physician immediately upon return. Should the service be provided before the physician signature is obtained, the record must contain a CSN justifying the change.

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Addendum POC/Goal Sheet

An addendum POC and/or Goal Sheet, used in conjunction with an existing POC if the space is insufficient on the current POC, must be labeled "Addendum POC" or "Addendum Goal Sheet" and must be attached to the existing POC. The addendum must include the signature and title of the MHP who formulated the addendum(s), and the date it was formulated. The addendum(s) must also be signed by the reviewing physician. In order to avoid duplication or repeating unchanged information from the original POC, the addendum can state, "see POC of [appropriate date]."

Progress Summaries

Progress summaries are periodic reviews to evaluate a client's progress toward the treatment objectives, appropriateness of the services being furnished and need for the client's continued participation in the community mental health service program. A review of the client's participation in all services will be conducted at least every 90 calendar days from the date clients begin receiving services and must be summarized by the MHP and documented in the POC Progress Summary Report. The MHP will review the following areas:

- The client's progress toward treatment objectives and goals
- The appropriateness of the services provided and their frequency
- The need for continued treatment
- Recommendations for continued services

POC Review

Upon termination of the treatment period, the MHP must review the POC, preferably with the client, and evaluate the client's progress in reference to each of the treatment objectives. The clinician should also assess the need for continued services and the specific services needed based on the progress of the client. Newly recommended services will either be added to the existing POC, or a new POC can be developed that includes needed services.

The POC must include the signature and title of the MHP, and the date when the review was completed.

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Continued Treatment

In situations where it appears necessary to continue treatment beyond the initially authorized duration, the POC can be reviewed up to 30 days prior to its expiration date without altering the due date of the initial POC. The physician must sign and date the POC, and then state an effective date, which is presumably consistent with the current POC expiration date. Failure to list an effective date will result in the POC expiring six (6) months from the physician's signature date. At this time, the MHP should meet with the client to discuss the continuation of treatment and make the necessary changes on the POC.

Physician Signature on the POC

For services to be eligible for Medicaid reimbursement, the POC must be signed by the reviewing physician within 90 calendar days of a client's admission to the Community Mental Health Center (CMHC).

The physician must sign a continued POC immediately after the MHP reviews it and prior to any delivery of services. This is crucial when the POC is not reviewed until its expiration date.

Clinical Service Note (CSN)

All community mental health services provided to Medicaid beneficiaries shall be documented on a CSN. PMA services rendered by a physician/psychiatrist may be documented on a Physician's Medical Order (PMO). Each service should be documented on a separate CSN or PMO. CSNs and PMOs must also be typed or handwritten using only black or blue ink, legible, and filed in chronological order. Additionally, CSNs must be dated, legibly signed, and include professional titles of appropriately credentialed staff. CSNs should be completed immediately after the delivery of a service.

Only approved abbreviations and symbols may be used in the clinical documentation. An Abbreviation Key must be maintained to support use of abbreviations and symbols in entries.

The CSN must reflect the following:

- Delivery of specific billable services as identified on the POC
- Documentation that services correspond to billing in type, amount, duration, and date
- A pertinent clinical description of the service

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

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

- The date and actual time the service was rendered
- A signature, with the name and title, of the appropriate service provider
- The duration of the service rendered

When two or more staff members write on the same CSN, the individual responsible for that segment must sign each entry.

Generic Notes

Generic notes may be used as an extension of the CSN. These notes should be filed adjacent to the corresponding CSN and kept in chronological order. It is preferable that generic notes be used rather than writing on the back of the CSN to prevent destruction of critical information concerning a client.

Referenced Information

Additional information, for example test results and interview information that is located within the medical record, must be referenced on the CSN, and the CSN should clearly identify where this information can be located.

When a physician/psychiatrist renders services to clients, the documentation on the CSN should reference the PMO.

Availability of Clinical Documentation

A CSN or PMO should be completed and placed in the medical record immediately after the delivery of a service. If this is not possible due to the nature of the service, the CSN must be placed in the medical record no later than three working days from the date of the service, unless otherwise indicated in the service standard. Weekly CSNs must be in the medical record within five working days from the date of the last service on the indicated week.

If a CSN or PMO is dictated, the transcription must occur within one working day from the date of the service. The note must be placed in the medical record no later than five working days from the date the service was provided.

CSN Billing Information

The following billing information should be included in the documentation:

- The specific service that was rendered or its approved abbreviation
- The date, start time, and bill time that the service

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

CSN Billing Information (Cont'd.)

was rendered (Bill time is defined as time spent face-to-face with clients providing direct care.)

- The signature and title of the clinician who renders the service
- The place of service as appropriate for the particular service provided

  See the "Billable Places of Service" heading for each service under "Program Services" in this manual section. The following list provides the codes most commonly used:

  - 11 – Doctor's Office
  - 12 – Client's Home
  - 21 – Inpatient Hospital
  - 22 – Outpatient Hospital
  - 23 – Emergency Room
  - 51 – Inpatient Psychiatric Facility
  - 53 – Community Mental Health Center (CMHC)
  - 99 – Other Unlisted Facility

For billing purposes, services provided in the client's natural/community environment, school, Community Residential Care Facility, nursing facility, other approved community mental health facility, or other allowable places of service will use the place of service code 99 - Other Unlisted Facility.

Clinical Documentation on the CSN

The documentation of services must provide a pertinent clinical description, assure that the service conforms to the service description, and authenticate the charges.

The documentation of the CSNs should include the information outlined in the next two subsections of this manual, with the exception of the following services:

- Psychiatric Medical Assessment (PMA)
- Injectable Medication Administration
- Crisis Intervention
- MH Assessment
- MH Service Plan Development by Non-Physician

SECTION 2 POLICIES AND PROCEDURES

DOCUMENTATION REQUIREMENTS

Clinical Documentation on the CSN (Cont'd.)

- Targeted Case Management (TCM)

The content of the CSNs for the excepted services is detailed under their individual service descriptions.

Content of Individual Intervention Notes

This format applies to all one-to-one interventions, whether therapeutic or rehabilitative in nature. Individual Intervention notes should include the following:

- The focus or reason for the session/intervention (This should be related to a treatment objective or goal listed on the POC.)
- The intervention(s) provided by the clinician
- The response of the client to the clinician's intervention(s)
- The results of tests or measurements, if applicable
- The general progress and status of the client in reference to the treatment goals and objectives
- The plan for the next session

For individuals with co-occurring disorders receiving billable mental health interventions for a mental health diagnosis, attention to the substance use disorders or other medical disorders should be documented on the CSN using the criteria listed above. This is in addition to the documentation relating to the mental health diagnosis.

Content of Group Intervention Notes

This format applies to all group interventions, whether the group is therapeutic or rehabilitative in nature. Group Intervention notes should include:

- The focus or objective of the session (This should be related to a treatment objective listed on the POC.)
- The activities in which the client participated (Rehabilitative group activities should reflect the activities listed in the specific service descriptions.)
- The individualized response of the client to the interventions
- The progress of the client in reference to the treatment objectives and goals as stated on the POC
- The plan for the next session(s)

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

Medicaid community mental health services are billed in units of 15, 30, 60 minutes, or daily, depending on the service. Units billed must be substantiated by the clinical documentation.

Each procedure code has a unit time and maximum frequency limit. All services must be billed in units, not to exceed the maximum number of units allowed per day. A billable unit of time is defined in increments of 15, 30, or 60 minutes of service time with an eligible client. Service time is defined as the actual time the service provider spends "face-to-face" with clients and/or time spent working on behalf of clients while providing a community mental health service. Service time does not include any "non-billable" activities, to include preparation time, and travel time. The heading "Non-Billable Medicaid Activities" below outlines additional activities that fall under this category.

Service time must be converted to units and the total number of units is required to be submitted on the claim form. In all instances, service documentation must justify the number of units billed. See the "Documentation" heading in this manual section.

In some cases, service time may exceed the allowable billing time. For billing purposes, only the converted bill time (total number of units) is required on the documentation, up to the maximum number of units allowed per day.

A unit of TCM is 15 minutes. With an adequate audit trail, all TCM service delivery contacts occurring on the same day may be combined until a full unit is reached.

NON-BILLABLE MEDICAID ACTIVITIES

The following is a list of activities that are not Medicaid-reimbursable under the Community Mental Health Service Program guidelines. Professional judgment should be exercised in distinguishing between billable and non-billable activities. This list is not exhaustive, but serves as a guide to non-billable activities.

- Travel time
- Attempted phone calls, home visits, and face-to-face contacts
- Record audits

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Completion of any specially requested information regarding clients from the state office or from other agencies for administrative purposes
- Recreation or socialization with a client
- Documentation of service notes
- Completion of Management Information System (MIS) reports and monthly statistical reports
- Unstructured client time (Inactivity, free, and unstructured time may be necessary for a client, but is not part of a billable service.)
- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (GED, Adult Development), or tutorial services in relation to a defined education course
- Education interventions that do not include individual process interactions
- Filing and mailing of reports
- Medicaid eligibility determinations and re-determinations
- Medicaid intake processing
- Prior authorization for Medicaid services
- Required Medicaid utilization review
- Early and Periodic Diagnostic Screening and Treatment (EPDST) administration
- "Outreach" activities in which an agency or a provider attempts to contact potential Medicaid recipients
- Participation in job interviews
- The on-site instruction of specific employment tasks
- Staff supervision of actual employment services
- Assisting clients in obtaining job placements
- Assisting clients in filling out applications (*i.e.*, job, disability, etc.)

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

NON-BILLABLE MEDICAID ACTIVITIES (CONT'D.)

- Assisting clients in performing the job or performing jobs for clients
- Drawing client's blood and/or urine specimen, and/or taking the specimen(s) to the lab
- Visiting clients while in another mental health service program, unless for a special treatment activity
- Retrieving medications for a client kept at the CMHC and handing out prescriptions or medications
- Scheduling appointments with the physician or any other clinician at the CMHC
- Providing non-authorized services to children placed in high or moderate management group homes
- Staffing between clinicians in the same clinical unit within the mental health center for the purpose of supervision
- Provision of direct services (medical, educational, or social) to Medicaid clients under TCM
- Transporting clients to appointments or waiting for clients in waiting rooms
- Respite care

TELEPSYCHIATRY

To qualify for Medicaid reimbursement, interactive audio and video equipment must be involved that permits two-way – real-time (synchronous) or near-real-time (asynchronous) – communication between the client, consultant, interpreter, and referring clinician.

Please note the following requirements:

- Reimbursement requires the "real-time" presence of the client.
- Reimbursement is available only for community mental health services that do not require face-to-face, "hands on" encounters.
- All equipment must operate at a minimum communication transfer rate of 384 kbps.

SECTION 2 POLICIES AND PROCEDURES

BILLING REQUIREMENTS

TELEPSYCHIATRY (CONT'D.)

Exception: Reimbursement is available for equipment operating at a minimum 128 kbps for the following services:

- TCM (all clients)
- PMA and Service Plan Development (SPD) rendered to Medicaid-eligible deaf clients or clients whose primary language for communication is not English

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PSYCHIATRIC MEDICAL ASSESSMENT (PMA) AND PSYCHIATRIC MEDICAL ASSESSMENT-ADVANCED PRACTICE REGISTERED NURSE (PMA-APRN)

Service Description

Psychiatric Medical Assessments are face-to-face clinical interactions between a client and a physician (PMA) or advanced practice registered nurse (PMA-APRN) to assess and monitor the client's psychiatric and/or physiological status for one or more of the following purposes:

- Assess the mental status of a client and provide a psychiatric diagnostic evaluation, including the evaluation of concurrent substance use disorders
- Provide specialized medical, psychiatric, and/or substance use disorder assessment
- Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent substance use disorders
- Provide or review information on which to base a psychiatric evaluation and establish the medical necessity for care
- Assess or monitor a client's status in relation to treatment
- Assess the need for a referral to another health care, substance abuse, and/or social service provider
- Diagnose, treat, and monitor chronic and acute health problems. This may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Plan treatment and assess the need for continued treatment

Delivery of this service may include contacts with collateral persons for the purpose of securing pertinent information necessary to complete an evaluation of the client.

Eligibility

All Medicaid clients admitted to a mental health facility are eligible to receive PMA service and must receive this service at least once within the first 90 days from the date of admission to the mental health center or as the first service thereafter. PMAs may be repeated as often as is medically necessary.

If a PMA has not been rendered during a retroactively covered period, the PMA must be rendered within 90 calendar days from the date a client is retroactively determined Medicaid eligible.

Children admitted to School-Based, Family Preservation and Truancy Diversion programs are required to receive a PMA rendered in a school setting within the first nine months from the date of admission to the program or as the first service thereafter.

Clients receiving psychotropic medications are strongly encouraged to receive a PMA every six months at a minimum.

Clients who have not had a face-to-face treatment service during a six-month period will require a new PMA completed by a physician or an Advanced Practice Registered Nurse (APRN) within 90 calendar days.

Staff Qualifications

Any physician or APRN who is deemed suitable under the provider qualification's provisions may render PMA services.

APRN Restriction

An APRN may render subsequent PMA services only after a physician has conducted the initial or first psychiatric assessment.

Service Documentation

PMAs are not required to be listed on the POC. The physician or APRN who renders the service must include a properly completed Physician's Medical Order (PMO) form in the record. The physician or APRN must sign and date the PMO. A Clinical Service Note (CSN) must be entered in the record that references the PMO.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Documentation (Cont'd.)

A community mental health services provider may obtain a copy of a PMA performed by another provider for the purpose of the initial PMA requirement, provided there are no clinical indications that necessitate another PMA. In these cases, under all circumstances, the receiving service provider is responsible for ensuring that clients receive PMAs as clinically necessary and for Medicaid billing purposes, in accordance with Medicaid requirements.

Billing/Frequency Limits

PMAs and PMA-APRNs are billed in unit increments of 15 minutes for a maximum of six units per day.

Any services rendered after 90 calendar days from the day a client enters service and before the rendering of a PMA may not be billed. Once the PMA has been completed, billing may resume.

Billable Places of Service

PMAs or PMA-APRNs may be provided in a client's home, an inpatient or outpatient general hospital, a Community Mental Health Center (CMHC), school, nursing facility, or other approved facility.

Relationship to Other Services

A PMA or PMA-APRN is not reimbursable on the same day as Crisis Intervention-Mental Health Service (CI-MHS).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

INJECTABLE MEDICATION ADMINISTRATION (MED. ADM.)

Service Description

Injectable Medication Administration is the injection of a medication in response to the order of a licensed physician. It is used as an adjunctive treatment to primary mental health services to restore, maintain, or improve a client's role performance or mental status.

Eligibility

All Medicaid clients in need of this service that have been identified by a physician or an APRN are eligible for this service.

Staff Qualifications

A physician licensed to practice medicine in the state of South Carolina may render Medication Administration Services. A Registered Nurse (RN), Licensed Practical Nurse (LPN), or licensed Physician Assistant (PA) under the supervision of a physician or APRN may also render this service. However, when an RN, LPN, or PA renders this service, the supervising physician must be accessible in case of an emergency.

Service Provision

Medication Administration is rendered in response to a physician or APRN order documented on a PMO. The physician or APRN must assure the form is properly completed and included in the medical record to confirm the initial and any subsequent contacts with the client.

Only the provision of administration of those injectable procedure codes listed on the following page are reimbursable under this service:

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PROGRAM SERVICES

REIMBURSABLE MEDICAID CODES FOR INJECTIONS	
J2060	Ativan, to 4 mg
J1200	Diphenhydramine, up to 50 mg
J0515	Benztropine, up to 1 mg
J1630	Haldol, up to 5 mg.
J1631	Haldol Decanoate to 50 mg. IM.
J1990	Librium, up to 100 mg.
J2330	Navane IM, up to 4 mg
J2680	Prolixin Decanoate, Fluphenazine, up to 25 mg
J3230	Torazine, Chlorpromazine, up to 50 mg
J3310	Perphenazine, up to 5 mg
J3360	Valium, up to 5 mg
J3410	Vistaril, up to 25 mg
J2794	Risperidone, 0.5 mg
J3490	Unclassified Drugs (Document)

Service Documentation

Injectable Medication Administration is not required to be listed on the POC. A CSN will be used to document this service. This service must be entered as the service to be rendered on the CSN. The provider of the service should include the following items in order to provide a relevant clinical description, assure the service conforms to the service description, and authenticate the charges:

- The medication administered
- The dosage given (quantity and strength)
- The route (I.M., I.D., I.V.)
- The injection site
- The side effects or adverse reactions noted

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing/Frequency Limits

Only the injectable procedure codes listed in the table on the previous page are reimbursable under this service. Injections must be billed using the appropriate procedure code. Injection codes include both the cost and the administration of the drug.

Billable Places of Service

Medication Administration may be provided at a client's home or natural environment, CMHC, or a Community Residential Care Facility.

Relationship to Other Services

No restrictions.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

NURSING SERVICES (NS)

Service Description

Nursing Services offer a variety of face-to-face or telephonic interventions to a client. When providing this service, RNs utilize a holistic approach that addresses the medical, physical, and psychiatric needs of a client, recognizes the interaction of the two, and prevents unnecessary psychiatric hospitalization. Services are designed to:

- Provide limited or comprehensive medically necessary nursing care intervention to address the physical and/or mental health needs of a client to promote positive psychiatric treatment outcomes, and/or
- Promote health education/intervention regarding coexisting conditions that affect psychiatric symptomatology and functioning and promote client competence. This includes education about psychiatric medications and concurrent substance use in accordance with national practice guideline standards, and/or
- Determine and evaluate the nutritional status of mentally ill clients in support of improved treatment outcomes when it medically interferes with the psychiatric status of clients, and/or
- Provide follow-up nursing care to address identified problems and assess progress, and/or
- Promote the consistent use of health/medical services designed to promote positive psychiatric treatment outcomes.

Medication Monitoring is provided to do any or all of the following:

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Educate clients as to the dosage, type, benefits, actions, and potential adverse effects of the prescribed medications
- Educate clients about psychiatric medications and substance abuse in accordance with nationally accepted practice guidelines

Eligibility

All Medicaid beneficiaries who physicians and APRNs, within the scope of their medical or nursing practice, believe will benefit from this service are eligible.

Staff Qualifications

Any RN, under the supervision of a physician or an APRN, may render Nursing Services. The physician must be accessible in case of emergency.

An RN or a Licensed Pharmacist, under the supervision of a physician or an APRN, may render medication-monitoring activities. The physician or the APRN must be accessible in case of emergency.

Special Restrictions

Telephone contacts between an RN and clients are not Medicaid reimbursable under the following circumstances:

- Brief conversations to inform clients about appointment times
- Monitoring a client's general condition
- Billing more than two units per day

Telephonic contact may occur between a client and/or collateral to assess the client's physiological or psychological response to a medication order, but cannot be billed for more than two units per day.

Service Documentation

Nursing Services are not required to be listed on the POC. A CSN will be used to document this service. Nursing Services shall be entered on the CSN as the service to be rendered.

The provider of the service should also include the following items in addition to those required in the general CSN requirements:

- The medications the client is currently taking, or reference to the physician's order or other document in the medical record that lists all the medications prescribed to the client

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Documentation (Cont'd.)

- The side effects or adverse reactions experienced by the client
- Whether the client is refusing or unable to take medications as ordered, or is compliant in taking medications as prescribed
- How effective the medication(s) is in controlling symptoms
- Any issues relating to concurrent substance use, documentation of education to the client, and support for the rationale for continuing the necessary medication

Billing/Frequency Limits

Nursing Services are billed in units of 15 minutes for a maximum of seven units per day.

Billable Places of Service

Nursing Services may be rendered at a client's home, natural environment, or at a CMHC.

Relationship to Other Services

Nursing Services cannot be billed on the same day as CI-MHS.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

CRISIS INTERVENTION MENTAL HEALTH SERVICE (CI-MHS)

Service Description

Crisis Intervention Mental Health Service (CI-MHS) is a time-limited service that provides an alternative to psychiatric hospitalization for clients who are experiencing a period of such acute stress that the capacity to cope with normal life circumstances is severely impaired. Due to the pervasive deterioration of the role functioning of psychiatrically impaired clients, the program provides a combination of psychiatric services designed to address their psychiatric, social, psychological, or behavioral needs. Individuals in psychiatric crisis frequently have concurrent substance use issues and disorders that contribute to the crisis. CI-MHS will routinely engage such individuals and incorporate attention to their substance abuse issues into the programming and services offered. The presence of active substance use should not be a barrier to admission for individuals meeting criteria for this service; demonstration of abstinence should never be a requirement for access to care.

This service is intended to bring together a number of therapeutic modalities that can be utilized by the staff of the program, based on client need. Services shall provide intensive support, as well as close observation and supervision. These services should focus on acute symptom reduction and control.

This program lasts for six weeks. As the program progresses, it is expected that billed units per day will decrease in accordance with less intensive client needs.

The program will focus on the provision of these specific activities during program hours. A calendar outlining scheduled program activities and hours shall be posted and available.

In order to provide a structured environment, the CI-MHS offers the following therapeutic modalities that are integrated into the program and are not separately billable.

- A **Psychiatric Medical Assessment** is conducted on all clients entering the program to assess their mental status, provide a diagnostic evaluation, or

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

provide a specialized medical and/or psychiatric assessment including integrated substance abuse assessment, an evaluation of the appropriateness of initiating or continuing the use of medications, and monitoring the client's status in relation to treatment with medication. Successive physician contacts are on an "as needed" basis. Individuals in psychiatric crisis who are also using substances should be maintained on all non-addictive medications necessary for treatment of their psychiatric conditions during the crisis stabilization period.

- **Client Stabilization and Crisis Intervention** is a face-to-face, intensive, time-limited service provided by an MHP that follows an abrupt substantial change in behavior toward the severe impairment of functioning and/or a marked increase in personal distress. The presence of co-occurring substance abuse during a period of psychiatric crisis may contribute to additional risk and should be addressed in an integrated fashion. Client stabilization and crisis intervention is employed to:
  - Identify the precipitant(s) or causal agent(s) that has resulted in the crisis
  - Reduce the immediate personal distress felt by the client
  - Present a facilitative environment allowing clients to make choices leading to personal growth
  - Reduce the chance of future crisis situations through the implementation of preventive strategies

  Such choices and strategies may include making better choices about substance use or abuse and developing skills to reduce or eliminate substance use that may contribute to crisis.
- **Nursing Services** provide a variety of face-to-face interventions, provided by an RN utilizing a holistic approach, that addresses the following:
  - The medical, physical, and psychiatric needs of a client

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Recognizing the interaction of these needs
- Preventing unnecessary psychiatric hospitalization

This service also includes assessing a client's need to see the physician; or determining overt physiological side effects of medications, determining psychological effects of medications, monitoring compliance to medication directions, or educating the client and his or her family with regard to proper usage and potential side effects of prescribed medication.

- **Psychological Evaluation** consists of a face-to-face interaction between a client and a psychologist as requested by a member of the treatment team. It involves the use of projective tests, standardized personality inventories, intellectual assessments, and tests for specific disorders. The evaluations facilitate any of the following:
  - Differential diagnosis
  - Increasing the understanding of the client's behavioral and psychological assets and deficits
  - Identifying hidden factors that could impact the outcome of therapy
  - Providing data, which can assist in the formation of the POC
- **Individual Therapy** is a face-to-face interaction between an MHP and a client. The individual client's behavior and symptoms will provide the basis for need and frequency. The primary emphasis of this therapy is the restoration of role functioning in the natural environment. Sessions are conducted to do the following:
  - Assess the client's behavior, including substance use and abuse; modify treatment goals
  - Allow a client to verbalize thoughts, feelings, and ideas
  - Promote the client's awareness of adaptive behavior
  - Provide the opportunity for the client to practice appropriate behavior and interactional skills

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Reduce preoccupation with obsessive thoughts/ rituals
- Decrease anxieties
- Decrease depression
- Increase the client's sense of self-esteem/self-worth

- **Group Therapy** is a face-to-face interaction between staff and a group of three to eight clients. The types of therapies offered include communication skills, relaxation training, stress management, anger management, transactional analysis, goal-setting groups, stage-specific substance abuse groups, and problem solving groups. Group Therapy is employed to do the following:
  - Clarify the clients' perceptions of self and others within the treatment setting, and/or
  - Improve the understanding of communication skills through utilization of multiple sources of stimuli, and/or
  - Expose behaviors which hinder the cultivation of beneficial interpersonal relationships, and/or
  - Use the support of peers to make better choices and decisions regarding substance use, and/or
  - Develop skills to reduce substance use, and or
  - Provide an opportunity to express thoughts and feelings and receive feedback in a therapeutic atmosphere, and/or
  - Develop the ability to benefit from positive reinforcement
  - Increase the clients' sense of self-esteem/self-worth, and/or
  - Integrate behaviors and interactional skills for the purpose of enhancing interpersonal relationships

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- **Family Therapy** involves planned interactions between an MHP, a client, and the client's family members and/or significant others. Depending on the needs of each individual client, various methods of therapy may be employed. Family Therapy is designed to do the following:
  - Identify and assist in resolving conflicts which might arise in the family or living environment, and/or
  - Coordinate efforts between staff, family, and significant others to maintain the client in a natural support system, and/or
  - Ascertain the client's behavior away from the facility, and/or
  - Educate the client and client's family as to the dynamics of the client's illness, including education regarding concurrent substance abuse, and/or
  - Provide methods of dealing with the client's behavior including the effects of psychotropic medications on the client, and/or
  - Provide information and assistance to the client or family member in negotiating for appropriate services from community agencies

  In the event that emotional or behavioral disturbances, including substance abuse by family members, are contributing to the crisis, efforts will be made to engage family members as supportively as possible. Motivational strategies will be used to facilitate the family members in making better decisions about how to manage their behavior or substance use, in order to provide support to the client.
- **Psychosocial Rehabilitation Services** are based on the assessed needs of clients. This therapy is employed to enable clients to do the following:
  - Verbalize their thoughts, feelings, and ideas in a supportive environment, and/or
  - Reduce preoccupation with their own thoughts or rituals, and/or

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Develop their motor skills and coordination, and/or
- Decrease their level of anxiety, hostility, or depression, and/or
- Manage daily living without using substances, and/or
- Develop feelings of self-esteem and self-worth

- **Recreational Therapy** is a therapeutic modality subject to specific goals delineated on the POC. The activity may be implemented on a one-to-one basis or within a small group depending upon the individual client's needs and behavior. The therapy is conducted to do the following:
  - Provide a means of reducing anxiety through a therapeutic physical activity
  - Alleviate depression by involvement in an activity
  - Provide positive feelings about themselves and others
  - Provide methods of resolving feelings without using substances
  - Provide structured activities in lieu of substance use
  - Facilitate an appropriate release of hostile feelings

  Recreational activities must be related to the client's assessed mental health needs. Recreational activities that are not subject to specific goals on the client's POC will be considered diversional in nature and shall not be billed.

- **Skills Development** activities will focus on the development of the skills necessary for adequate personal care. The structure of specific skill development interventions may include counseling, discussion, didactic instruction, group process, or experiential learning. This service will be rendered with staff involvement in the process and will include the following items as appropriate to individual needs:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Personal hygiene
- Decision making, including decisions regarding concurrent substance abuse
- Medication use
- Orientation

Eligibility

All clients are eligible if they are referred by a physician and experiencing mental or emotional problems that severely restrict the activities of daily living. As previously noted, individuals with concurrent substance abuse disorders are eligible for this service and should not be restricted from access. The presence of substance abuse in a psychiatric crisis may add to a client's risk and increase the need for crisis intervention services to maintain safety.

Clients who are released from an acute psychiatric inpatient facility and need short-term stabilization in order to be successfully oriented to a new living environment are also eligible, and/or individuals who are at a substantial risk of admission to a psychiatric or substance abuse facility, inpatient acute care, or emergency department of a general hospital.

Physician Direction Requirement

With regard to directing services, physician requirements include **all** of the following:

- Be involved in the provision and supervision of this service and must be available during program hours
- Instruct and supervise staff regarding medication effects, usage, and monitoring
- Attend regular treatment team meetings to discuss clients' status
- Spend as much time as necessary in the program to assure clients are provided services in accordance with accepted medical practice in a safe, efficient manner
- Evaluate every 30 days whether continued treatment in the CI-MHS program is appropriate, and document this need on a PMO form

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Physician Direction Requirement (Cont'd.)

When the physician provides services to a client, the CI-MHS CSN shall reference the PMO form where the physician's clinical documentation may be found. The physician services rendered to a client in CI-MHS shall be included in the billing for the service.

The physician's involvement in the service shall include participation in regular treatment team meetings of the CI-MHS program staff. These meetings are not separately billable.

Staff Qualifications/ Supervision

CI-MHS shall be rendered by an MHP or Non-MHP under the direction of an MHP and under the supervision of a physician. The following standards must be met:

- The MHP shall direct the program's daily activities. The MHP shall meet the credentialing standards defined by the authorizing community mental health services provider.
- The MHP must be on site during program hours to assure that services are provided to clients in accordance with accepted standards of clinical practice in a safe, efficient manner.
- The MHP shall attend and chair meetings at least weekly regarding the planning for weekly activities and treatment.
- The MHP shall act as a liaison to other mental health services.

Bachelor's level Non-MHP staff, under the direction of the MHP, may render services. The Non-MHP will have access to appropriate training and in-service to assure services are rendered in accordance with accepted clinical practice.

Staff-to-Client Ratio

A minimum of one staff member for each five clients shall be in direct contact with clients during program hours.

The staff required to meet the staff-client ratios shall not bill for other mental health services during program hours.

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Periodic Review

A review of the client's progress will be conducted every 90 days and will be included in the Progress Summary. The review will be conducted by a member of the treatment team in a regular staffing and will address issues pertinent to the functioning of the client. The review outcome will be included in the 90-Day Summary of the POC and will conform to its requirements.

The physician and the MHP supervising the service shall attend the regular staffing. This staffing is not separately billable as another clinic service.

Service Documentation

CI-MHS is required to be included on the POC with a planned frequency and must be documented daily on a CSN.

Billing/Frequency Limits

CI-MHS may be billed in units of 60 minutes each, for a maximum of 12 units per day the first 15 days and a maximum of seven units per day thereafter.

Billable Places of Service

CI-MHS can be provided at the CMHC, or one of its approved facilities.

Relationship to Other Services

Only TCM, Injectable Medication Administration, Comprehensive Community Support Service, MH Service Plan Development by Non-physician, and Crisis Intervention Services can be billed the same day as CI-MHS. Mental Health Assessments may also be billed, but only on the day of admission. Billing an MH Assessment on the day of discharge is not authorized.

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PROGRAM SERVICES

CRISIS INTERVENTION (CI) SERVICE

Service Description

Crisis Intervention (CI) is a face-to-face or telephonic, time-limited, intensive therapeutic intervention provided by an MHP.

Face-to-face interventions are intended to:

- Stabilize the client
- Identify the precipitant(s) or causal agent(s) that triggered the crisis
- Reduce the immediate personal distress felt by the client
- Reduce the chance of future crises through the implementation of preventive strategies

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

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

Eligibility

All clients who experience an abrupt substantial change in their role function and/or emotional state resulting in a marked increase in personal distress that results in an emergency for the client and/or the client's environment are eligible.

Individuals in crisis who require this service may commonly be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion, as it may add to risk, increasing the need for engagement in care.

Staff Qualifications

CI services shall be rendered by an MHP.

Special Restrictions

Telephonic interventions are limited to a maximum of four units per day.

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PROGRAM SERVICES

Service Documentation

CI services are not required to be listed on the POC. A CSN must be completed daily on contact and should include the following:

- The focus of the session or the nature of the crisis
- The content of the session
- The intervention of the staff
- The response of the client to the intervention(s) of the staff
- The client's status at the end of the session
- The disposition at the end of the session

Billing/Frequency Limits

CI services are billed in units of 15 minutes for a maximum of 20 units per day. Face-to-face interventions may be billed in units of 15 minutes for a maximum of 16 units per day. Telephonic interventions may be billed in units of 15 minutes for a maximum of four units per day.

Billable Places of Service

CI services may be provided at the CMHC, client's home or natural environment, Doctor's office, nursing facility, or outpatient hospital.

Relationship to Other Services

CI services cannot be billed on the same day as MHS-NOS.

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PROGRAM SERVICES

MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN (ASSMT)

Service Description

Mental Health Assessment by Non-Physician is a face-to-face clinical interaction between a client and an MHP that determines the following:

- The nature of the client's problems
- Factors contributing to those problems
- The client's strengths, abilities, and resources to help solve the problems
- One or more of the client's diagnoses
- The basis upon which to develop a POC for a client

When a client is unable to supply the information detailed above, the MHP may use this service when securing information from collaterals who have reason to know information pertinent to the status of the client.

The Initial Clinical Assessment or comprehensive bio-psychosocial examination must be completed for all clients within the first three non-emergency visits.

Eligibility

All Medicaid clients requesting mental health services, including those who present with co-occurring substance abuse symptomatology, are eligible.

Staff Qualifications

Assessment services shall be rendered by an MHP.

Non-MHP staff time, if used while assisting the MHP, may be added to the MHP's bill time when the Non-MHP participates in the evaluation process. Staff time includes only face-to-face service time.

Service Provision

Assessments may be provided at different times during the treatment, to include:

- At the beginning of treatment, when the client first requests services at the clinic

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Service Provision (Cont'd.)

- At any time during the treatment when it is necessary to ascertain the client's progress, response to treatment, need for continued participation in treatment, or change in behavior and/or condition
- At the time of the review of the POC to reassess the client's progress, response to treatment, and need for continued participation in treatment. The reassessment must be documented separately on a CSN and comply with the service documentation requirements.
- At the end or termination of treatment, to justify discontinuing treatment
- To conduct a court-ordered evaluation and designated examinations that meet Medicaid reimbursement requirements
- For screening a client for placement in an outpatient setting, only once per inpatient admission to a general hospital, to assess the services necessary for the client's treatment modality after discharge

Assessment Components

The following activities are considered an assessment:

- **Initial Clinical Assessment or Comprehensive Bio-psychosocial Evaluation** that is conducted at the beginning of treatment when a client first request services: It serves as the basis for the POC and includes a clinical history, as well as any substance abuse history. The service establishes one or more diagnoses and the medical necessity of treatment.
- **Psychological Testing** conducted by a psychologist or MHP within the scope of their qualifications: This test is used to assess the client's interests, ability, personality, or level of function as related to the medical and/or psychiatric diagnosis.
- **Integrated Substance Use Disorder Assessment** that provides the MHP with past patterns of substance use. This assessment includes the following:
    - When the substance disorder occurred in relation to the mental health symptoms

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Assessment Components (Cont'd.)

- The specific abuse or dependence diagnoses
- An identification of periods of abstinence or reduced use
- A description of mental health symptoms, functioning, and treatment
- Successful substance treatment during those periods
- The client's current patterns of use, diagnoses, treatment participation, withdrawal risk, and the impact of substance use on the client's current mental health symptoms

- **Diagnostic Interview** that is conducted at the beginning of treatment or at any other time during treatment as deemed necessary by members of the treatment team: It is used to clarify a diagnosis or diagnoses and plan a course of treatment.

Service Documentation

Mental Health Assessment is not required to be listed on the POC, but shall be documented daily upon contact.

Billing/Frequency Limits

Assessment services are billed in units of 30 minutes for a maximum of six units a day.

Billable Places of Service

Assessment services may be provided in a client's home or natural environment, an inpatient hospital, nursing facility, or a CMHC.

Relationship to Other Services

Assessment services may be billed with all services except with CI-MHS and Mental Health Services NOS, unless on the first day of admission.

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PROGRAM SERVICES

INDIVIDUAL THERAPY (IND. TX.)

Service Description

Individual Therapy involves face-to-face, planned therapeutic interventions. These interventions focus on the enhancement of a client's capacity to manage his or her emotions and behaviors through effective decision making, developing and acquiring coping skills, making better choices and decisions regarding co-occurring substance abuse, achievement of personal goals, and development of self-confidence and self-esteem.

Individual Therapy may be psychotherapeutic and/or therapeutically supportive in nature. The client's needs and diagnosis – including substance abuse, strengths, and resources – determine the extent of the issues addressed in treatment, as well as the psychotherapeutic modalities used by the clinician.

Individual Therapy is directed toward the solution of problems and learning new adaptive behavior. Psychotherapeutic modalities include, but are not limited to, non-experimental therapies such as cognitive, dynamic, behavioral, humanistic, existentialist, psychoanalytical, and other recognized specialized psychotherapeutic practices. Individuals with severe disabilities are likely to benefit from interventions that are cognitive and behavioral in nature but are simplified to accommodate their level of functioning. Interventions should also be designed to achieve specific behavioral targets, such as improving medication adherence or reducing substance abuse.

This service does not include educational interventions without therapeutic process interaction or any experimental therapy not generally recognized by the profession.

Eligibility

All clients who physicians, within the scope of their clinical practice, believe would benefit from this service are eligible, including those with co-occurring disorders.

Clients who are able to engage in personal exploration and who have no, or minimal, impairment of cognitive functions will benefit from more dynamic psychotherapeutic interventions. As noted above, clients with more severe cognitive disabilities will benefit from more cognitive and behavioral interventions with emphasis

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Eligibility (Cont'd.)	on decisions, choices, and skills. Clients experiencing an acute crisis or those with severe mental illness who need ongoing support are good candidates for supportive psychotherapy. These clients may also benefit from learning new skills that help them to manage the crisis and prevent recurrence.
Staff Qualifications	Individual Therapy shall be rendered by an MHP.
Service Documentation	Individual Therapy is required to be listed on the POC with a planned frequency and must be documented daily on contact.
Billing/Frequency Limits	Individual Therapy may be billed in units of 30 minutes for a maximum of four units per day.
Billable Places of Service	Individual Therapy may be provided in a client's home or natural environment, nursing facility, or in a CMHC.
Relationship to Other Services	Individual Therapy cannot be billed on the same day as CI-MHS or MHS-NOS.

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PROGRAM SERVICES

FAMILY THERAPY (FAM. TX.)

Service Description

Family Therapy includes interventions with the client's family unit (*i.e.*, immediate or extended family or significant others) with or on behalf of a client to restore, enhance, or maintain the function of the family unit.

Family Therapy promotes and encourages the family support to facilitate a client's improvement. Services include the identification and resolution of conflicts arising in the family environment – including conflicts that may relate to substance use or abuse on the part of the client or family members; and the promotion of the family understanding of the client's mental disorder, its dynamics, and treatment. Services may also include addressing ways in which the family can promote recovery for the client from mental illness and/or co-occurring substance use disorders.

Family Therapy may be rendered to family members of the identified client as long as the identified client is the focus of the session. Only issues pertinent to the active client may be addressed under this service. When the focus changes to a family member other than the client, a new client record must be opened. Within this context, it is appropriate to work within the family to provide motivational and decisional strategies to family members whose substance abuse is adversely affecting the client. The goal of this therapy should be having that family member begin to recognize and address the problem; including, if indicated, seeking treatment for themselves to provide a more supportive environment for the client.

This service does not include educational interventions without psychotherapeutic process interaction or any experimental therapy not generally recognized by the profession.

Eligibility

All clients who physicians, within the scope of their clinical practice, believe would benefit from this service are eligible.

Staff Qualifications

Family Therapy shall be rendered by an MHP.

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Service Documentation	Family Therapy is required to be listed on the POC with a planned frequency and documented daily on contact.
Billing/Frequency Limits	Family Therapy may be billed in units of 30 minutes for a maximum of four units per day.
Billable Places of Service	Family Therapy may be provided in a client's home or natural environment, a CMHC, or a general hospital.
Relationship to Other Services	Family Therapy cannot be billed on the same day as CI-MHS or MHS-NOS.

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GROUP THERAPY (GP. TX.)

Service Description

Group Therapy involves face-to-face, planned, therapeutic interventions directed toward the restoration, enhancement, or prevention of deterioration of role performance levels. Group Therapy allows the therapist to address the needs of several clients at the same time and mobilize group support for the client. The group therapy process provides commonality of client therapy experience and utilizes a complex of client interaction under the guidance of a therapist. The participants benefit from a commonality of experiences, ideas, and group support and interaction.

These services can be therapeutic, psychoeducational, or supportive in orientation.

- **Group psychotherapy** is intended to help clients improve and manage their emotions and behaviors. Further, it helps clients change behavior and learn how to cope with problems in their lives, as well as encouraging personal development through the dynamics generated by the group.
- **Stage-specific groups for co-occurring substance use disorders** is an evidence-based, best-practice integrated treatment approach that may be incorporated into any program that offers an array of group services. These motivational or persuasion groups utilize a framework of support of peers to either help the client make better choices and decisions regarding substance use, or help the client develop or maintain skills to reduce or eliminate substance use (active treatment or relapse prevention groups).
- **Medication Compliance Group Therapy** focuses on increasing reality orientation, decreasing disorientation, and improving the physical skills of the client. Issues addressed by this service are:
  - The orientation of a client to the psychiatric medical prescription and treatment
  - Increasing client awareness to medication effect
  - Concerns for undesirable side effects and the process of their disease through client instruction

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PROGRAM SERVICES

Service Description (Cont'd.)

Structured activities are the core of this service. These may include medication usage, oral dosage, timing, route, frequency, special instructions and side effects, personal safety when taking medications or experiencing a medical condition, and procedures for increasing compliance with medication.

- **Caregiver Groups** are direct services provided to persons serving in primary caregiver roles for community mental health clients. Caregiver groups are intended to promote effective support from the caregivers to facilitate the improvement and/or recovery of the clients. These groups are psychoeducational in nature. They provide information and education to the participants about the nature of the severe mental illness or serious emotional disturbance that the clients experience. They allow and promote the participants to process the information, ventilate their feelings, share their experiences in caring for the clients, and receive support from the group.
- **Multiple Family Group Therapy** is directed toward the restoration, enhancement, or prevention of deterioration of role performance of families. Multiple Family Group Therapy allows the therapist to address the needs of several families at the same time and mobilizes group support for the families. The Multiple Family Group Therapy process provides commonality of Family Therapy experience – including experiences with co-occurring substance use disorders – and utilizes a complex of family interaction under the guidance of a therapist. The intended outcome of such family-oriented, psychotherapeutic services is the management, reduction, or resolution of the identified mental health problems, thereby allowing the client/family units to function more independently and competently in daily life.

Special Restrictions

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

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PROGRAM SERVICES

Special Restrictions (Cont'd.)

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

Eligibility

All clients who physicians, within the scope of their clinical practice, believe would benefit from this service, including those who may have co-occurring substance use disorders, are eligible. The eligibility of participants for group, versus individual, therapy is the same. The advantage of the group over individual therapy is the commonality of experiences shared by the participants and the support received by the group. Further, when interpersonal relations play a role in triggering, maintaining, or worsening the client's symptoms and problems, group therapy may be more effective than individual therapy. Group interventions have been demonstrated to have particular value for individuals with co-occurring disorders.

Caregivers or family members of Medicaid eligible clients are also eligible to participate in either Caregiver Groups or Multiple Family Group Therapy as deemed appropriate by the physicians, within the scope of their clinical practice.

Staff Qualifications

Group Therapy shall be rendered by an MHP.

A bachelor's level Non-MHP may be privileged to provide caregiver groups or medication compliance groups, only under the supervision of an MHP and with appropriate training. A Licensed Practical Nurse (LPN) under the supervision of an MHP may be privileged to provide Medication Compliance Group Thrapy.

Staff-to-Client Ratio

The staff-to-client ratio requires one staff member and a group of up to 12 clients, or groups of up to six family units, but no more than 12 family members per group.

Service Documentation

Group Therapy is required to be listed on the POC with a planned frequency and documented daily on contact.

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Billing/Frequency Limits

For Caregiver Groups, both caregiver and staff must be actively involved in the group during the time to be billed. Group Therapy is billed in unit increments of 30 minutes for a maximum of eight units per day.

Billable Places of Service

Group Therapy may be provided at a CMHC, nursing facility, or other approved community mental health facility.

Relationship to Other Services

Group Therapy cannot be billed on the same day as CI-MHS, or MHS-NOS.

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PROGRAM SERVICES

COMPREHENSIVE COMMUNITY SUPPORT

Service Description

Comprehensive Community Support services are face-to-face planned interventions designed to support adult clients with a diagnosis of a serious mental illness who have difficulty in adapting to community living because of the severity of their symptoms and/or after prolonged institutionalization.

The service encourages the client's integration into their families and natural environment, prevents decompensation and promotes hope and recovery.

Comprehensive Community Support services are time limited, short- or long-term, and are provided face-to-face, individually or in small groups based on the assessed needs of the individual and include the following activities:

- Promoting the client's understanding and practice of healthy living habits
- Coaching and encouraging the client to complete activities of daily living – hygiene, grooming, effective management of living space, meal preparation, and time management.
- Assisting the client to develop abilities in keeping up his or her personal belongings and living space
- Assisting the client in maintaining adequate relationships with others (neighbors, roommates, and landlords)
- Helping the client to learn basic money management and purchasing of basic goods
- Ongoing monitoring of the client's symptoms
- Assisting the client to manage his or her symptoms to include: use and effects of medication, compliance with prescribed medication and medication management
- Promoting the client's expression of his or her needs, feelings, and thoughts in a supportive and safe environment.
- Promoting the safe use of community resources

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PROGRAM SERVICES

Service Description (Cont'd.)

- Assisting clients on issues of personal safety
- Promoting hope through the client's understanding of their illness, its effect on their lives and alternatives to improve their quality of life
- Assisting the client to develop basic decision-making and problem-solving skills
- Encouraging the client to reestablish and maintain a family support system
- Assisting the client develop a sense of identity, self-esteem, and confidence
- Assisting the client to restore basic functional abilities he or she may have lost because of a mental illness

Eligibility

Adult clients diagnosed with a serious mental illness, with or without co-occurring substance use disorder, that, due to the severity and/or presence of residual and/or active symptoms are unable to lead independent lives without frequent support and coaching to conduct activities of daily living are eligible. The client's symptoms are of such severity that the client requires direct therapeutic and rehabilitative interventions to sustain him or her in the community.

Staff Qualifications

Comprehensive Community Support services may be rendered by a Mental Health Professional (MHP) or a Non-MHP under the direct supervision of an MHP.

This staff member should work under the direct supervision of an MHP and should render only those activities related to previous experience and training.

When this service is rendered by a Non-MHP without a bachelor's degree, clinical service notes must be co-signed by the supervising MHP.

MHP Supervision Requirements

An MHP will have the responsibility of planning and guiding the delivery of services provided by the Non-MHP. The MHP will supervise the performance of the Non-MHP staff and evaluate and assess the client as needed.

The MHP shall be available for supervision, although their presence is not required when the services are being provided. However, the MHP must spend as much time as

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PROGRAM SERVICES

MHP Supervision Requirements (Cont'd.)

is necessary to assure that services are provided in a safe, efficient manner and in accordance with accepted standards of clinical practice.

The MHP must co-sign service notes when the service is rendered by a Non-MHP without a bachelor's degree

A general staffing, chaired by the MHP, will be conducted every two weeks to discuss administrative, individual client treatment and program issues. Issues relevant to the individual clients will be documented in a staffing note and noted in the client(s) medical record.

A review of each client's participation in Comprehensive Community Support services will be conducted at least every 90 days to assess the benefits or impact of the program in the client's improvement, the progress made by the client toward their treatment goals, and the justification for continued services. The review will be chaired by the MHP, and the review outcome will be documented in the Plan of Care (POC) under progress summary, and will include the date, signature, and title of the MHP.

If the MHP evaluates the client as part of the review process, this evaluation may be billed separately as MH Assessment.

Staff-to-Client Ratio

This service is provided individually and face-to-face with the client, or in small groups of one staff to six clients.

Service Documentation

Comprehensive Community Support is required to be listed on the POC with a planned frequency and should be documented upon contact with the client.

The person providing the services is responsible for completing and placing the CSN in the medical record.

In addition to general documentation requirements, the documentation of these services will include the following content:

1. The focus or objectives of these activities
2. The staff's interventions
3. The response of the client to these interventions
4. The progress of the client, in reference to the treatment objectives and goals as stated in the POC

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PROGRAM SERVICES

Service Documentation (Cont'd.)

5. The plan for the next session
6. Signature of the staff person rendering the service and co-signature, if necessary

Billing/Frequency Limits

Comprehensive Community Support is billed in unit increments of 15 minutes for a maximum of 48 units per day. Service delivery contacts occurring on the same day may be combined in one clinical service note.

Billable Places of Service

Comprehensive Community Support may be provided in the client's home or natural environment, CMHC, nursing facility, or other approved community mental health facility**.**

Relationship To Other Services

Comprehensive Community Support cannot be billed on the same day as STAD. All other services can be billed the same day.

Services must not be provided to clients concurrently with any other service. Other allowable community mental health services occurring on the same day may be billed only if the time billed for Comprehensive Community Support is reduced. Staff must be sure to reduce billing frequency for clients when they are not participating in this service.

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PROGRAM SERVICES

PSYCHOSOCIAL REHABILITATION SERVICES (PRS)

Service Description

Psychosocial Rehabilitation Services are designed to prepare clients to function as actively, adaptively, and independently in society as possible and appropriate. The service assists clients strengthen, restore and/or develop the necessary individual skills, abilities and environmental supports to improve their personal, social, family, occupational/educational lives, and overcome the isolation and withdrawal experienced by the seriously mentally ill adult clients and emotionally disturbed children and adolescents.

This service will help the clients assume responsibility over their lives and behaviors, and improve their general well being.

Psychosocial Rehabilitation Services are individualized and directly related to the client's strengths, needs, level of functioning, and preferences. These services help the clients identify, cope with, or eliminate functional deficits and interpersonal barriers created by their disabilities, and address their short and long-term goals.

Services can be provided on a short- or long-term basis. When services are provided three or more days per week, a calendar outlining scheduled activities and hours shall be posted and available to the clients.

The following planned and structured activities are directed to promote recovery, restore skills, and develop adaptive behaviors:

Rehabilitative Interventions include enabling clients to verbalize thoughts, feelings, and ideas in a supportive environment; helping the client reduce disorientation, distraction, preoccupation with disturbing thoughts and rituals, withdrawal, level of anxiety, hostility and/or depression; promoting the client's development of feelings of self-esteem, self-worth, social adaptation, and hope.

Interpersonal Skills deal primarily with communication skills, problem solving, assertiveness training, and goal setting.

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PROGRAM SERVICES

Service Description (Cont'd.)

Daily Living Skills include activities leading to the enhancement of self care and personal hygiene; selection of food and appropriate eating skills and habits; management of living space and upkeep of personal belongings or property; health and safety; rational problem solving and decision making; retail purchasing, budgeting, and economic issues; medication use and management of symptoms.

Restorative Independent Living Skills include interventions focusing on the development, enhancement, and support of the skills necessary to develop successful roles in the community (*i.e.*, ethics development, time management, self-concept, stress reduction, coping skills, and work readiness skills).

Eligibility

Adult clients diagnosed with a serious mental illness and severely emotionally disturbed children and adolescents with or without co-occurring substance use disorders are eligible for Psychosocial Rehabilitation Services.

Staff Qualifications

Psychosocial Rehabilitation Services may be provided by a Mental Health Professional (MHP) or a Non-MHP credentialed and privileged by the CMHC to render this service under the direct supervision of a MHP.

MHP Supervision/ Requirement

A MHP will have the responsibility of planning and guiding the delivery of services provided by the Non-MHP. The MHP shall be available for supervision during the Psychosocial Rehabilitation Services program hours to assure that services are provided in a safe, efficient manner and in accordance with accepted standards of clinical practice. The MHP will supervise the performance of the Non-MHP staff and evaluate and assess the client as needed.

A general staffing, chaired by the MHP, will be conducted every two weeks to discuss administrative, individual client treatment, and program issues. Issues relevant to the individual clients will be documented in a staffing note and noted in the client(s) medical records.

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MHP Supervision/ Requirement (Cont'd.)

A review of each client's participation in Psychosocial Rehabilitation Services to assess the benefits or impact of the program in the client's improvement, the progress made by the client toward their treatment goals, and the justification for continued services will be conducted at least every 90 days when the services are provided within a therapeutic milieu and more than three times a week. The review will be chaired by the MHP, and the documentation will be placed in the client's medical record under progress summary, and will include the date, signature, and title of the MHP.

If the MHP evaluates the client as part of the review process, this evaluation may be billed separately as MH Assessment.

Special Restrictions

Psychosocial Rehabilitation Services may be provided up to six hours per day, seven days per week.

Staff performing this service cannot be included in the rendering of other service(s) concurrently. Only the time spent in contact with client is billable.

Educational services provided by the public school system such as homebound instruction, special education, or defined educational courses (GED, Adult Development) are excluded from billable services. Tutorial services in relation to a defined educational course are non-billable. However, assisting consumers to develop reading skills, arithmetic, and other skills necessary to perform everyday functions may be included within the program.

Staff-to-Client Ratio

The Psychosocial Rehabilitation Services must maintain a minimum of one staff for every 12 clients as determined by the needs of the clients. The staff shall be in direct contact and involved with the clients' activities during service and program hours.

Service Documentation

Psychosocial Rehabilitation Services are required to be listed on the POC with a planned frequency and should be documented upon contact with the client.

The MHP supervising the Psychosocial Rehabilitation Services is responsible for the documentation of the CSNs. The MHP will co-sign the notes written by a Non-MHP.

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PROGRAM SERVICES

Service Documentation (Cont'd.)

When services are provided less than three days a week, the documentation should be completed immediately upon delivery of the service. When services are provided three or more days a week, the documentation may be completed on a weekly basis.

The documentation of these services will include the following content:

1. The nature of the activities in which the client participated (These shall be within the Service Description specified in this Standard.)
2. The focus or objectives of these activities
3. The staff's interventions
4. The response of the client to these interventions regarding the development of psychosocial/behavioral skills
5. The progress of the client, during the week, in reference to the treatment objectives and goals as stated in the POC
6. The plan for the next week/session (according to whether it is a weekly note or individual session)

Billable Places of Service

Psychosocial Rehabilitation Services provided as a program, or as planned activities less than three days a week, can be provided at an approved facility designated by the community mental health center authority that can assure a structured therapeutic milieu, or in the client's natural environment, or at the CMHC.

Billing/Frequency Limits

This service is billed in unit increments of 15 minutes for a maximum of 24 units per day.

Relationship To Other Services

Psychosocial Rehabilitation Services cannot be billed on the same day as CI-MHS or MH-NOS.

This service must not be provided to clients concurrently with any other service. Other allowable community mental health services occurring on the same day may be billed only if the time billed for Psychosocial Rehabilitation Services is reduced. Staff must be sure to reduce billing frequency for clients when they are not participating in this service.

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PROGRAM SERVICES

PEER SUPPORT SERVICE (PSS)

Service Description

Peer Support Service is person-centered with a recovery focus. This service allows clients the opportunity to direct their own recovery and advocacy processes. This, in turn, promotes skills for coping with and managing symptoms while facilitating the utilization of natural resources and the preservation and enhancement of community living skills.

Peer Support Service is a helping relationship between clients and Peer Support Specialists that promotes respect, trust, and warmth and empowers clients to make changes and decisions to enhance their lives. At any time, individuals participating in the service are encouraged to make decisions about the activities and services offered within the Peer Support Service.

This service is directed toward the achievement of specific goals that have been defined by the client and specified in the POC. The activities provided by this service emphasize the acquisition, development, and expansion of the rehabilitation skills needed to move forward in recovery. Interventions are built on the unique therapeutic relationship between the Peer Support Specialist, the clients, and their family units, as requested and defined by the clients.

Services are multi-faceted and emphasize the following:

- Personal safety
- Self-worth
- Introspection
- Choice
- Confidence
- Growth
- Connection
- Boundary setting
- Planning
- Self-advocacy
- Personal fulfillment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- The helper principle
- Crisis management
- Education
- Meaningful activity and work
- Effective communications skills

Due to the high prevalence of clients with co-occurring substance use disorders and the value of peer support in promoting dual recovery, identification of PSS for individuals with co-occurring disorders, who require assistance to achieve dual recovery, is a particular priority.

Eligibility

Adult clients diagnosed with severe mental illness and/or co-occurring disorders are eligible.

Eligible services are those necessary to provide support and encouragement to clients and their families when the clients first begin to receive services. Intake and assessment, adjusting to new medications, relapse, and discharge planning are examples of beginning services.

Staff Qualifications

Peer Support Service shall be rendered by a Peer Support Specialist, under the direct supervision of an MHP.

Staff-to-Client Ratio

These services are provided one-to-one or in groups. When rendered in groups, the ratio of staff to clients shall not exceed one staff to eight clients.

MHP Supervision/ Requirements

The MHP must be available for supervision and shall assure that the Peer Support Specialist provides services in a safe, efficient manner in accordance with accepted standards of clinical practice and certification-training standards for Peer Support Specialists as approved by the South Carolina Department of Health and Human Services (DHHS).

The MHP is required to attend and chair a staffing meeting with the Peer Support Specialist during which administrative and individual treatment issues are considered. At a minimum, this regular staffing will occur every two weeks. It is not separately billable under another clinical service unless the staffing includes a physician consultation. The MHP will specify services that address specific program content and assess individual needs.

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PROGRAM SERVICES

MHP Supervision/ Requirements (Cont'd)

The MHP is also required to make a minimum of one evaluation no later than six months after admission. The evaluation is repeated annually to monitor the recovery of the client and the focus of the services provided. This evaluation may be billed separately as a Mental Health assessment.

Service Provision

Services are structured or planned one-to-one or group activities that promote socialization, recovery, self-advocacy, and preservation. They are provided to enhance community living skills and develop natural supports. These types of service intervention include the following:

- **Self Help** cultivates the client's ability to make informed, independent choices. This helps clients develop a network for information and support from others who have been through similar experiences.
- **Self Improvement** involves planning and facilitating specific, realistic activities leading to increased self-worth and improved self-concepts.
- **Assistance with Substance Use Reduction or Elimination** provides support for self-help, self-improvement, skill development, and social networking to promote healthy choices, decisions, and skills regarding substance abuse.
- **System Advocacy** assists clients in making telephone calls and composing letters about issues related to mental illness or recovery. This can also involve teaching clients to talk or write about what it means to have a mental illness to an audience or group.
- **Individual Advocacy** discusses concerns about medications or diagnoses with the physician or nurse at the client's request. Further, it helps clients arrange necessary treatment when requested, guiding them toward a proactive role in their own treatment.
- **Crisis Support** assists the client with the development of a crisis plan or a Psychiatric Advance Directive. It teaches clients:
    - How to recognize the early signs of a relapse

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Provision (Cont'd.)

- How to request help to head off a crisis
- How to use a crisis plan
- How to use less restrictive, hospital alternatives
- How to divert from using the emergency room
- How to make choices about alternative crisis support

- **Housing** interventions instruct clients in learning how to maintain stable housing or learning how to change an inadequate housing situation.
- **Social Network** interventions assist clients with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.
- **Education/Employment** interventions assist clients in obtaining information about going back to school or getting job training. They learn about going back to full- or part-time paid work. Further, they learn to facilitate the process of obtaining reasonable accommodations under the Americans with Disabilities Act (ADA).

Service Evaluation and Outcome Criteria

Clients receiving Peer Support Service will be monitored and reviewed quarterly using the following measures:

- Participatory action research processes
- Consumer advisory board reports
- Focus groups with clients
- Comments from suggestion boxes

Particular attention will be given to measuring outcomes for individuals who identify as having concurrent mental illness and substance use disorders, as well as those who may have greater difficulties with access to the appropriate services.

Service satisfaction surveys and system-wide surveys will produce outcome measures in the following areas for Peer Support Service:

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PROGRAM SERVICES

Service Evaluation and Outcome Criteria (Cont'd.)

- **Satisfaction with Services –** Clients will rate their satisfaction with Peer Support Service, as evidenced by their own perception of care.
- **Access to Services –** Clients will demonstrate high access to services as documented by the Mental Health Statistical Improvement Project (MHSIP) instrument, or an MHSIP-like instrument.
- **Clinical Outcomes –** Clients receiving Peer Support Service will maintain or improve their functioning as evidenced by a combination of the client's self-report measure of outcome (*e.g.*, MHSIP); and a clinical measure, such as the Global Assessment of Functioning (GAF).

Within 90 calendar days after the close of the state fiscal year, providers shall submit an annual report to the DHHS Program Manager summarizing the program evaluation and outcome criteria.

Service Documentation

Peer Support Services are required to be listed on the POC with PRN frequency and documented daily on contact.

Billing/Frequency Limits

Peer Support Services are billed in unit increments of 15 minutes for a maximum of 16 units per day.

Billable Places of Service

Peer Support Services may be provided in the client's home or natural environment, CMHC, or other approved community mental health facilty.

As a group service, it may operate in the same building as other day services. However, with regard to staffing, content, and physical space, a clear distinction must exist between these day services during the hours the PSS is in operation.

Peer Support Services do not operate in isolation from the rest of the programs in the CMHCs

Relationship to Other Services

Peer Support Services cannot be billed on the same day as CI-MHS.

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PROGRAM SERVICES

SKILLS TRAINING AND DEVELOPMENT (STAD)

Service Description

Skills Training and Development refers to face-to-face rehabilitation interventions with the client to strengthen his or her personal, social, and vocational skills to function as actively, productively, and independently in the community as possible, and improve his or her quality of life.

Skills Training and Development services are based on the assessed needs and level of functioning of the client and include the following interventions:

Therapeutic assistance/interventions consist of teaching the client the necessary skills to appropriately perform activities that sustain independence, such as:

- Personal grooming
- Periodic monitoring and evaluation of the client's symptoms and response to treatment
- Effective management of living space including housekeeping, meal preparation, retail purchasing, shopping, and laundry
- Managing and budgeting money
- Using community resources such as transportation, social services, medical services, etc
- Locating, financing, and maintaining decent, safe and affordable living arrangements
- Job readiness skills – identifying and managing symptoms, attitudes, and behaviors that interfere with seeking, obtaining, and maintaining a job; improving concentration and attention; task orientation, establishing short- and long-term goals, and meeting these goals; effective communication and assertiveness training; problem-solving skills and interpersonal conflict resolution; ethics development and time management; developing and utilizing necessary supports to maintain emotional stability and a productive life within the limitations of the illness

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PROGRAM SERVICES

Service Description (Cont'd.)

Counseling services are supportive in nature and directed toward the improvement of symptoms, and/or reestablishing or developing the client's adaptive behaviors and/or maintaining emotional stability. Interventions include:

- Promoting the client's acceptance of personal responsibility for a constructive life
- Direct interventions to assist the client identify and reduce stressors, develop coping skills and prevent decompensation
- Establishing and maintaining effective, meaningful interpersonal relationships
- Assisting the client to actively integrate into his or her family and as appropriate, seeking family support to assist the client in managing his or her mental illness by helping the family member(s) understand and accept the client's condition

Eligibility

Adult clients diagnosed with a serious mental illness – with or without co-occurring disorders – who, although reasonably stable in their community placement and experiencing moderate to mild symptoms, need support to maintain independent community living are eligible.

Staff Qualifications

A Mental Health Professional (MHP) is qualified to render this service.

A Non-MHP with a bachelor's degree in the social sciences, privileged by the CMHC, is qualified to render this service under the direct supervision of an MHP.

MHP Supervision/ Requirement

An MHP will have the responsibility of planning and guiding the delivery of services provided by the Non-MHP. The MHP will supervise the performance of the Non-MHP staff and evaluate and assess the client as needed.

The MHP shall be available for supervision, although their presence is not required when the services are being provided. However, the MHP must spend as much time as is necessary to assure that services are provided in a safe, efficient manner and in accordance with accepted standards of clinical practice.

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PROGRAM SERVICES

MHP Supervision/ Requirement (Cont'd.)

A general staffing, chaired by the MHP, will be conducted every two weeks to discuss administrative, individual client treatment, and program issues. Issues relevant to the individual clients will be documented in a staffing note and noted in their medical records. If the service providers in a clinic site are all MHPs, the staffing every two weeks requirement is waived.

The MHP is required to make a minimum of one review every 90 days to monitor the psychiatric/psychosocial development of the client, as well as to evaluate the focus of the service, the progress made by the client toward their treatment goals, and the justification for continued services. The review will be chaired by the MHP and the documentation will be placed in the client's medical record under progress summary and will include the date, and the signature and title of the MHP.

If the MHP evaluates the client as part of the review process, this evaluation may be billed separately as MH Assessment.

Staff-to-Client Ratio

The staff to client ratio will be one staff to one client.

Service Documentation

STAD is required to be listed on the POC with a planned frequency and should be documented upon contact with the client.

The documentation of these services, will include the following content:

1. The focus or objectives of these activities
2. The staff's interventions
3. The response of the client to these interventions regarding the development of psychosocial/ behavioral skills
4. The progress of the client in reference to the treatment objectives and goals as stated in the POC
5. The plan for the next session

Billable Places of Service

Skills Training and Development can be provided at the CMHC, nursing facility, or in the client's home or natural environment.

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PROGRAM SERVICES

Billing/Frequency Limits

This service is billed in unit increments of 15 minutes for a maximum of 20 units per day.

Relationship to Other Services

Skills Training and Development cannot be billed on the same day as CCS and CI-MHS.

This service must not be provided to clients concurrently with any other service. Other allowable community mental health services occurring on the same day may be billed only if the time billed for STAD is reduced. Staff must be sure to reduce billing frequency for clients when they are not participating in this service.

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PROGRAM SERVICES

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

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

Services for chronically mentally ill adults and seriously emotionally disturbed children will enable clients to have timely access to the services and programs that can best deal with their needs. Services will also assure follow-up on placements and services to assure that children and adults are in programs that are best suited to meet their needs.

Concurrent care shall be rendered to an individual for whom another provider has been designated the Primary Case Manager. When concurrent care is provided, the service is documented as Case Management. The concurrent care provider renders different, distinctive types of services from the Primary Care Manager.

Service Description

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

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

The **care planning** component builds on the information collected through the assessment phase. Activities under this component include ensuring the active participation of clients, working with individuals and others to develop goals, and identifying a course of action to respond to the assessed needs of clients. The goals and actions in the POC should address medical, social, educational, and other services needed by the client.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

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

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

TCM components may also include the following:

- Assisting clients in obtaining required educational, treatment, residential, medical, social, or other support services by accessing available services or advocating for service provision
- Contacting social, health, and rehabilitation service providers, either via telephone or face-to-face, in order to promote access to and appropriate use of services by clients. Additionally, services by multiple providers may be coordinated.
- Monitoring clients' progress through the services and performing periodic reviews and reassessment of treatment needs
    - When assessing an individual's need for services includes a physical, psychological, or mental status examination or evaluation, billing for the examination or evaluation must be under the appropriate medical service category. Referral for such services may be considered a component of TCM services, but the actual provision of the service does not constitute TCM.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

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

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

Eligibility

Only eligible clients may be provided TCM services. Clients must meet the criteria established for psychiatrically disabled adults or emotionally disturbed children.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Eligibility (Cont'd.)

Coverage is limited to psychiatrically disabled adults with a diagnosis of a major mental disorder included in the current edition of the DSM under schizophrenic disorders, major affective disorders, severe personality disorders in the absence of serious antisocial behaviors, psychotic disorders, and delusional (paranoid) disorders. Clients who have been diagnosed with a mental disorder and have had at least one hospitalization for treatment as a result will also meet the criteria for chronically mentally ill.

Coverage is limited to seriously emotionally disturbed children. This criteria includes a diagnosis for an emotional disturbance or neurological impairment as outlined in the current edition of the DSM, and a serious emotional disturbance that has either lasted for more than six months or is projected to continue for more than six months.

Staff Qualifications

Case managers serving this population must, at a minimum, hold a doctoral degree or a masters degree in social work; or a master's degree in psychology, counseling, or a closely related field. Case managers may also possess a bachelor's degree in the aforementioned disciplines, or be an RN licensed to practice by the State Board of Nursing.

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

Service Documentation

This service is not required to be listed on the POC, but should be documented daily on contact.

Billing/Frequency Limits

TCM is billed in unit increments of 15 minutes for a maximum of eight units per day.

Concurrent care shall be rendered to an individual in which another provider has been designated the Primary Case Manager. Concurrent care is billed in unit increments of 15 minutes for a maximum of eight units per day.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billable Places of Service

TCM and CM may be provided at a doctor's office, a client's home or natural environment, an inpatient or outpatient hospital, a CMHC, or other approved community mental health facility. Only CM may be provided in a nursing facility.

Special Restrictions

No clients participating in any waiver program that includes case management services will be case managed under this program.

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

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

- The contact is necessary to assist clients in accessing care from health care providers or community agencies and/or informing clients of actions they must take to successfully access these services. In these situations, the case manager must document the specific service-access actions clients were instructed to take, as well as any actions taken by the case manager to assure this service access. This contact includes brief communication directing clients to Crisis Management or other medical care.
- The contact is necessary to follow up on specific service-access needs of clients. The access arrangements must have been previously planned for clients, and the contact must be designed to monitor the completion of the service by the disabled or otherwise non-compliant individual.

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

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

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PROGRAM SERVICES

Residential Treatment Facility (RTF)

Medicaid reimbursement for case management services rendered to children, from birth to age 21, residing in a Residential Treatment Facility (RTF) or Institution for Mental Disease (IMD) (also known as a "psychiatric hospital") is limited to the following:

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

TCM Overlap and Hierarchy Guidelines

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

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

When a Primary Case Manager (PCM), as well as a secondary provider, for each overlapping situation has been determined, the PCM shall:

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

The PCM has the primary responsibility of integrating information and recommendations from other providers for clients, so that they can develop an integrated, person-centered plan for addressing their multiple needs.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

TCM Overlap and Hierarchy Guidelines (Cont'd.)

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

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

The concurrent care provider will provide different, distinctive types of services from the PCM. Billing is restricted to specific activities.

Community mental health service providers may render TCM services to those clients receiving PCM from another case management provider.

If overlap occurs, these guidelines shall be followed:

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

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

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

DDSN Early Intervention/DMH Targeted: Overlap not anticipated

DMH Managed Care/DMH Targeted: Overlap not permissible

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

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

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

DMH Targeted/SCSDB - Commission for the Blind: SCSDB - Commission for the Blind primary case manager with DMH providing case management services

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

TCM Overlap and Hierarchy Guidelines (Cont'd.)

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

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

DMH Targeted/Baby Net: Overlap is not anticipated

DMH Targeted/HSCI: HSCI primary care manager with DMH providing case management services

In the above list:

- CCEDC = Continuum of Care for Emotionally Disturbed Children
- DDSN = Department of Disabilities and Special Needs
- DMH = Department of Mental Health
- DSS = Department of Social Services
- SCSDB = South Carolina School for the Deaf and Blind
- CLTC = Community Long Term Care
- DAODAS = Department of Alcohol and Other Drug Abuse Services
- CRS = DHEC's Children's Rehabilitation Services
- TMCM = Targeted Maternal Case Management Program
- HSCI = Head and Spinal Cord Injury

The community mental health services providers shall be responsible for all of the following:

- Attempting to identify during the intake process whether an applicant is already receiving case management services from another Medicaid provider
- Notifying any other involved Medicaid case management providers of an applicant's request for services
- Billing Medicaid according to Case Management Hierarchy guidelines for each client receiving case management services from another Medicaid provider

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

TCM Overlap and Hierarchy Guidelines (Cont'd.)

- Not denying needed services to an individual because another provider has been designated the Primary Case Manager
- Notifying other involved agencies or providers if an individual in an overlapping situation terminates their services

Exceptions To TCM Overlap and Hierarchy Guidelines

Community mental health service providers are encouraged to resolve any exceptions to the Case Management Hierarchy at the local agency level. When an exception exists, these guidelines must be followed**:**

- If the community mental health service provider is predominantly meeting the treatment and service needs of the individual, or if the Primary Case Manager has failed to adequately coordinate care and services, the provider may initiate contact with the Primary Case Manager at the local agency level to request a change in the Primary Case Manager. A meeting should be set up between the two agencies to discuss the feasibility of a change in the Primary Case Manager.
- Contacts (telephone or face-to-face) between community mental health service providers and the Primary Case Manager concerning a change in the Primary Case Manager, as well as the final determination of a Primary Case Manager, must be documented in each provider's case management record. Although documentation of these activities is required, the activities are administrative and are not reimbursable by Medicaid.
- If the local providers are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the appropriate state agency levels or main office for review.
- If the state agency or main office administrators are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to DHHS for review.

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PROGRAM SERVICES

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

- DHHS may make the determination of the most appropriate Primary Case Manager or may request that a team of other agency representatives make the determination.
- The involved Medicaid providers will be notified within 45 days after the case is received by DHHS whether a change in the Primary Case Manager is warranted.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

BEHAVIORAL HEALTH DAY TREATMENT (BH-DT)

Service Description

Behavioral Health Day Treatment (BH-DT) provides a continuum of individual, family, and group services that meet the developmental needs of children with severe emotional and/or behavioral disturbances and chronically mentally ill adults. BH-DT provides a time-limited, intensive, coordinated, structured milieu. It is designed to serve the client's needs within the least-restrictive, therapeutically appropriate context. The service is both community- and family-based. The client and the client's family are expected to develop clinically adaptive behavior. The ultimate goal is to produce sufficient change so that the client no longer requires restrictive and intense treatment. Programs will routinely integrate attention to co-occurring substance issues into all aspects of programming, as a high prevalence of co-occurring substance abuse issues and disorders may exist in this population and/or in their families.

BH-DT provides individual, family, and group services for children under 21 years of age with emotional, behavioral, and/or developmental disturbances. These time-limited, intensive, coordinated, and structured milieus are designed to comprehensively evaluate children and their families to develop effective intervention strategies. The child and the child's family are expected to develop clinically adaptive behavior with the ultimate goal of producing sufficient change so that the child will not require restrictive and intensive treatment in the future.

As a result of this service, clients will:

- Show a significant reduction in disruptive and intense problem behaviors that interfere with the child's ability to participate successfully in normal developmental experiences or present a danger to self and/or others
- Develop age-appropriate social and behavioral competencies that will result in enhanced problem solving, coping strategies, self-control, and more successful interactions with other children and adults

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

- Demonstrate an enhanced ability to meaningfully perform age-appropriate role functions and to learn from the home and educational environments

  This will be seen in the child's ability to attend, remain seated, interact, and participate in various tasks for longer periods of time. Further, it provides for an increased capability to interact with adults in therapeutic and educational tasks, resulting in increased educational and emotional functioning.

- Show significant improvements in mood as evidenced by reductions in excessive irritability and/or sadness so the child is emotionally stable and even-tempered

  The improvements in mood will be accompanied by positive changes in self-worth and confidence.

- Reduce behavior which previously made the child unmanageable in the home, school, and community, including reduced use of substances

Parents of participants will:

- Learn strategies for managing problem behaviors and interacting effectively with their children
- Identify and reduce maladaptive patterns and stresses in the home that compound the participating child's emotional problems
- Improve choices and decision making concerning the use of substances in the home as they may affect healthy parenting skills, contribute to stress, and complicate the management of difficult behaviors in the child

BH-DT provides specific assessment, evaluation, treatment activities, and therapeutic structure during program hours. A calendar of scheduled program activities and hours will be posted and available. A clinical summary of the child's participation in the scheduled activities shall be included in the documentation of services received.

BH-DT provides a range of evaluation and therapeutic activities for the children. Child-centered activities occur on an individual and group basis. The activities are designed to promote social and behavioral competencies for children.

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PROGRAM SERVICES

Service Description (Cont'd.)

These competencies include, but are not limited to, increased social participation and involvement, better self-management and control, brighter mood and positive self-worth, greater confidence, reduced aggression, and improved motor abilities.

In order to provide a structured environment, BH-DT offers the following evaluation procedures and therapeutic content. These procedures and content may be rendered through a variety of treatment modalities. The evaluation procedures and therapeutic contents are integrated into the BH-DT programs and are not separately billable during program hours.

- **Behavioral and Emotional Evaluation –** Behavioral and emotional evaluation services involve a determination of the nature of the child's and/or family's problems and contributing factors, and of the strengths and resources of the child and family. BH-DT provides a stable setting in which to evaluate the child's functioning. Behavioral objectives are established and monitored for each child. The child's behavior is reviewed daily and interventions to promote the attainment of the specific objectives are developed. The child's status is documented. Further, parent or caretaker feedback is gathered to identify specific environmental events of relevance, as well as to identify positive and negative behaviors occurring in the home.

  Behavioral evaluation integrates attention to the possible presence of substance abuse issues and disorders in parents. It also evaluates how to engage parents in a discussion about healthy choices in a non-threatening manner, while simultaneously evaluating the possible contributions of the substance abuse to creating a risky environment for the child.

- **Role Performance and Functioning –** This includes face-to-face process interactions between staff and clients that are directed towards the restoration, enhancement, or prevention of deterioration of the client. The interactions are intended to promote social and behavioral

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

competencies for children. BH-DT focuses on the development of age-appropriate emotional, intellectual, behavioral, and interpersonal role functioning within groups. Settings for this intervention may vary from group discussion to age-appropriate developmentally psychotherapeutic practices. Other group modalities facilitating problem identification, processing, and resolution are also used. Groups will incorporate specific attention to making choices and decisions about using substances as a coping strategy. It helps the child or the child's family to develop alternative choices and the necessary skills to implement them.

The child's participation in each activity is assessed to identify problem areas for the child and develop interventions to promote success within the activity.

- **Family Functioning –** BH-DT includes planned interactions between the staff, the child, the child's family, and/or significant others. Interactions with the family and/or caretakers are intended to promote the child's social and behavioral competencies and are directed toward enhancing family functioning. Family functioning treatment must focus on the client's needs and not be directed toward the therapeutic needs of non-clients. The interaction is directed towards the restoration, enhancement, or prevention of deterioration of role performance levels. The therapy assists in the formation of a therapeutic alliance with the family that is directed toward normalizing the role functioning of the client.

  Parent-child interaction is used to evaluate the parent-child dyad. An observation or evaluation of the child in the home environment may also be conducted. Treatment strategies are developed to assist the family or caretakers in promoting positive behaviors in the child, as well as making healthier choices to promote positive behavior and improve parenting skills in themselves.

- **Social and Behavioral Intervention –** This process involves client-staff interactions designed to develop, strengthen, and direct the client towards both acceptable coping and adaptive behavior

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Description (Cont'd.)

within the structured program setting. Staff will provide both individual-based and group-based interactions on a daily basis. The goals of these interactions are to shape and model positive behaviors and reduce disruptive problem behaviors by the use of direct consequences and contingency management.

BH-DT includes the provision of coordination and linkage with needed community services and resources. Services include accessing needed medical, psychiatric, substance abuse, social, and other support services essential to meeting the child's identified needs.

Activities serve as a vehicle for the evaluation and intervention processes that are inherent in the tasks. This includes attention to tasks, pro-social participation, following instructions, self-control, and cooperative efforts.

Eligibility

Children that manifest severe emotional, psychological, and behavioral problems, including co-occuring substance abuse disorders, are eligible. This includes children in the following circumstances:

- Whose current preschool, school, childcare, and/or home placement is at risk without intensive structured services
- Who are returning home or to a family-like setting following a hospitalization or residential placement when the client is not ready to return to a regular school setting
- For whom less restrictive treatments have failed or are not safe
- Who have at least one parent or responsible adult, with whom the child resides, willing to participate in BH-DT, with the goal of keeping the child in, or returning the child to, the school and home
- Who need intensive, highly structured, non-residential services to restore age-appropriate independent functioning

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Special Restrictions

The initial evaluation of a client for admission to the program will not be part of the BH-DT service and may be billed separately as an MHP Assessment. The comprehensive reevaluation, when rendered outside of billed program participation hours for the client, may also be billed separately as an MHP Assessment.

Activities that are purely educational may be necessary components of the BH-DT program, but may not be included as part of the Medicaid service content. The interventions described above, when performed during school hours by mental health staff, are considered part of the treatment and may be billed to Medicaid.

Staff Qualifications

BH-DT services may be provided by any MHP credentialed by the community mental health service provider authority and privileged to render the services through the CMHC's credentialing and privileging process.

Non-MHP staff who possesses a bachelor's degree in a human services field or related area from an accredited university or college are also qualified when supervised by an MHP. The Non-MHP must also have one year of experience in mental health treatment or a related area.

The Non-MHP shall be credentialed and privileged by the community mental health service provider to render BH-DT and shall have access to appropriate training, supervision, and in-services to assure services are rendered in accordance with accepted clinical practice.

Staff-to-Client Ratio

When BH-DT services are rendered in a group setting, the staff-to-client ratio shall be, at a minimum, one staff to eight clients.

The staff required to meet the staff-client ratio for BH-DT shall not bill for other services during the hours of service delivery and shall not be education services staff. Staff shall be in direct contact with clients during program hours.

Physician Direction Requirement

The physician shall be a member of the multi-disciplinary treatment team and must be available during program hours. Additionally, the physician must spend as much time as necessary in the program to assure clients are provided services in a safe, efficient manner in accordance with accepted medical practice.

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PROGRAM SERVICES

Physician Direction Requirement (Cont'd.)

The physician's involvement in the service shall include participation in the multi-disciplinary treatment team meeting of BH-DT program staff.

MHP Supervision Requirement

The program will be supervised by an MHP, who shall be on-site and participate directly in providing program services during program hours.

The MHP is responsible for implementation of the service content. BH-DT does not require the MHP's presence during all program hours; however, an MHP must spend as much time in the program as is necessary to assure that clients receive services in accordance with accepted standards of clinical practice.

Professional staff must also periodically perform a comprehensive review of a client's progress, response to BH-DT, and the need for continued participation in this or alternative treatments. The content of this assessment should be referenced or summarized in the required 90-day Progress Summary.

An MHP affiliated with the program will specify program content to be addressed based on a particular client's needs. The identified needs will be documented on a clinical history and evaluation form or as an entry in the individual client medical record signed by the MHP.

The MHP affiliated with the program must also chair a staff meeting at a minimum of every two weeks during which administrative and client treatment issues are discussed. The staffing results will be referenced or summarized on the POC 90-Day Progress Summary. The staff meeting is not separately billable under another clinical service.

Duration of Treatment

Discharge from BH-DT services should occur within one year from the date of admission to the service. However, an extension of services may be authorized based upon a clinical evaluation of the client's progress in treatment. An MHP affiliated with the service must request the extension.

The physician reviewing the client's treatment plan may grant an extension. The extension may be granted in up to three-month increments. No more than two extensions may be granted during an episode of BH-DT care. In order to foster independence in the client and family, clients must

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PROGRAM SERVICES

Duration of Treatment (Cont'd.)

be discharged from the service within a maximum of 18 months from the date of admission. If the client continues to be unmanageable without the support of the service, at the end of the 18-month, intensive- treatment episode, staff should consider a highly structured, residential placement for the client.

Post discharge from the service, follow-up should be billed under the appropriate community mental health service code, not as BH-DT, even when provided by BH-DT staff. Therefore, the follow-up is not included in the Duration of Treatment, and may continue beyond the 18 months from date of admission.

Service Documentation

BH-DT is required to be listed on the POC with a planned frequency and may be documented on a daily or weekly basis.

If a weekly service note is utilized, it must be placed within the client's record within five working days of the last date of service. The weekly service note must address the dates and the number of hours the client participated in the program. Daily notes should be placed in the medical record within three working days of the date of service.

Professional staff must periodically perform a comprehensive review of a client's progress, response to BH-DT, and need for continued participation in this or alternative treatments. The content of this assessment should be referenced or summarized in the required 90-Day Progress Summary.

The MHP will ensure that the delivery of services with the required service content is documented on a CSN. Either an MHP or other staff may document the interventions provided within BH-DT.

The CSN documenting the service must provide a pertinent clinical description of the interventions, assure that the service conforms to the service description, and authenticate the charges.

There cannot be charges for unstructured client time. Unstructured time may be necessary for a client, but it is not part of the billable service.

Billing/Frequency Limits

BH-DT services are billed in unit increments of 60 minutes with a maximum of eight units per day.

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Billable Places of Service

BH-DT services may be provided at a CMHC or other approved mental health facility.

Relationship to Other Services

Individual Therapy, Family Therapy, Group Therapy, TCM, or MHP Assessment needed by the client outside of service delivery hours may also be billed. Staff must be sure to document the reason these services were necessary after hours. When rendered by BH-DT staff, these services are considered a part of the BH-DT program and should not be billed separately.

Other community mental health services may be billed during BH-DT hours only if BH-DT service time is reduced. Staff must be sure to reduce service time for clients when they are absent from the program to receive these additional services.

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COMMUNITY-BASED WRAPAROUND SERVICES (WRAPS)

Service Description

Community-Based Wraparound Services are rendered to a child with special emotional and/or behavioral needs and/or the child's family which will stabilize or strengthen the child's placement or prevent out-of-home care. Community-Based Wraparound Services are defined as treatment-oriented, goal directed services which provide a therapeutic benefit for the child. Specific services included in the array of Community-Based Wraparound Services are intended to help stabilize and strengthen the placement of emotionally/behaviorally disturbed children, some of whom are severely emotionally disturbed, aggressive, and multi-handicapped. Without the provision of services the emotionally/behaviorally disturbed child may be at jeopardy of placement disruption and/or movement to a more intensive and costly setting or service. Community-Based Wraparound Services must be directed exclusively toward the effective treatment of the emotionally/ behaviorally disturbed child. Under the rehabilitation services option, services may be rendered to other family members provided that the services are directed exclusively to the effective treatment of the child and are not used as a means of treating others rather than the child.

Medical Necessity/ Eligibility

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 Community-Based Wraparound 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. Community-Based Wraparound Services must be initiated as soon as possible after a need is identified. The Medical Necessity Statement is no longer valid if services are not initiated within 90 days of the signature on the Medical Necessity Statement.

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Medical Necessity/ Eligibility (Cont'd.)

Medical necessity must be documented on a Department of Health and Human Services Medical Necessity Statement (An example of a Medical Necessity Statement can be found in Section 5 of this manual under the heading "Exhibits."). A Medical Necessity Statement signed by a physician or other Licensed Practitioner of the Healing Arts, or a Physician's Medical Order (PMO) signed by a physician must be completed for each child in need of a Community-Based Wraparound Service.

The Medical Necessity Statement(s) must clearly identify the therapeutic need(s) of the Community-Based Wraparound Service(s) to be rendered. The Medical Necessity Statement must be completed at the time of referral. A copy of the fully executed Medical Necessity Statement or PMO must be maintained in the client record. The Medical Necessity Statement serves to:

- Establish the level of care the child requires. A separate Medical Necessity Statement or PMO is required for each Community-Based Wraparound Service (*i.e.*, Behavioral Intervention, Caregiver Services, etc.)
- Identify current problem areas that need to be addressed by the treatment provider, **and**
- Provide documentation that placement has been recommended by a physician or other Licensed Practitioner of the Healing Arts.

Staff Credential/Minimum Education Requirements

Identification/Assessment, Evaluation, Counseling, and/or Therapy providers must meet, at a minimum, one of the following credentialing criteria:

Psychologist – A holder of a doctoral degree in Psychology from an accredited university or college who is licensed by the appropriate State Board of Examiners in the clinical, school or counseling areas and who has a minimum of one year of experience working with the population which is to be served

Mental Health Counselor – A holder of 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 who has a minimum of one-year of

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Staff Credential/Minimum Education Requirements (Cont'd.)

experience working with the population which is to be served

Social Worker – A holder of a master's degree from an accredited university or college who is licensed by the State Board of Social Work Examiners and who has a minimum of one year of experience working with the population which is to be served

Mental Health Professional Masters Equivalent – A holder of a master's degree in a closely related field that is applicable to the bio/psycho/social sciences or to treatment of the mentally ill; or a Ph.D. candidate who has bypassed the masters degree but has sufficient hours to satisfy a masters degree requirement; or a professional who is credentialed as a Licensed Professional Counselor and who has a minimum of one year of experience working with the population which is to be served

Clinical Chaplain – A holder of a Master of Divinity degree from an accredited theological seminary who has one year of Clinical Pastoral Education that includes provision of supervised clinical services and who has a minimum of one-year of experience working with the population which is to be served

Behavior Intervention, Caregiver Services, Independent Living, and Community Support Services providers must hold, at a minimum, a High School diploma or the equivalent, and be supervised by an appropriately credentialed professional as defined by the Children's Behavioral Health Services standard for Lead Clinical Staff.

Temporary De-escalation Care (TDC)/Crisis Stabilization providers must meet the minimum qualifications for the level of service where the TDC is being provided. Example: If TDC is being rendered in a group home, the credentialing criteria for a group home must be met.

Training Requirements

The referring state agency shall ensure and document that all staff, subcontractors, volunteers, interns, or other individuals under the authority of the provider who come in contact with referring agency clients are properly qualified and trained. The referring state agency will ensure that para-professional providers of Behavior Intervention, Independent Living, Community Support

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Training Requirements (Cont'd.)

Services and Caregiver services receive training as follows:

Pre-Service delivery – a minimum of four hours in the following topics:

- Orientation
- Characteristics of emotional disturbances
- Responsibility of a WRAP Worker
- Identification of Abuse/Neglect

Providers must also complete an additional one hour of documentation training.

If a worker is to perform a restraint/therapeutic hold, then an additional four hours of restraint/therapeutic hold training must occur.

Follow-up training must occur. The requirement is an annual two-hour refresher course. In addition, if the workers utilize restraint/therapeutic hold, workers need to complete recertification in the type of restraint/ therapeutic hold.

Service Content

Identification/Assessment – Services delivered for the purpose of identifying, assessing, diagnosing, and developing recommendations for treatment or service needs

Evaluation – The systematic appraisal of a child's functional level in various domains such as educational, social, and psychological to determine the nature and extent of psychological treatment and/or services which may be required

Counseling – Regularly scheduled goal-oriented interventions which are responsive to the needs of the client and delivered by an appropriately credentialed professional for the purposes of assisting the child in solving problems related to emotional and/or behavioral issues through cognitive and affective modes

Therapy – Intensive psychological or psychiatric intervention aimed at behavioral, attitudinal or emotional change that is inclusive of individual, family, and/or group therapy modalities. The purpose includes the following: to help the child understand the meaning of his or her behavior so that he or she can deal with his or her feelings; to control the child's anxiety and aggression and channel

Service Content (Cont'd.)

them more constructively; to help family members/caregivers see how their attitudes are affecting the child; and/or to help family members/caregivers find new ways to interact appropriately with the emotionally disturbed child.

Behavioral Intervention – Regularly scheduled interventions designed to optimize a child's emotional and behavioral functioning in his or her natural environment through the application of clinically planned techniques that promote the development of healthy coping skills, adaptive patterns of interacting with others, and appropriate responses to environmental stimuli. Behavioral shaping and redirection are essential components of the service. A primary focus is to assist the child in restructuring his or her milieu so that more positive treatment outcomes can be realized. The service provides a child the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment. This is accomplished through a one-on-one relationship (face-to-face) contact between a child and the Behavioral Interventionist as they participate in a variety of structured therapeutic activities. Behavioral Intervention may be employed to analyze the dysfunctional behavior and design specific techniques to reduce or eliminate undesired behaviors. Specific strategies may be used to change, control, or manage dysfunctional behavior.

Temporary De-escalation Care/Crisis Stabilization (to be provided in a residential setting) – Short-term community-based services that are available to children with emotional and/or behavioral disturbances and primary caregivers whose lives are often marked by social stressors due to the constant demands of caring for an emotionally/behaviorally disturbed child. These stressors are severe enough to cause disruption in the child's living arrangements. Services focus on the child's medical necessity for the service, and are designed to de-escalate a potential crisis situation and/or provide a therapeutic outlet for a child's emotional/behavioral problems. The overriding goal is to prevent the permanent disruption of a child's placement. While in care, the child receives supervised and structured services with provisions for meeting the child's basic health, nutritional, daily living, and treatment needs.

Temporary De-escalation Care will usually be provided for

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PROGRAM SERVICES

Service Content (Cont'd.)

one to four days at a time. With adequate justification, the child's treatment team (or, if there is no treatment team, the state agency case manager) may allow Temporary De-escalation Care to be for a maximum of 30 days at a time. The County or Regional Director of the referring state agency or his or her designee may approve no more than two 15-day extensions to the total length of stay. Documentation of this approval must be present in the record. In no case will a child remain in Temporary De-escalation Care for more than 60 days at one time.

Independent Living (non-residential) – Individualized instruction and supportive services provided in the community for youth who are transitioning into independent living. Services are divided into two categories: Basic Living Skills and Social Skills.

- **Basic Living Skills** – Development and restoration of basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness, and mobility skills
- **Social Skills** – Development or redevelopment of skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques

Caregiver Services – Face-to-face interventions with the caregiver (parent, guardian, or custodian) to enable the caregiver to serve as the primary treatment agent in the delivery of therapeutic service to their emotionally/behaviorally disturbed child. This service is designed to develop and/or improve the ability of caregivers to care for their emotionally/behaviorally disturbed child and enhance the treatment process. Instruction, formal or informal, will be provided to the caregiver for the purpose of enabling the caregiver to better understand and care for the emotional/behavioral needs of the child and participate in the treatment process for the child. Services must only be provided to the caregiver and directed exclusively to the effective treatment of the emotionally/ behaviorally disturbed child. Services are available to the biological family/guardian of a child who is transitioning home from an out-of-home placement. Otherwise, the emotionally disturbed child must reside in the caregiver's home.

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PROGRAM SERVICES

Service Content (Cont'd.)

Community Support Services – Community Support Services must be specifically designed to address a child's mental health needs and are supervised by appropriately qualified staff. Services are designed to develop skills and maintain or improve overall emotional/behavioral functioning and maintain functional and behavioral gains from the school year. Services must be tied to identified needs with achievable outcomes for acquiring desired behaviors or eliminating maladaptive behaviors.

The goal of Community Support Services is to remediate significant impairments and improve the client's level of functioning. All therapies and activities must be therapeutically designed to meet specific goals in the child's treatment plan and be related to management of the child's emotional/behavioral needs, skill building, and improvement or maintenance of functioning. Group activities would be appropriate, provided they promote developmentally appropriate behaviors, skill building, and improvement or maintenance of functioning. Activities must assist children in developing/enhancing self-expression, social interaction, and self-esteem. Community Support Services may be provided on school grounds, at a community program, or in therapeutic camps during periods when child is not in school.

The staff to client ratio for Community Support Services shall be a minimum of one staff to eight children during program hours. Therapeutic camps operate on an overnight, full-day, or half-day schedule.

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

- A minimum of two staff must be present in each cottage/residence. On-call staff must be available for emergencies; AND
- A minimum ratio of one staff to 10 children must be maintained during sleeping hours in each cottage/residence.
- Staff shall be physically available, on-site at the program. There must be staff designated as "on-call" who are available for emergencies.

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PROGRAM SERVICES

Treatment Planning

The Service/Treatment Plan validates the necessity and appropriateness of services. It outlines the needed Community-Based Wraparound Services identified by the state agency and/or treatment team. Activities rendered to the child must relate directly to the Community-Based Wraparound Services goals and objectives identified on the Service/Treatment Plan.

All of the following requirements must be met:

- Each specific Community-Based Wraparound Service **(excluding Temporary De-escalation Care)** must be listed on each child's Service/Treatment Plan and be individualized to the specific needs of each child.
- A Service/Treatment Plan goal must be written for each service that is outcome oriented and individualized to the specific needs of each child.
- The provider of each service must be listed on the Service/Treatment Plan.
- The frequency of the service must be listed on the Service/Treatment Plan as "PRN, but not to exceed a specific number of units/hours per week/month." In addition, if the number of units/hours rendered exceeds the frequency listed on the service/treatment plan, the service provider must document the reason(s) for exceeding the frequency. The state agency case manager must authorize that the additional units were appropriate and necessary on a CSN.
- The Initial Service/Treatment Plan must be signed (with title and date) by the authorized state agency representative and placed in the client's record by the 30th day of admission to the program.
- A documented review of the Service/Treatment Plan must be completed every 90 days.
- Service/Treatment Plans must be reformulated, at a minimum, every 365 days.

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Service Documentation

Community-Based Wraparound Services records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order such that the records can be easily and clearly reviewed, copied, and audited. Records shall be retained for a period of three years after the last payment date. If any litigation, claims, or other actions involving the records have been initiated prior to the expiration of the three year period, the records shall be retained until completion of the action/resolution of all issues which arise from it or until the end of the three year period, whichever is later.

Records must be maintained as follows:

- Clinical Service Notes (CSNs) must be typed or handwritten using only black or blue ink.
- CSNs must be legible and filed in chronological order.
- CSNs must be dated and legibly signed by appropriately credentialed staff and the staff who provided the Community-Based Wraparound Services.
- CSNs must be placed in the client's record within 30 days from the date of rendering the service.
- Only approved abbreviations and symbols may be used. An abbreviation key must be maintained to support the use of abbreviations and symbols in entries.

Since Community-Based Wraparound Services records are legal documents; providers, therapists, and appropriately credentialed staff should be extremely cautious in making alterations to them. Whenever errors are made or late entries are required, adhere to the following guidelines:

Proper Error Correction Procedures

If an error is made, clearly draw one line through the error, write "error" to the side in parentheses, enter the correction, and add signature and date.

Errors cannot be totally marked through, as the information in error must remain legible.

No correction fluid may be used.

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PROGRAM SERVICES

Service Documentation (Cont'd.)

Handling Omissions in Documentation

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 rarely be used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

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

Index

An Index as to how the Community-Based Wraparound Services record is organized must be maintained and made available to Medicaid reviewers/auditors at the time of an on-site visit.

CSNs

CSNs must address the following in order to provide a pertinent clinical description, assure the service conforms to the service description, and authenticate the charges:

- Type of service
- Date of service
- Amount of time of service provision (listed for each date of service)
- Description of client's emotional state, physical appearance if pertinent, and location of the service
- Actions of the staff, interventions rendered, and interaction between the staff and the client
- Client's response to interventions/treatment including progress or lack of progress made in treatment,

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PROGRAM SERVICES

Service Documentation (Cont'd.)

- Recommendations and future plans for working with the client.

CSNs must be individualized, specific to each child, and relate to the Community-Based Wraparound Services goals and objectives. CSNs should clearly document why an activity was selected, what the staff expected to accomplish, all individuals involved in the activity, and whether the activity was successful.

Other Criteria/Special Restrictions

The time that a Community-Based Wraparound Services provider participates in Service/Treatment Planning meetings may be billed to Medicaid. CSNs must include the provider's involvement in the Treatment Planning meetings. Only the actual time spent in the meeting may be billed. Discussions with other professionals prior to or following the meeting may not be included in the "bill time."

Coordination/arrangement/follow-up of appointments or other services to meet the needs of an emotionally/behaviorally-disturbed child must be completed by the appropriately credentialed staff and not by the Community-Based Wraparound Services provider.

Interventions must be therapeutic in nature and medically necessary.

Overnight therapeutic camp programs are an all-inclusive service and are billed at a daily rate. Medicaid reimbursement under the Absentee Day policy is not available for out-of-home placement services for the days a child attends an overnight therapeutic camp if the out-of-home placement provider also provides the therapeutic camp services.

Only emotionally/behaviorally disturbed children who reside in "regular" foster care, therapeutic foster care, with their parents, other family members, or significant others are eligible to receive Community Support Services.

The only Community-Based Wraparound Services component which can be billed on the same day as MHS-NOS is Behavior Intervention.

Community-Based Wraparound Services may not be billed concurrently with Clinical Day Programming (CDP) (*i.e.*, during the CDP program hours).

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PROGRAM SERVICES

Other Criteria/Special Restrictions (Cont'd.)

Coordination of care must occur for clients who are being served by multiple agencies. Coordination between agencies should occur within 30 days of an agency providing Community-Based Wraparound Services for a client. Each provider shall be responsible for: a) attempting to identify during the intake process whether a client is already receiving Community-Based Wraparound Services from another Medicaid provider, and b) notifying any other involved Medicaid providers of the client's need for services. Needed services should never be denied to an individual because another provider has been identified as a Community-Based Wraparound Services provider. Each provider shall notify other involved agencies or providers within 30 days if an individual in an overlapping situation terminates their services.

Community Support Services that are provided in a therapeutic camp setting cannot be billed concurrently (during the same time frame) with any other Community-Based Wraparound Services.

Non-reimbursable Activities

Medicaid reimbursement is not available for respite care. Therefore, the documentation to support the reimbursement for Temporary De-escalation Care (TDC) must clearly document the treatment services rendered and the therapeutic benefit to the child. If the treatment components are not included, the services will be subject to recoupment in a Medicaid post-payment review.

Community-Based Wraparound Services and transportation services must not be billed to Medicaid simultaneously, even though there may be situations where the two services are rendered simultaneously.

Example: In a situation where a Behavior Intervention provider is transporting a child to the doctor, Medicaid will not pay the Behavior Intervention provider to render services at the same time it is reimbursing mileage. **However, Medicaid can pay a transportation provider for mileage under a Medicaid transportation contract and a Behavior Intervenist for Behavior Intervention services provided two different people render the services and an escort is not billed under the Medicaid transportation contract.**

Medicaid may not be billed for "no shows."

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PROGRAM SERVICES

Non-reimbursable Activities (Cont'd.)

Medicaid may not be billed for more time than is actually spent with the person to whom the service is rendered. For example, if a service is directed exclusively to the child, the time spent communicating with the family cannot be included in the time/units billed to Medicaid.

Medicaid reimbursement is available only for services that are:

- Included in the treatment plan
- Have a therapeutic component or purpose
- Not solely formal educational training or academic tutoring, job training, or vocational services
- Not social, recreational, or religious activities

Medicaid does not cover fees for community recreational opportunities, memberships in a YMCA or YWCA programs, regular summer camp programs, sports-related camps, riding lessons, fishing lessons, or music lessons.

Medicaid may not be billed if the CSN only documents observation.

Medicaid reimbursement is not available for Community Support Services provided to clients in residential placements (excluding "regular" and Therapeutic Foster Care).

Measurable Outcomes

Outcomes will be reported by state agencies to DHHS in an annual report to be received within 90 days after the close of the state fiscal year. The outcomes report should summarize the programs and client outcomes including the number of children receiving Community-Based Wraparound Services, their ages, and the specific Community-Based Wraparound Services component(s) received.

Note: The Department of Behavioral Health Services will monitor agency and school district billings for services under the new Community-based Wraparound Services Standard, and any billings that appear to be excessive will be reviewed. In addition, excessive billings may be audited by either the Division of Program Integrity or the Division of Audits.

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PROGRAM SERVICES

Billable Places of Service

WRAPS may be provided in the client's home or natural environment or other approved community mental health facility.

Relationship to Other Services

WRAPS may not be billed on the same days as BHP-ES or PRS. The only WRAP component that may be billed on the same day as MHS-NOS is Behavior Intervention. This service may not be billed concurrently with BH-DT.

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PROGRAM SERVICES

MENTAL HEALTH SERVICES NOS (MHS-NOS)

Service Description

Mental Health Services Not Otherwise Specified (MHS-NOS), formerly known as Intensive Family Services, are time-limited, clinical interventions predominantly provided within the home and community environment of an identified child. These services are designed to serve children and adolescents under the age of 21.

MHS-NOS are behavioral, psychological, and psychosocial in orientation. They are multi-faceted and include crisis management, individual and family counseling, skills training, coordination and linkage with other necessary services, resources, and supports to prevent utilization of more restrictive residential services. The services are child centered, have a family focus, and have an ecological, holistic perspective. This would include the child's family, community, educational 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 how to anticipate and defuse future crises. Consequently, the likelihood of recurrence is reduced.

Planned interventions assist the family to develop relationships with naturally occurring community networks that support positive adaptation and facilitate the child's adjustment with schools, peers, and community activities.

MHS-NOS are intended to affect the following outcomes for child clients and their families:

- 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, and residential treatment facility)

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Service Description (Cont'd.)

- 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
- Prevent disruption of the child's home environment
- Promote reunification of the child back into a family
- Ensure the child client's safety and protection within their home environment

Medical Necessity and Prior Authorization

MHS-NOS must be recommended by a physician or other Licensed Practitioner of the Healing Arts (LPHA) who will certify that the identified child meets at least one of the following medical necessity criteria:

- The identified child will be removed from the home if MHS-NOS is 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.
- The identified child's return home is deemed likely to be unsuccessful if MHS-NOS is not rendered. The child and family require this service in order to successfully return the child back into the home environment following an out-of-home placement.
- The identified child and/or the child's home environment is experiencing problems that threaten the child's safety and well-being or family stability.
- The child is at risk of involvement with, or further penetration into, the juvenile justice system.
- An immediate family member of the client meets the criteria for psychoactive substance abuse or dependency according to the most recent edition of the American Psychiatric Association's (APA) *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 APA's *DSM*. This includes the use of appropriate V Codes for diagnostic purposes. Refer to Section 4 of this manual for a listing of V Codes.

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PROGRAM SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

The medical necessity is documented by the completion of a Medical Necessity Statement. Refer to "Exhibits" in Section 5 of this manual for an example of the Medical Necessity Statement. The designated referring agent must ensure that a physician or other LPHA evaluates the identified child and recommends that he or she meets the medical necessity criteria for MHS-NOS. The Medical Necessity Statement provides documentation and/or justification of the identified child's problem areas and/or needs which require MHS-NOS. After the medical necessity for services has been determined, the designated referring agent will provide the Medical Necessity Statement, if appropriate, to the service provider, prior to or no later than, 10 days after the time of initial service delivery. The Medical Necessity Statement must be placed in the child's clinical record with the child's initial treatment plan. For further information, refer to "Medical Necessity" under the heading "Program Requirements" in this section.

In order to be Medicaid reimbursable, the service must be authorized by a designated referring agent prior to service delivery. If applicable, authorization for services is accomplished through the completion of a DHHS Referral Form/Authorization for Services Form 254. Refer to "Exhibits" in Section 5 of this manual for an example of DHHS Form 254. DHHS Form 254 is required whenever state agencies refer a client to a private treatment provider. The designated referring agent will provide the treatment provider with the original copy of this form within 10 days of the date of referral.

Staff Qualifications

Services shall be rendered by appropriately trained Lead Clinical Staff (LCS) and/or trained staff who work under the direct supervision of LCS.

Lead Clinical Staff – All LCS shall meet the professional standards defined by DHHS as outlined under the heading "Provider Qualifications" in this section of the manual. Before rendering 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

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PROGRAM SERVICES

Staff Qualifications (Cont'd.)

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 MHS-NOS, the following professionals may serve as LCS ***in addition*** to those listed in the "Clinical Staff" section of this manual:

- **Physicians** must be doctors of medicine and be licensed by the appropriate State Board of Medical Examiners. They are also required to have a minimum of one year of experience working with the population to be served.
- **Psychiatrists** must be licensed MDs who have completed a residency in psychiatry. They are also required to have a minimum of one year of experience working with the population to be served.
- **Early Childhood Specialists** must possess a master's degree in early childhood education or child development. Further, they must have a minimum of one year of experience working with the population to be served.
- **Advanced Practice Registered Nurses** must be licensed to practice as RNs with AP certification and currently be practicing under a physician preceptor according to a mutually agreed upon protocol. APRNs must also have a minimum of one year of experience working with the population to be served.
- **Licensed Marriage and Family Therapists** must be licensed by the appropriate State Board of Examiners as Marriage and Family Therapists. They must also have a minimum of one year of experience working with the population to be served.
- **Advanced Practice Registered Nurses Specializing in Psychiatric Nursing** must be licensed to practice as an RN with AP certification and be currently practicing under a physician preceptor according to a mutually agreed upon protocol. Additionally, APRNs must have completed advanced study and clinical practice in a

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PROGRAM SERVICES

Staff Qualifications (Cont'd.)

master's program in psychiatric nursing and have gained expert knowledge in the care and prevention of mental disorders. They must also have a minimum of one year of experience working with the population to be served.

Non-Lead Clinical Staff – Non-LCS who are supervised by an LCS may provide services. Non-LCS must be at least 21 years of age and be privileged by the program to render the service. Further, they 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 must also sign 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 or 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 LCS member to function as a supervisor for clinical oversight of the program's LCS and Non-LCS. In some cases, the same individual can perform the two roles.

Supervising Lead Clinical Staff

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

- Providing direct involvement in evaluating, assessing, and treating children and families
- Developing and signing treatment plans
- Providing and/or supervising service delivery, as well as periodically confirming the medical necessity of continued treatment

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PROGRAM SERVICES

Supervision (Cont'd.)

- Assuring that services are provided in accordance with accepted standards of clinical practice in a safe, efficient manner
- Providing supervision to all staff. Supervision must be provided weekly. Periods of supervision may be scheduled incrementally as deemed appropriate. Supervision must include opportunities for discussion of treatment plans and client progress. Documentation of supervision must be maintained. Case supervision and consultation do not supplant training requirements.
- Facilitating regular staffings, once a week at a minimum, in which administrative and client treatment issues and progress are considered. Staffings shall consist of an overview of the services rendered, the identified child 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.
- Assuring that supervision shall be available to the staff 24 hours per day, seven days per week
- Co-signing all Medicaid documentation of Non-LCS
- Providing and documenting weekly supervision of all LCS and Non-LCS in an individual or group setting. Regular supervision includes 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

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PROGRAM SERVICES

Referral and Intake

The MHS-NOS provider shall have a mechanism in place that allows for a 24 hours per day, seven days per week response to initiate screening of a referred child or family.

For children whose physical safety may be at risk and/or children at risk of imminent removal, a prompt response (acceptance or rejection) regarding the appropriateness of the referral should be made within 72 hours.

For children in need of the services, but not at risk of imminent removal, a prompt response (acceptance or rejection) regarding the appropriateness of the referral should be made within one week.

Notification will be sent to the referring agency, *if applicable*, of the acceptance or rejection of the identified child or family for MHS-NOS. If the MHS-NOS are denied, a justification for a decision of rejection should be included.

At least one family member with whom the identified child is living, or will be returning to live with, should be willing to participate in MHS-NOS. The goal is to keep the child in the home, return the child to the home, or strengthen the family unit when abuse and/or neglect is the reason for the referral. When the referral is brought forward due to family conflict, delinquent acts, or chronic runaway behaviors of the identified child, at least one family member, which may include the child, must be willing to participate.

Program Content

MHS-NOS shall be provided for identified children based on assessed needs. These services may be rendered either face-to-face or telephonically. The intent is that this service be provided face-to-face, but it may be provided by telephone under extenuating circumstances. Documentation must support the extenuating circumstances which warrant telephonic provision. 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 an identified child's abilities to function within his or her home environment and to enhance the family's level of functioning

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Content (Cont'd.)

- Identify and assist an identified child and his or her family in resolving conflicts
- Coordinate efforts between the LCS, a child and family, and the designated referring agent
- Communicate and demonstrate methods of appropriate skills and/or behavior management techniques to help family members effectively manage certain behaviors
- Support or strengthen an 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 a child's peer relations and school performances
- Encourage family members to promote a child's positive social relations and academic performance

Clinical Interventions

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

- 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 or mental health systems
- Teach the family to interact with the identified child in ways that increase parental authority 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 him or her in behaviors that lead to acceptance in pro-social peer groups
- Collaborate with family members and schools in obtaining the identified child's conformance to school rules and improving his or her academic performance

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PROGRAM SERVICES

Clinical Interventions (Cont'd.)

- Teach the identified child to increase recognition of the associations between problems he or she is having and his or her behavior, set goals, evaluate the consequences of antisocial responses to conditions that impede the child from realizing goals, and develop and implement pro-social plans in their place
- Make, coordinate, and follow up on referrals for more specialized therapeutic interventions

Duration of Services

Services are available 24 hours a day, seven days a week.

Services will not exceed 24 weeks in a single year (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 be consecutive.

Staff-to-Client Ratio

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

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.

Service 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 the heading "Documentation Requirements" in this section of the manual. 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 treatment to be provided, the expected frequency of contact and

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PROGRAM SERVICES

Client Record (Cont'd.)

duration of treatment, financial responsibility, and the rights and responsibilities of the identified child/family in the treatment process

- A standardized fact sheet containing the following:
  - The name, date of birth, sex, race, and educational level of the child
  - A current address and telephone number, and family's addresses and telephone numbers if different
  - Names, relationships, addresses, and telephone numbers of other members of child's primary family or 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 providing service(s) 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 or needs of the child, family, school, peers, neighborhood, community, and linkages between the systems
- Assessments should be derived from interactions and interviews with the identified child, family, or key informants conducted in the child's social environment. Assessments should 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Individualized Treatment Plan

Initial Treatment Plan – An initial treatment plan must be developed within 10 days of the date 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 family and the LCS, after a thorough assessment of the child and family's strengths and needs. The referring agency's case manager must also collaborate on the development of the plan.

This plan must be signed and dated by the supervising LCS and the primary LCS. The identified child and/or family members should sign the treatment plan indicating their commitment to the treatment process.

Components of the plan – The treatment plan shall address the following:

- **The specific problems or behaviors that require the provision of MHS-NOS**

  This would include the combination of factors in the family, home, school peer group, neighborhood, and community that contribute to the child's referral problems

- **Intermediary goals to be accomplished**

  The goals should be realistic (*i.e.*, obtainable), measurable, individualized, and should relate to the assessed problems and needs of the identified child. The goals should also be outcome-oriented and based on the child's current level of functioning.

- **Methods and frequencies of intervention**

  This should include the responsibilities of the LCS, the responsibilities of 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 services must be reviewed, at a minimum, every four weeks. However, when a significant event occurs which affects the course of treatment, a review is required. The purpose of the review(s) is to assess the treatment progress and continued need for services, as well as ensuring

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PROGRAM SERVICES

Individualized Treatment Plan (Cont'd.)

services and treatment goals continue to be appropriate to the identified child's needs. The LCS shall continually make any necessary revisions to the treatment plan. Further, the LCS shall sign and date the plan at each review. For further information on treatment plans, refer to "Individual Treatment Plans" under the heading "Documentation Requirements" in this section of the manual.

Clinical Documentation

All services must be documented in Progress Summary Notes. The Progress Summary Notes must be completed as follows:

- Each time a service is rendered
- Whenever information is obtained that has a bearing on the identified child's treatment
- On dates of plan of care 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

The LCS must sign and date the form as the person responsible for the provision of services. The LCS' 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 and date the Progress Summary Note as the service provider. For further information, refer to "Progress Summaries" under the heading "Documentation Requirements" in this section of the manual.

Discharge Summary

Upon completion of an MHS-NOS program, a discharge summary shall be completed. The summary shall include the problems addressed during the course of treatment, the status of the identified child and family with regard to each treatment intervention taken, and recommendations for continuing treatment if appropriate.

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

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PROGRAM SERVICES

Program Evaluation and Outcome Criteria

To the extent measurable, programs will be evaluated on their effectiveness in the prevention of costly and restrictive treatment options, as well as their ability to assist children in functioning successfully within their home and school environments. Additionally, programs are required to submit an annual report to the DHHS Program Manager describing their progress in meeting the outcome criteria within 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, 80% of the children reside in the home of family or a consistent stable caregiver.

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

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

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

OC5 – For a one-year period after planned discharge, 85% of the children do not return to MH-NOS or a more restrictive level of services (*i.e.*, a residential placement).

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

OC7 – After discharge, 75% of family responses indicate satisfaction with services received.

OC8 – After discharge, 75% of referring agencies indicate satisfaction with services received.

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PROGRAM SERVICES

Billable Places of Service

MHS-NOS may be provided in the client's home or natural environment, or other approved community mental health facility.

Relationship to Other Services

Only Injectable Medication Administration, PMA, Nursing Services, MH Service Plan Development and MH Assessment by Non-Physician may be billed on the same day as MHS-NOS. MH Assessment by Non-Physician may only be billed on the first day of MHS-NOS.

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PROGRAM SERVICES

BEHAVIORAL HEALTH PREVENTION-EDUCATION SERVICES (BHP-ES)

Service Description

Behavioral Health Prevention-Education Services (BHP-ES) are interventions provided, with parental consent, to clients who are enrolled in school and exhibiting emotional and behavioral difficulties. This includes children who may have co-occurring emotional disturbance and substance use issues or disorders. Services to this population are provided within the school environment and are both community- and family-based. An ecological perspective is utilized in the treatment of these clients and their families.

Through BHP-ES, a continuum of mental health services for children, adolescents, and their families is provided. BHP-ES offer treatment and support at early points to children and youth who are already exhibiting significant emotional disturbances, and assist parents, teachers, and counselors in working with them. BHP-ES target troubled youth who often are not otherwise identified (*i.e.*, depressed youth). BHP-ES provide increased efficiency and accessibility of traditional child and family mental health services and are able to take advantage of opportunities for early intervention and preventive work. Through the delivery of BHP-ES, youth and their families are expected to make clinically adaptive behavior changes such that the youth can successfully function in school, as well as the community and family setting.

BHP-ES shall be provided for each client based on assessed needs. School-based services take advantage of school settings to maximize treatment effects. The program components of school-based services include the following:

Care Coordination – BHP-ES often include the coordination of needed community services and resources. Care coordination may involve accessing needed medical, psychiatric, substance abuse, social, educational, and other support services essential to meeting the needs of identified children, adolescents, and their families. Coordination of care helps children and families develop skills such that they can more efficiently manage multiple needs.

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PROGRAM SERVICES

Service Description (Cont'd.)

Consultation – Consultative services are an integral part of BHP-ES, sometimes occurring several times a day for a single client with school professionals. Consultation with teachers, guidance counselors, and other school professionals, as well as parents, community service providers, treatment teams, court systems, etc., is necessary to facilitate appropriate sharing of clinical information, and to enhance the coordination of services. Issues such as discipline and poor interpersonal relations are often related to clinical treatment. Consultative services often allow early intervention (*e.g.*, limited service contacts) to occur, preventing the need for more formal treatment to be established. A significant consultative role with families is centered on clarifying treatment needs and aiding in efforts on behalf of the client. Parent and/or teacher conferences are included in this service component.

Individual and Family Counseling – Counseling is a face-to-face, goal-oriented intervention between the BHP-ES clinician and an identified child and/or family members. This systematic intervention may be required for the following reasons:

- To stabilize the child's situation at school or within the family setting
- To provide a therapeutic and supportive process to verbalize thoughts, feelings, and ideas in a supportive environment
- To solve identified problems (including addressing concurrent substance use difficulties), decrease levels of anxiety, hostility, and/or depression
- To develop feelings of self-esteem and self-worth

Crisis Resolution –Crises that require immediate mental health intervention occur fairly regularly in school and family settings. Crisis resolution strategies can be employed to reduce immediate personal distress, assess the precipitant(s) that resulted in the crisis, or reduce the chance of future crisis situations through the implementation of preventive strategies.

Crisis intervention services must be prepared to integrate attention to co-occurring substance use that may contribute to the crisis.

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PROGRAM SERVICES

Service Description (Cont'd.)

Group Counseling/Skills Development – This component allows the BHP-ES clinician to address the needs of several clients at the same time and mobilize group support for the clients.

This is a critical ingredient in the treatment of children and adolescents.

The focus of this intervention can be process treatment groups, or it can be structured with social competence themes such as children handling divorce, anger management, and communication skills. Groups for children with emotional disturbances may create a productive environment for discussing substance use, choices, decisions, and skills. For those children who may not accept or need formal substance abuse treatment, or who would not accept any service outside the school setting, it helps develop a peer context that supports abstinence.

This service can also provide interventions to family members where their involvement relates directly to the identified needs of the client (*e.g.*, understanding ADHD).

Eligibility

Students (including those with co-occurring substance use disorders) exhibiting behavioral and/or emotional difficulties, DSM criteria for emotional disturbance, or significant deterioration of school role performance and/or functioning are eligible for this service.

Note: Students experiencing academic achievement problems only (without behavioral and/or emotional difficulties) are not eligible for this service.

All clients must be enrolled in school to be eligible for BHP-ES. Students actively enrolled in school, but temporarily out of school (*e.g.*, suspensions, illness) remain eligible for this service. Students out of school must receive a face-to-face service to restart the billing for this service after three consecutive billing days of telephonic contacts.

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PROGRAM SERVICES

Staff Qualifications

To provide services, a Non-MHP shall be under the supervision of an MHP, and must possesses a bachelor's degree in a human services field or related area from an accredited university or college and one year of experience in mental health treatment or a related area, or be currently enrolled in a master's level program in the human services field at an accredited university or college.

The Non-MHP shall be credentialed and privileged by the community mental health services provider authority to render BHP-ES and shall have access to appropriate training, supervision, and in-services to assure services are rendered in accordance with accepted clinical practice.

Staff-to-Client Ratio

The minimum staff-to-client ratio assigned to the program shall be one staff to eight clients.

The staff required to meet the staff ratio for the BHP-ES program shall not bill for other services during program hours or be education services staff. All staff present for the purpose of satisfying the ratio shall be in direct contact with clients during program hours.

MHP Responsibility

The MHP is responsible for implementation of the service content. BHP-ES does not require the MHP to be present during all program hours; however, an MHP must spend as much time in the program as is necessary to assure that clients receive services in accordance with accepted standards of clinical practice.

An MHP affiliated with the program will specify program content to be addressed based on client needs. The client needs will be stated on the Clinical History and Evaluation form as an entry on an individual client's medical record signed by the MHP.

An MHP affiliated with the program will conduct a staffing at least every two weeks in which treatment issues are discussed. The staffing results will be referenced or summarized on the POC, 90-Day Progress Summary. The staffing is not separately billable under other center services.

Service Documentation

BHP-ES are required to be listed on the POC with planned frequency and documented daily on contact.

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Billing/Frequency Limits	This service is billed in daily unit increments for a maximum of one per day.
Billable Places of Service	BHP-ES may be provided at the CMHC, in the client's home or natural environment, or other approved facility.
Relationship to Other Services	BHP-ES may not be billed on the same day as BH-DT or MHS-NOS.

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PROGRAM SERVICES

MH SERVICE PLAN DEVELOPMENT BY NON-PHYSICIAN

Service Description

MH Service Plan Development by Non-Physician is a face-to-face or telephonic interaction between a physician and a Mental Health Professional (MHP) to jointly assess the client's mental and physical strengths, weaknesses, social history, and support systems; and to establish treatment goals and treatment services to reach those goals.

Eligibility

All clients are eligible for MH Service Plan Development by Non-Physician.

Staff Qualifications

A physician or MHP may render this service.

Service Documentation

The CSN shall document the physician and MHP's involvement in the following:

- The development, staffing, review and monitoring of the POC
- Outcome data as it impacts diagnosis, treatment discharge plans, frequency and focus of types of service (may include progression through stages of change reduction in use, reduction in risky or harmful behavior associated with use, reduction in acute service utilization, as well as achievement of abstinence if the client has a co-occurring disorder)
- Confirmation of medical necessity
- Establishment of one or more diagnoses, including co-occurring substance abuse or dependence if present
- Recommended treatment

The MHP and the physician are required to sign and date the CSN corroborating the delivery of the service.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Service Content

MH Service Plan Development by Non-Physician is the joint interaction between a physician and MHP designed to:

- Assess the client's mental and physical history, mental status examination, symptoms, strengths, weaknesses, social history and support systems, etc.
- Establish treatment goals and treatment services to reach these goals

The physician shall establish one or more diagnoses, including co-occurring substance abuse or dependence if present; confirm medical/psychiatric necessity of treatment; determine the appropriateness of treatment services – including the need for integrated treatment of co-occurring disorders; and upon periodic review, determine progress towards goals and justify continuation of treatment.

The MHP shall provide multidisciplinary input and assure effective linkage and continuity of care.

Billable Places of Service

MH Service Plan Development by Non-Physician may be provided at the community mental health center, inpatient hospital or other approved community mental health facility.

Billing/Frequency Limits

MH Service Plan Development by Non-Physician is billed in unit increments of 15 minutes for a maximum of two units per day.

Relationship To Other Services

No restrictions.