



LOCAL EDUCATION AGENCIES (LEA) SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PART I-SCHOOL BASED REHABILITATIVE THERAPY SERVICES

PROGRAM OVERVIEW

The South Carolina Department of Health and Human Services (SCDHHS) provides Medicaid reimbursement for medically necessary services provided to Medicaid-eligible individuals in the Local Education Agency (LEA). Medical Necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is reasonably expected to relieve pain, improve and preserve health, or be essential to life. This includes, but is not limited to, children under the age of 21 years who have or are at risk of developing sensory, emotional, behavioral or social impairments, physical disabilities, medical conditions, intellectual disabilities or related disabilities, or developmental disabilities or delays.

Each LEA recognized as such by the South Carolina Department of Education (SCDE) has contracted with SCDHHS to provide Medicaid-reimbursable school-based services to Medicaid-eligible children with special needs. Individual service providers employed or contracted by a LEA must meet the specified Medicaid provider qualifications.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT AND MEDICAID

The development of an Individualized Education Program (IEP), Individualized Family Service Plan (IFSP) is a requirement of the Individuals with Disabilities Education Act (IDEA). The development of an Individualized Health Plan (IHP) is a requirement of Section 59-63-80 of the South Carolina Code of law. Medicaid requires school-based services to be indicated on the IEP, IFSP, IHP or the Individualized Treatment Plan (ITP). However, Medicaid will not reimburse for any administrative or direct services performed for pre-IEP/IFSP/IHP activities. Medicaid will not reimburse for the IEP team member meetings or the cost related to attendance at those meetings by medical professionals.

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

- Medicaid-reimbursed school-based rehabilitative therapy services must be included in the IEP or IFSP.
- Medicaid-reimbursed school-based rehabilitative behavioral health services are required to be included in the IEP, IFSP, ITP or Individual Plan of Care (IPOC).

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

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

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

School-Based Rehabilitative Therapy Services

In order to be eligible for school-based rehabilitative therapy services, a Medicaid-eligible individual must:

- Be under the age of 21 years
- Have a current and valid IEP, IFSP or an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) examination that identifies the need for rehabilitative therapy services

Orientation and Mobility Services (O&M)

To be eligible to receive Medicaid-reimbursable orientation and mobility (O&M) services, an individual must meet all of the following requirements:

- Be a Medicaid beneficiary under the age of 21 years whose need for services is identified through a current and valid IEP or IFSP.
- Have a vision report completed by an optometrist or ophthalmologist that verifies visual impairment or blindness

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

LEAs and/or subcontractors must meet all applicable Medicaid provider qualifications, as well as the applicable state licensure regulations, in addition to any specified requirements by the South Carolina Department of Education for the provision of Medicaid school-based services. The contracted LEA is responsible for ensuring the individuals rendering Medicaid school-based services are approved, credentialed or licensed.

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

All subcontracts (e.g., billing contracts, contracted providers, etc.) are subject to the terms of the LEA's contracts with SCDHHS, and the LEA provider is held solely responsible for the performance of the subcontractor. Additionally, a copy of the LEA's contract with SCDHHS, if applicable, must be provided to the subcontractor by attachment to the subcontract. Please contact the SCDHHS Provider Service Center (PSC) at +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> if a copy of the current SCDHHS subcontract format is needed.

Medicaid reimbursement is available for school-based rehabilitative therapy services (e.g., speech-language pathology, audiology, physical therapy, occupational therapy and O&M services) when provided by or under the direction of the qualified rehabilitative therapy provider for which the beneficiary has been referred. Referrals must be made by a physician or other licensed practitioner of the healing arts (LPHA) within the scope of his or her practice under state law.

Supervision of Staff

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

At no time may the individual being supervised perform tasks when the supervisor cannot be reached by personal contact, phone, e-mail, pager or other immediate means. The supervisor must make provisions, in writing, for emergency situations including designation of another qualified provider who has agreed to be available on an as-needed basis to provide supervision and consultation to the individual when the supervisor is not available. All clinical service note entries made by a staff who requires supervision must be cosigned by the supervisor unless otherwise indicated for a specific Medicaid reimbursement service.

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

All supervisory staff licensed by Labor, Licensing and Regulation (LLR) must adhere to any provisions as required by LLR.

In addition to the above requirements, South Carolina Medicaid requires a supervising entity (physician, dentist or any program that has a supervising health professional component) to be physically located in South Carolina or within the 25-mile radius of the South Carolina border.

Audiological Services Program

Please refer to Section 440.110(c)(3) of the Code of Federal Regulations for guidance regarding qualified audiological services staff.

Physical Therapy Services

Physical Therapist

A physical therapist is a person licensed to practice physical therapy by the South Carolina Board of Physical Therapy Examiners. In accordance with 42 CFR 440.110(a)(2)(i)(ii), a qualified physical therapist is an individual who is (i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and (ii) where applicable, licensed by the State.

Physical Therapist Assistant

A physical therapist assistant is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. A physical therapy assistant provides services under the direction of a qualified physical therapist.

Supervision of Physical Therapy Assistants

Physical therapist assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed physical therapist. Additionally, the supervising therapist must review and initial each summary of progress completed by the assistant. These licensed individuals must adhere to any provisions as required by the South Carolina Department of LLR.

Occupational Therapy Services

Occupational Therapist

An occupational therapist is a person licensed to practice occupational therapy by the South Carolina Board of Occupational Therapy. In accordance with 42 CFR 440.110(b)(2)(i)(ii), a qualified occupational therapist is: (i) certified by the National Board of Certification for Occupational Therapy; or (ii) a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before certification by the National Board of Certification for Occupational Therapy.

Occupational Therapy Assistant

An occupational therapy assistant is an individual who is currently licensed as a certified occupational therapy assistant by the South Carolina Board of Occupational Therapy who works under the direction of a qualified occupational therapist pursuant to 42 CFR 440.110(b)(2)(i) or (ii).

Supervision of Occupational Therapy Assistants

Occupational therapy assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed occupational therapist. Additionally, the supervising therapist must review and initial each progress summary completed by the assistant. These licensed individuals must adhere to any provisions as required by South Carolina Department of LLR.

Speech-Language Pathology Services

Speech language pathology services are provided by or under the direction of a speech-language pathologist. We recognize that some individuals in the school setting will be licensed through LLR as speech-language pathologists, speech-language pathology assistants, speech-language pathology interns or speech-language pathology therapists. These licensed individuals will need to adhere to any provisions as required by LLR. The licensed speech-language pathologist can supervise the licensed speech-language pathology intern and speech-language pathology assistant or speech-language pathology therapist.

A speech-language pathologist, in accordance with 42 CFR 440.110(c)(2)(i)(ii)(iii), is an individual who meets one of the following conditions: (i) Has a certificate of clinical competence from the American Speech and Hearing Association; (ii) has completed the necessary equivalent educational requirements and work experience to qualify for the certificate; and (iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

A speech-language pathology assistant is an individual who is currently licensed by the South Carolina Board of Examiners in speech-language pathology. The speech-language pathology assistant works under the direction of a qualified speech-language pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

A speech-language pathology intern is an individual who is currently licensed by the South Carolina Board of Examiners in speech-language pathology and is seeking the academic and work experience requirements established by the American Speech and Hearing Association for the Certification of Clinical Competence in speech-language pathology. The speech-language pathology intern works under the direction of a qualified speech-language pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

A speech-language pathology therapist is an individual who does not meet the credentials outlined in the 42 CFR 440.110(c)(2)(i)(ii) and (iii) that must work under the direction of a qualified speech language pathologist.

Orientation and Mobility Specialist

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

Other Medicaid-Covered School-Based Services Staff

A nurse is defined as an individual who is currently licensed as a registered nurse (RN) or a licensed practical nurse (LPN) by the State Board of Nursing for South Carolina.

Services performed by health room aides, nurses' aides or any other unlicensed medical personnel are not Medicaid reimbursable.

Licensed Practical Nurse

An LPN must adhere to the following when providing nursing services:

- An LPN must be supervised at all times by a RN. The RN may either be physically present or accessible by phone or pager (exceptions to onsite supervision are allowable in accordance with SC Code of Law, Title 40-33-770).
- The LPN can provide any service allowable under state licensure and regulations.
- The LPN must follow the policies, procedures and guidelines for the employing entity.
- The RN supervisor will provide the initial assessment of the child's condition as appropriate and establish a plan of care based on the child's medical condition in accordance with state licensure and regulation. If the LPN receives additional information regarding the child's health condition after the initial assessment, the LPN will consult with the RN.
- Supervision by the RN of the LPN must be performed at a minimum of every 60 days. This can be done through direct observation or a review of clinical service notes.

Physician Oversight

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

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

Special Needs Transportation Program

In order to participate in the Special Needs Transportation Program, the LEA must meet all participatory requirements set forth in the program's contractual agreement with the South Carolina Department of Education (SCDE). The term "Local Education Agency" refers to any of the local entities that are recognized by SCDE as school districts. Information concerning participation in the Medicaid Transportation Program may be obtained by contacting the PSC at +1 888 289 0709, submitting an online inquiry at <http://www.scdhhs.gov/contact-us> or writing to Post Office Box 8206, Columbia, SC 29202-8206.

Special needs transportation providers (LEAs) shall provide required transportation services to meet the needs of Medicaid-eligible school students with special needs in a vehicle adapted to serve the

needs of the disabled. This shall include a specially adapted school bus used for transporting beneficiaries to and from reimbursable Medicaid services that are provided at a school or other facility when identified in the IEP.

South Carolina Motor Vehicle Driving Record

If an employee's position description requires that he or she transport beneficiaries, a copy of their motor vehicle record (MVR) shall be kept in the employee's personnel record. Individuals whose MVR shows involvement in more than two accidents in the last three years in which said individual was at fault, or against whom more than eight current violation points have been assessed, shall be unqualified to transport beneficiaries.

Providers must also adhere to any other state or federal regulations regarding transportation of beneficiaries as applicable (e.g., "Jacob's Law").

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COVERED SERVICES AND DEFINITIONS

Reimbursement is available for services that conform to accepted methods of diagnosis and treatment. Reimbursement is not available for services determined to be unproven, experimental or research-oriented, in excess of those deemed medically necessary to treat the beneficiary's condition, or not directly related to the beneficiary's diagnosis, symptoms or medical history. Reimbursement is not available for time spent documenting services or traveling to or from services, or for canceled visits and missed appointments.

Medicaid reimbursement is available for the following school-based services:

- Rehabilitative Therapy Services
 - Audiological
 - Physical therapy
 - Occupational therapy
 - Speech and language pathology
 - O&M
- Nursing services for children under 21 years
- Administrative claiming
- MAPPS
- Non-emergency transportation

Reimbursement is not available for services provided in an inpatient hospital or other institutional care facility.

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Evaluations

Evaluations must occur prior to the provision of the Medicaid rehabilitative therapy service. Evaluations must be completed by the enrolled Medicaid provider of services after receiving the referral from another LPHA.

Reevaluations

A reevaluation is performed subsequent to the initial evaluation and relates to the disorder. A reevaluation must be completed after receiving an updated referral from another LPHA. A reevaluation must be conducted annually (every 12 months) for each beneficiary; however, a reevaluation can be within a six-month time frame. A reevaluation must be completed when enough time has passed to accurately assess the beneficiary's progress. This service may be performed twice a year.

The results of the evaluation must include a narrative summary. The documentation must justify the number of units billed.

Individualized Education Program (IEP)/ Individualized Family Service Plan (IFSP)/Individualized Health Plan (IHP)/Individual Treatment Plan (ITP)

If the evaluation findings indicate a Medicaid school-based service is medically necessary, the evaluation must result in the development of an IEP, IFSP or IHP, and the service must be indicated on the IEP, IFSP or IHP.

Individualized Health Plan

An IHP is a plan of care designed specifically for an individual student to provide for meeting the health monitoring and care of the student during the school day or at school- sponsored functions, Section 59-63-80(B) stipulates that students with special health care needs must have an IHP. Students with special health care needs are defined as students with health conditions requiring treatments, medical procedures, medications, and/or monitoring that must be performed by school personnel and meet one or more of the criteria below.

- (a) are complicated and/or lengthy,
- (b) require several contacts with the nurse or health assistant during the school day,
- (c) are needed to prevent death or disability on an emergent basis,
- (d) are needed for students who have medically fragile health conditions, and/or
- (e) are prescribed for treatment, medical procedures, medications and/or monitoring administered at school more than fourteen consecutive days.

Additionally, students who have been granted permission to self-medicate and/or self-monitor in accordance with the school district's policy are also considered to have special health care needs and an IHP must be established in order for a student to be allowed to self-medicate and/or self-monitor.

If the evaluation findings do not indicate the need for provision of a Medicaid school-based service, then the results of the evaluation must be indicated on the IEP, IFSP, IHP, ITP or the evaluation instrument in order to be reimbursed by Medicaid. The ITP may be developed as a separate document or may appear as a clinical service note.

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

Individualized Treatment Plan

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

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the beneficiary. The treatment plan must be individualized and should specify problems to be addressed, goals of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement and estimated duration of treatment. Each ITP should specify the exact service the beneficiary should be receiving (i.e., individual or group therapy). If it is found medically necessary for a beneficiary to receive both individual and group therapy services, the ITP must reflect the frequency and duration of treatment for each service (e.g., 30 minutes group therapy per week and 15 minutes individual therapy two times per week). Indicating the beneficiary's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the therapist and the date signed.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new referral must be obtained annually, and a new treatment plan must be developed after reevaluation.

Audiological Services

In accordance with 42 CFR 440.110©(1), audiological services for individuals with hearing disorders means diagnostic, screening, preventive or corrective services provided by or under the direction of an audiologist for which a patient is referred by a physician or other LPHA within the scope of his or her practice under state law. It includes any necessary supplies, equipment and services related to hearing aid use. Audiological services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment.

Audiological services include diagnostic, screening, preventive and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an audiologist. A physician or other LPHA, within the scope of his or her practice under state law, must refer individuals to receive these services. A referral occurs when the physician or other LPHA has asked another qualified health care provider (licensed audiologist) to recommend, evaluate or perform therapies, treatment or other clinical activities for the beneficiary.

Hearing Aids

Hearing aids may be provided for individuals under the age of 21 years when the medical need is established through an audiological evaluation. The attending audiologist may send a request for a

hearing aid or aids, along with a physician's statement completed within the last six months indicating that there is no medical contraindication to the use of a hearing aid, to the South Carolina Department of Health and Environmental Control's (DHEC) local Children's Rehabilitative Services (CRS) office. DHEC will arrange for the requested hearing aids. Children birth to 21 years of age should be enrolled in the CRS program. Requests for hearing aids for children birth to 21 years of age should be sent to:

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

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

Pure Tone Audiometry

In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies in each ear. This service may be performed six times every 12 months.

Audiological Evaluation

In comprehensive audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies on each ear. Bone thresholds are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sounds. The patient is also asked to repeat bisyllabic (spondee) words. The threshold is recorded for each ear. The word discrimination score is the percentage of spondee words that a patient can repeat correctly at a given intensity level above speech reception threshold in each ear. This service may be performed once every 12 months.

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

Tympanometry (Impedance Testing)

Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. This service may be performed six times every 12 months.

Acoustic Reflex Testing; Threshold

Acoustic reflex testing, threshold is used in determining the differential diagnosis between sensory, conductive or central hearing loss. Acoustic reflex test results give the clinician valuable information regarding the severity of a hearing loss and the possible cause of a hearing loss. It is also a valuable test in detecting problems in the auditory pathway. This service may be performed two times every 12 months.

Electrocochleography

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

Hearing Aid Examination and Selection

History of hearing loss and ears are examined, medical or surgical treatment is considered, if possible, and the appropriate type of hearing aid is selected to fit the pattern of hearing loss. This service may be performed six times every 12 months.

Hearing Aid Check

The audiologist inspects the hearing aid and checks the battery. The aid is cleaned, and the power and clarity are checked using a special stethoscope that attaches to the hearing aid. This service may be performed six times every 12 months.

Evaluation of Auditory Rehabilitation Status

This service involves the measurement of patient responses to electrical stimulation used to program the speech processor and functional gain measurements to assess a patient's responses to his or her cochlear implant. Instructions should be provided to the parent/guardian, teacher and/or patient on the use of a cochlear implant device to include care, safety and warranty procedures. This procedure is to be completed only by a licensed audiologist on a cochlear implant team and may be performed 10 times a year.

Fitting/Orientation/Checking of Hearing Aid

Includes hearing aid orientation, hearing aid checks and electroacoustic analysis. The service may be provided six times every 12 months.

Dispensing Fee

The dispensing fee is time spent handling hearing aid repairs. This service may be performed six times every 12 months.

Ear Impression

Taking of an ear impression; please specify one or two units for one or two ears. This service may be performed six times every 12 months.

Modifiers LT and RT have been removed from ear impression services. If you are billing this service, instead of using the modifiers to identify the right and left ear impression, SCDHHS asks that you put one unit with no modifier if you are billing only one ear impression. If you are billing both ear impressions, SCDHHS asks that you put two units with no modifier.

Physical Therapy Services

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a physician or other LPHA within the scope of his or her practice under state law and provided to a beneficiary

by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment. Physical therapy services involve evaluation and treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Physical therapy involves the use of physical agents, mechanical means and other remedial treatment to restore normal physical functioning following illness or injury.

Physical Therapy Evaluation

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

Individual and Group Physical Therapy

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

Occupational Therapy Services

In accordance with 42 CFR 440.110(b)(1), occupational therapy means services prescribed by a physician or other LPHA within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment. Occupational therapy services are channels to improve or restore functional abilities for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Occupational therapy services are related to self-help skills, adaptive behavior, fine/gross motor, visual, sensory motor, postural and emotional development that have been limited by a physical injury, illness or other dysfunctional condition. Occupational therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Occupational Therapy Evaluation

An occupational therapy evaluation is a comprehensive evaluation that should be conducted in accordance with the American Occupational Therapy Association and South Carolina Board of Occupational Therapy guidelines, the physician or other LPHA referral, the occupational therapist's professional judgment and the specific needs of the child. The evaluation should include a review of available medical history records and an observation of the patient and interview, when possible.

The evaluation must include diagnostic testing and assessment and a written report with recommendations.

Individual and Group Occupational Therapy

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

Occupational therapy performed directly with one child should be documented and billed as individual occupational therapy. Occupational therapy performed for two or more individuals should be documented and billed as group occupational therapy. A group may consist of no more than six children.

Fabrication of Orthotics for upper and lower extremities and Thumb and Finger Splints

Fabrication of orthotics is the fabrication of orthotics for lower and upper extremities, and the fabrication of thumb splint and finger splint is the fabrication of orthotics for the thumb and likewise, the fabrication of finger splint is the fabrication of orthotic for the finger.

Wrist Hand Finger Orthosis

Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment.

Speech-Language Pathology Services

In accordance with 42 CFR 440.110(c)(1), speech-language pathology services include diagnostic, screening, preventive or corrective services provided by or under the direction of a speech-language pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. It includes any necessary supplies and equipment. Speech-language pathology services are defined as evaluative tests and measures utilized in the process of providing speech-language pathology services and must represent standard practice procedures. Only standard assessments (e.g., curriculum-based assessments, portfolio assessments, criterion referenced assessments, developmental scales and language sampling procedures) may be used. Tests or measures described as “teacher-made” or “informal” are not acceptable for purposes of Medicaid reimbursement.

Speech-language pathology services involve the evaluation and treatment of speech and language disorders for which medication or surgical treatments are not indicated.

Speech Evaluation

Upon receipt of the physician or other LPHA referral, a speech evaluation is conducted. A speech evaluation is a face-to-face interaction between the speech-language pathologist and the child for the purpose of evaluating the child’s dysfunction and determining the existence of a speech disorder. The evaluation should include review of available medical history records and must include

diagnostic testing and assessment, and a written report with recommendations. This service may be performed once per lifetime.

Note: Reimbursement is available for a subsequent initial evaluation if, and only if, it is conducted as the result of a separate and distinct speech disorder. Presentation of medical justification is required. Contact the PSC or submit an online inquiry for more information.

Reevaluation of speech, language, voice, communication and/or auditory processing

Speech reevaluation includes a face-to-face interaction between the speech-language pathologist or therapist and the child for the purpose of evaluating the child's progress and determining whether there is a need to continue therapy. If the reevaluation is completed by a speech-language therapist, the reevaluation must be cosigned by the speech language pathologist.

Reevaluation may consist of a review of available medical records and diagnostic testing and/or assessment but must include a written report with recommendations.

Any evaluation performed subsequently to the initial evaluation and related speech disorder is considered a reevaluation.

Individual and Group Speech Therapy

Individual or group speech therapy is the delivery of remedial services for identified speech and/or language handicaps to a child whose speech and/or language patterns deviate from standard, based on evaluation and testing, to include training of teacher or parent with child present. Individual and group speech therapy services may be provided in a regular education classroom.

Speech therapy performed directly with one child should be documented and billed as individual speech therapy. Speech therapy performed for two or more individuals should be documented and billed as group speech therapy. A group may consist of no more than six individuals.

Speech Language Disorders

Reimbursement may be available for assessment and treatment of the following categories of speech-language disorders:

- A developmental language disorder is the impairment or deviant development of comprehension and/or use of a spoken, written and/or other symbol system (e.g., sign/gesture). A developmental language disorder ranges from mild delays to severe impairment. The disorder may evidence itself in the form of language (phonologic, morphologic and syntactic systems), content of language (semantic system) and/or function of language in communication (pragmatic system) in any combination.
- An acquired language disorder (non-developmental) occurs after gestation and birth, with no common set of symptoms. Acquired language disorders may differ in the areas of language affected and in severity, and may occur at any age. Causes may include focal and diffuse

lesions such as those associated with traumatic brain injury and other kinds of brain injury or encephalopathy.

- An articulation disorder is incorrect production of speech sounds due to faulty placement, timing, direction, pressure, speech or integration of the movement of the lips, tongue, velum or pharynx.
- A phonological disorder is a disorder relating to the component of grammar that determines the meaningful combination of sounds.
- A fluency disorder is an interruption in the flow of speaking characterized by atypical rate, rhythm and repetitions in sounds, syllables, words and phrases. This may be accompanied by excessive tension, struggle behavior and secondary mannerisms.
- A voice disorder is any deviation in pitch, intensity, quality or other basic vocal attribute which consistently interferes with communication or adversely affects the speaker or listener or is inappropriate to the age, sex or culture of the individual.
- A resonance disorder is an acoustical effect of the voice, usually the result of a dysfunction in the coupling or uncoupling of the nasopharyngeal cavities.
- Dysphagia is difficulty in swallowing due to inflammation, compression, paralysis, weakness or hypertonicity in the oral, pharyngeal or esophageal phases.

Orientation and Mobility Services

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

O&M services is the use of systematic techniques designed to maximize development of a visually impaired child's remaining sensory systems to enhance the child's ability to function safely, efficiently and purposefully in a variety of environments. O&M services enable the child to improve the use of technology designed to enhance personal communication and functional skills such as the long cane, pre-mobility and adapted mobility devices, and low vision and electronic travel aids.

O&M services must meet the following requirements:

- The service must be recommended by a physician or other LPHA within the scope of his or her practice under state law.
- The service must be provided for a defined period of time for the maximum reduction of physical or mental disability and restoration of the individual to his or her best possible functional level.

- The service must be furnished by individuals working under a recognized scope of practice established by the state or profession.

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

Assessment

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

Reassessment

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

Other Medicaid-Covered School-Based Services

Services that are part of an EPSDT examination are not reimbursable under this program. However, services rendered subsequent to and as a result of an anomaly discovered during an EPSDT exam are reimbursable. EPSDT provides comprehensive and preventive health services to Medicaid -eligible children from birth to age 21 years through periodic medical screenings. If you would like additional information about the EPSDT program, contact the PSC at +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>. Mass screenings are not reimbursable under this program; however, vision and hearing assessments are reimbursable if they are performed in conjunction with a nursing assessment for IEP services.

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

Reimbursable nursing services under this program will include any service that an RN or LPN is allowed to provide under state licensure and regulation. Nursing services can include, but are not limited to, the following: nursing care assessments, nursing procedures, emergency care or individual/group health counseling.

Nursing Services for Children Under 21 Years

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

The need for services must be appropriately documented in an IEP, IFSP, IHP or ITP or clinical service notes, when appropriate.

Nursing Assessment

- Nursing assessment of applicants registering for early child development programs
- Nursing assessment of children referred for special education eligibility evaluation
- Nursing assessment related to the IEP, IFSP, IHP or ITP
- Nursing assessment of new or previously identified medical/health problems based on child initiated or teacher/staff referral to nurse, including substance use assessment, child abuse assessment, pregnancy confirmation, etc.
- Home visits for comprehensive health, developmental and/or environmental assessment

Nursing referrals for any reasons are Medicaid reimbursable only when they occur as a part of a nursing assessment.

Nursing Care Procedures

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

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

Emergency Care

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

The provision of emergency care may include the following:

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

Telemedicine

Please refer to the Physicians Services Provider Manual for information regarding coverage and billing for this service.

Medicaid Adolescent Pregnancy Prevention Services

MAPPS shall be provided in accordance with South Carolina Medicaid guidelines set forth in SCDHHS' Medicaid Enhanced Services Provider Manual and appropriate Medicaid bulletins.

Special Needs Transportation Program

The special needs transportation program is designed to provide transportation to Medicaid-eligible school students with special needs requiring transportation to medically necessary services in school-based settings provided directly by the LEA. This population includes but is not limited to children under the age of 21 years who have sensory impairments, physical disabilities, intellectual disabilities or related disabilities, and/or developmental disabilities or delays. Each LEA recognized by the SDE is responsible for the arrangement and coordination of special needs transportation services.

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

- Audiological
- Physical therapy
- Occupational therapy
- Speech and language pathology
- Psychological testing and evaluation
- O&M
- Behavioral health services
- Nursing services for children under 21 years
- Administrative claiming

- MAPPS
- Non-emergency transportation

An appropriate Medicaid-reimbursable school-based service other than transportation must be rendered on the date of transport to be reimbursable for special needs transportation. Medicaid transportation is not reimbursable when the requirement for transportation service is not identified in the IEP.

Beneficiary Escorts

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

Beneficiary Complaints

Beneficiaries with complaints regarding special needs transportation services should first contact their LEA provider. If the complaint cannot be resolved, a meeting should be scheduled with the LEA, SDE and the complainant. If the complaint still cannot be resolved, SCDE should contact the PSC or submit an online inquiry with the beneficiary's concerns. The complainant should contact SCDHHS directly at +1 888 549 0820.

Vehicle Requirements

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

CARE COORDINATION

It is the responsibility of the LEA to coordinate care among all service providers.

If a beneficiary is receiving treatment from multiple service providers, there must be evidence of care coordination in the beneficiary's clinical record.

If the LEA refers the child or adolescent to a private RBHS provider for services, the private RBHS provider must not exceed the recommendations from the LEA. The LEA should provide the specific recommendations for services in writing to the private RBHS provider.

OUT OF HOME PLACEMENT

In accordance with the Code of Federal Regulations, 42 CFR § 435.1009-1011, Rehabilitative Services are not available for beneficiaries residing in an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution may be deemed for mental diseases based on its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTF) receive an all-inclusive, per diem rate for services. Rehabilitative Behavioral Health Services provided to beneficiaries in these settings are not Medicaid reimbursable.

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UTILIZATION MANAGEMENT

All providers will ensure that only authorized amounts of services are provided and submitted to SCDHHS for reimbursement. The provider will ensure that all services are provided in accordance with all SCDHHS policy requirements. Reimbursement received in excess of authorized amount/duration is subject to recoupment.

PRIOR AUTHORIZATION

School-Based Rehabilitative Therapy Services

School districts that refer children to private therapists/audiologists must provide their seven-digit prior authorization number (beginning with “ED”) to the private therapist/audiologist. The private therapist/audiologist then must enter this number in field 23 on the CMS-1500 claim form.

OTHER SERVICE LIMITATIONS

Special Needs Transportation Program Compliance Review

A program review will be conducted at least once during the contract year to evaluate compliance with program policies and procedures. Contract compliance reviews are conducted to identify areas where programmatic development or improvement is needed and to ensure that Medicaid policy is being met. The completed review will identify service delivery problems and recommend corrective action utilizing quality assurance methodologies approved by SCDHHS. This is also an opportunity to note program strengths and recognize the dedication and commitment the LEA provides to Medicaid beneficiaries.

During a compliance review, the following will be evaluated:

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

Non-emergency contractual transportation services may be provided by the LEAs for Medicaid-eligible students requiring transport off site to and from Medicaid-reimbursable services. Transportation services must be contracted directly through SCDHHS.

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REPORTING/DOCUMENTATION

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Clinical Records

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

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

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

- A referral for services by a physician or other LPHA
- A Release of Information form signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the child (this may be incorporated into a Consent for Treatment form)
- Test results and evaluation reports
- A current and valid IEP or IFSP, IHP or valid ITP indicating the child's need for services
- Clinical service notes
- Progress summary notes

Records Maintenance

There must be a record for each beneficiary that includes sufficient documentation of services rendered to justify Medicaid participation. The record should be arranged in a logical manner so that the clinical description, course of treatment and services can be easily and clearly reviewed and audited. All clinical records must be kept in a confidential and safeguarded manner as outlined in the Provider Administrative and Billing Manual.

Medical Services Documentation

Documentation of services should comply with guidelines set forth under each service in this section. Adequate documentation must reflect the following:

- A description of the service
- The need for the service
- The provider who delivered the service
- The length of time of the service delivered
- Future plans for continued care, if applicable

A reviewer should be able to discern from the information that adequate and appropriate observations were used in assessing needs and planning care.

Notations should be concise, but descriptive and pertinent. Although minimum parameters must be addressed, documentation should reflect individualization of care.

Abbreviations and Symbols

Each provider must maintain a list of approved abbreviations and symbols used in the beneficiary's clinical record.

Legibility

All entries must be in ink or typed, legible and in chronological order. These entries must be dated (month, day, and year) and legibly signed with the appropriate signatory authority. Providers must maintain a signature sheet that identifies all staff names, signatures and initials.

Error Correction Procedures

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

Referrals

Referral by other licensed practitioners of the healing arts for rehabilitative therapy services only

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

When the IEP//IFSP multidisciplinary team is used as the referral source for rehabilitative therapy services, the team must include an individual who meets the other LPHA as defined by Medicaid. The other LPHA initial referral must be obtained from a LPHA other than the individual direct provider of the rehabilitative service.

The referral documentation must occur prior to the provision of the Medicaid evaluation and rehabilitative therapy service. The referral must meet the following requirements:

- Be updated before the annual renewal of reevaluation and the IEP
- Be obtained from an LPHA other than the direct provider of services (e.g., the referring LPHA cannot supervise the service or co-sign the documentation)
- Be clearly documented in the clinical record with the name, date and title of the provider
- Include the date of the referral
- Explain reason for referral

The following list indicates the professional designations of those considered as LPHAs for the purpose of Medicaid reimbursement of school-based rehabilitative therapy services (speech-language pathology, occupational therapy, physical therapy, O&M services and audiology):

- Licensed physician assistant
- Licensed advanced practice RN
- RN
- Licensed audiologist
- Licensed occupational therapist
- Licensed physical therapist
- Licensed speech-language pathologist
- Licensed professional counselor

- Licensed marriage and family therapist
- Licensed psychologist
- Licensed independent social worker
- Licensed master social worker
- Licensed baccalaureate social worker

A beneficiary is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

Release of Information

A Release of Information form must be signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims. This is required for requesting payment of government benefits on behalf of the child. This may be incorporated into a Consent for Treatment form.

Clinical Service Notes

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

Clinical service notes must:

- Provide a pertinent clinical description of the activities that took place during the session, including an indication of the child's response to treatment as related to stated goals listed in the IEP, IFSP, IHP or ITP
- Reflect delivery of a specific billable service as identified in the physician's or other LPHA's referral and the child's IEP, IFSP, IHP or ITP
- Document that the services rendered correspond to billing [as to date of service and type of service rendered. Length of time-of-service delivery should be noted if clinically indicated] Evidence of rendering services must be documented on CSNs.
- Be individualized with patient's level of participation and response to intervention when documenting group services

When completing clinical service notes:

- Each entry must be individualized and patient specific. Each entry must stand on its own and may not include arrows, ditto marks, “same as above,” etc.
- All entries must be made by the provider delivering the service and should be accurate, complete and recorded immediately.
- All entries must be typed or legibly handwritten in dark ink. Copies are acceptable but must be completely legible. Originals must be available if needed.
- All entries must be dated and legibly signed with the provider’s name or initials and professional title.
- All entries must be filed in the child’s clinical record in chronological order by discipline.

All clinical service notes used must include a narrative summary. The documentation must justify the number of units billed.

Progress Summary Notes

The progress summary is a written note outlining the child’s progress that must be completed by the physical therapy practitioner at least every three months from the start date of treatment or when medically necessary. The purpose of the progress summary is to record the longitudinal nature of the child’s treatment, describe the child’s attendance at therapy sessions, document progress toward treatment goals and objectives, and establish the need for continued participation in treatment. The progress summary must be written by the provider, contain the provider’s signature and title as well as the date written and must be filed in the child’s clinical record. The progress summary may be developed as a separate document or may appear as a clinical service note. If a progress summary is written as a clinical service note, the entry must be clearly labeled “progress summary”.

SPECIAL NEEDS TRANSPORTATION PROGRAM

Trip and Passenger Pupil Log Form

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

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

District forms shall include:

- District Name, Address, Phone Number
- Route Number (as applicable)
- Driver (Name)
- Vehicle Number/License Tag Number/District Number
- Date
- Passenger Name

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

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BILLING GUIDANCE

SCHOOL-BASED ADMINISTRATIVE CLAIMING

Some of the activities routinely performed by school districts are activities that could be eligible for Medicaid reimbursement under the School District Administrative Claiming Program. The South Carolina Medicaid School-Based Administrative Claiming Guide is intended to provide information for schools, State Medicaid Agencies, Centers for Medicare and Medicaid Services staff and other interested parties on the existing requirements for claiming Federal Financial Participation. To obtain a copy of the guide, contact the PSC or submit an online inquiry at <https://www.scdhhs.gov/Contact-Info>.

USE OF Z-CODES

The use of Z-codes is allowed but this is considered a temporary diagnosis for ages 7 and older. The use of Z-codes is not time limited for children ages 0 to 6 of age. Z-codes can be used in any diagnosis field on the claim form.

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PART II-SCHOOL BASED REHABILITATIVE BEHAVIORAL HEALTH SERVICES

PROGRAM OVERVIEW

The South Carolina (South Carolina or State) State Medicaid Plan allows an array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d). Rehabilitative Services are medical or remedial services that have been recommended by a Physician or other

Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South

Carolina State Law and as further determined by the South Carolina Department of Health and Human Services (SCDHHS) for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. This section describes these services, legal authorities and the characteristics of the Providers of services.

SCDHHS encourages the use of “evidence-based practices” and “emerging best practices” that ensure thorough and appropriate screening, evaluation, diagnosis and treatment planning, and fosters improvement in the delivery of behavioral health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as interventions for which systematic empirical research has provided evidence of statistically significant effectiveness.

The National Registry of Evidence-Based Programs and Practices (<https://www.samhsa.gov/ebpresource-center>) and other relevant specialty organizations publish lists of evidence-based practices that Providers may reference.

Rehabilitative Behavioral Health Services (RBHS) are available to all Medicaid beneficiaries diagnosed with mental health and/or a substance use disorder (SUD), as defined by the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) who meet medical necessity criteria. Services are provided to, or directed exclusively toward, the treatment of the Medicaid eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary’s ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

Eligible beneficiaries may receive RBHS from a variety of qualified Medicaid Providers. Public agencies that contract with SCDHHS as qualified service Providers may render these services directly to an eligible beneficiary.

PROVIDER CHOICE

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

SERVICE ARRAY

The following list includes all RBHS:

- **Assessment and Screening Services:**
 - Psychological Testing and Evaluation**
 - Behavioral Health Screening (BHS)*
 - Child and Adolescent Level of Care /Service Intensity Utilization System (CALOCUS-CASII) Assessment*
 - Diagnostic Assessment (DA) Services
- **Core Services:**
 - Individual Psychotherapy (IP)
 - Group Psychotherapy (GP)
 - Family Psychotherapy (FP)
 - Multiple Family Group Psychotherapy (MFGP)*
 - Service Plan Development (SPD)
 - Crisis Management (CM)
- **Community Support Services:**
 - Psychosocial Rehabilitation Services (PRS)*
 - Behavior Modification (B-MOD)*
 - Family Support (FS)*

**These services are only available for RBHS providers enrolled prior to July 1, 2022.*

***Only allowed to be rendered by School Psychologist and Licensed Psycho-Educational Specialist*

MANAGED CARE ORGANIZATION

All RBHS services are covered under the managed care benefit package. If a beneficiary is enrolled with one of the State's contracted Managed Care Organizations (MCOs), all RBHS Providers must receive prior approval from the MCO. SCDHHS allows for MCOs to set PA rules and guidance.

Please refer to the managed care policy and procedure manual at:

<https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp> for additional information regarding behavioral health and substance abuse services.

The policy herein does not cover services under an MCO. Providers are encouraged to visit the SCDHHS website at: <https://msp.scdhhs.gov/managedcare/> for additional information regarding MCO coverage.

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

School-Based RBHS are available to all Medicaid beneficiaries under the age of 21 years old and diagnosed with mental health and/or SUD(s), as defined by the current edition of the American Psychiatric Association's DSM or the ICD who meet medical necessity criteria. The use of Z-codes is allowed but this is considered a temporary diagnosis. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of treatment is needed. Z-codes may not be used for ages seven and up for longer than six-month duration. The use of Z-codes is not time limited for children ages 0 to 6 of age.

Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

Medical Necessity

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services. A LPHA must certify that the beneficiary meets the medical necessity criteria for each service. LPHAs authorized to confirm medical necessity can be found under the Staff Qualification section within this manual.

Please refer to the *Reporting/Documentation* section for documentation requirements.

If the Medicaid recipient is in fee-for-service (FFS) Medicaid, the following guidelines must be used to confirm medical necessity. The determination of medically necessary treatment must be:

- Based on information provided by the beneficiary, the beneficiary's family, and/or collaterals who are familiar with the beneficiary.
- Based on current clinical information. (If the diagnosis has not been reviewed in 12 or more months, the diagnosis should be confirmed immediately.)
- Made by an LPHA enrolled in, or employed by a school district that is enrolled in, the South Carolina Medicaid Program.

Retroactive Coverage

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

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

LEAs and/or subcontractors must meet all applicable Medicaid provider qualifications, as well as the applicable state licensure regulations, in addition to any specified requirements by the South Carolina Department of Education for the provision of Medicaid school-based services. The contracted LEA is responsible for ensuring the individuals rendering Medicaid school-based services are approved, credentialed, or licensed.

LEAs may contract with any qualified provider for school-based services. The LEA may utilize the subcontract format approved and provided by SCDHHS. This can be found in the applicable appendix of the LEA contract. This format includes the federal and state contractual components required to ensure that Medicaid reimbursement is available. There may be additional state and/or federal requirements for approval by SCDHHS. LEAs may include other terms and conditions necessary to define the responsibilities, as they pertain to RBHS implementation, of both parties.

All subcontracts (e.g., billing contracts, contracted providers, etc.) are subject to the terms of the LEA's contracts with SCDHHS, and the LEA provider is held responsible for the oversight of the performance of the subcontractor. Additionally, a copy of the LEA's contract with SCDHHS, if applicable, must be provided to the subcontractor by attachment to the subcontract. Please contact the SCDHHS Provider Service Center (PSC) at +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us> if a copy of the current SCDHHS subcontract format is needed.

Business Requirement

All Providers must demonstrate evidence of having the following required policies and procedures in place, and these policies and procedures must be maintained and updated as needed during enrollment as a Provider:

- Confidentiality and protection of health information
- Consent for treatment
- Record security and maintenance
- Record retention
- Use of secure electronic signatures if Provider uses an electronic health record or electronic medical record program
- Release of information

- Beneficiary’s rights and responsibilities
- Prohibition of abuse, neglect, and exploitation of beneficiaries
- Code of ethics
- Freedom of choice
- Limited English proficiency
- Compliance program (including fraud, waste, and abuse)
- Admission and discharge of beneficiaries
- Conditions for termination of beneficiaries from services, including:
 - › A list of reasons for termination,
 - › Methods of averting the termination,
 - › Education/consultation with beneficiary and/or family about termination (e.g., resources and options), and
 - › Evidence beneficiary/family informed of termination.

Staff Qualifications

All Providers of RBHS must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession, as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation. Professionals who have received appropriate education, experience, have passed prerequisite examinations as required by the applicable State laws and licensing/certification Board and additional requirements as may be further established by SCDHHS, may qualify to provide RBHS. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in South Carolina, or the state in which licensed clinical professionals render services and must be operating within their scope of practice.

TITLE OF PROFESSIONAL	QUALIFICATIONS	SERVICES ABLE TO PROVIDE
Certified School Psychologist I, II, III	Must hold a master's or doctoral degree from a program that is primarily psychological in nature (e.g., counseling, guidance or social science equivalent) from an accredited university or college and one year of experiences working with the population to be served. Training and/or certification information must be sent to SCDHHS for approval.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS, PTE
Licensed Psycho-Educational Specialist	Must hold a current license from the appropriate State Board of Examiners or a regionally accredited institution of higher education whose program is approved by the National Association of School Psychologists or the American Psychological Association or from a degree program that the Board finds to be substantially equivalent based on criteria established by the South Carolina Board in regulation. In addition, a psycho-educational specialist is certified by the South Carolina Department of Education as a school psychologist level II or III, must have two years of experiences as a certified school psychologist (at least one year of which is under the supervision of a licensed psycho-educational specialist) and a satisfactory score on the PRAXIS Series II exam.	DA, IP, FP, GP, MFGP, SPD, BHS, CM, B-Mod, FS, PRS, PTE
Licensed Independent Social Worker — Clinical Practice (LISW-CP)	Master's or doctoral degree from a Board-approved social work program and licensed by South Carolina Board of Social Work Examiners.	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD
Licensed Marriage and Family Therapist (LMFT)	A minimum of 48 graduate semester hours or 72 quarter hours in marriage and FP along with an earned master's degree, specialist's degree, or doctoral degree. Each course must be a minimum of at least a three semester hour graduate level course with a minimum of 45 classroom hours or 4.5 quarter hours; one course cannot be used to satisfy two different categories.	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD
Licensed Professional Counselor (LPC)	A minimum of 48 graduate semester hours during a master's degree or higher degree program and have been awarded a graduate degree as provided in the regulations. All coursework, including any additional core coursework, must be taken at a college or university accredited by the Commission on the Colleges of the Southern Association of Colleges and Schools, the Association of Theological Schools in the United States and Canada, or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or a regionally accredited institution of higher learning subsequent to receiving the graduate degree	B-MOD, BHS, CM, DA, FS, FP, GP, IP, MFGP, PRS, SPD
Licensed Master Social Worker (LMSW)	Master's or a doctoral degree from a social work program, accredited by the Council on Social Work Education and one year of experience working with the population to be served.	B-MOD, BHS, CM, DA**, FS, FP, GP, IP, MFGP, PRS, SPD

TITLE OF PROFESSIONAL	QUALIFICATIONS	SERVICES ABLE TO PROVIDE
Mental Health Professional	Master's or doctoral degree from a program that is primarily psychological in nature (e.g., counseling, guidance, or social science equivalent) from an accredited university or college and one year of experience working with the population to be served.	B-MOD, BHS, CM, DA**, FS, FP, GP, IP, MFGP, PRS, SPD

** A LMSW is considered a LPHA in South Carolina and can establish and/or confirm medical necessity when employed by a State Agency. For private Providers and LEAs, a LMSW must be supervised by an independently LPHA and must have the DA co-signed by an independently LPHA. An MHP will also need to be supervised by an independently LPHA and have the DA co-signed by an independently LPHA.

Note: A school psychologist I must be supervised by a school psychologist II, III or a licensed psycho-educational specialist, and each evaluation must be signed by the supervising school psychologist.

Service	Abbr	Service	Abbr
• Diagnostic Assessment	• DA	• Psychological Testing and Evaluation	• PTE
• Behavioral Health Screening	• BHS*	• Individual Psychotherapy	• IP
• Crisis Management	• CM	• Multiple Family Group Psychotherapy	• MFGP*
• Behavioral Modification	• B-Mod*	• Psychosocial Rehabilitative Services	• PRS*
• Family Support	• FS*	• Service Plan Development	• SPD
• Family Psychotherapy	• FP	• Group Psychotherapy	• GP

• **Only currently available to RBHS Providers enrolled prior to July 1, 2022.*

Maintenance of Staff Credentials

- Providers shall ensure that all staff, including subcontractors, volunteers, students/interns, and other individuals under the authority of the Provider who render services beneficiaries are properly qualified, trained and supervised. Providers must comply with all other applicable state and federal requirements.

- Providers must maintain documentation which verifies that all staff are properly qualified, screened, trained and supervised, including subcontractors, volunteers, students and/or interns and other individuals under the authority of the Provider. Providers must maintain and make available upon request, appropriate records and documentation of such qualifications, trainings, and investigations. Failure of the Provider to comply with this provision may result in the immediate termination of enrollment. SCDHHS may, upon good cause shown by the Provider, and within the discretion of SCDHHS, allow the Provider a reasonable amount of time to provide the documents requested.
- Providers must maintain signature sheet(s) or electronic signature database(s) that identifies all individuals rendering services by name, signature, credentials and initials.
- The following required documents must be present in each personnel file, as applicable, prior to the start of employment and prior to rendering services to beneficiaries:
 - A completed and signed employment application form (including criminal disclosure).
 - A completed and signed job description that reflects the service(s) the person is responsible to render.
 - College transcripts from the education institution.
 - The degree must be from an accredited college or university listed in the U.S. Department of Education's Office of Post-Secondary Education database at: <http://ope.ed.gov/accreditation/>.
 - Copies and primary source verification of all applicable professional licenses and certifications upon the start of employment and annually thereafter.
 - Evidence of criminal background checks completed prior to the start of employment, and annually thereafter.
 - All criminal background checks must include information for each staff member with no less than a 10-year search. The criminal background check must include Statewide (South Carolina) data, and any other state(s) the worker has resided in within the prior 10 years. In order for Providers to make an offer of employment or retain current employees, the criminal background results shall not indicate any findings or criminal charges against the potential or current employee in the following categories:
 - Conviction for abuse, neglect or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35) or of children (as defined in the Children's Code, S.C. Code Ann. Title 63, Chapter 7).
 - Felony conviction for any of the following, including guilty pleas and adjudicated pretrial diversions:
 - Crimes against persons, such as murder, rape or assault, and other similar crimes.

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
- Any felony that placed the Medicaid Program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct).
- Any felonies outlined in section 1128 of the Social Security Act.
 - Conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices, and embezzling or otherwise misusing public assistance funds in any manner), and
 - Evidence of exclusion checks from Medicare or Medicaid Programs completed prior to the start of employment and annually thereafter. The following sources shall be checked for all individuals:
 - South Carolina Excluded Providers list: <https://www.scdhhs.gov/site-page/bureaucompliance-and-performance-review>
 - Office of the Inspector General Provider exclusion database: <https://exclusions.oig.hhs.gov/>
 - Federal System for Award Management: <https://www.sam.gov>
 - Evidence of State and national sex offender registries checks completed prior to the start of employment and annually thereafter.
 - Results of the sex offender registries checks should not indicate any findings or criminal charges against an individual.
 - Evidence of child abuse registry checks completed prior to the start of employment and annually thereafter
 - Results of the child abuse registry checks should not indicate any findings or criminal charges against an individual.
 - Evidence of professional sanctions checks completed for licensed, certified, and unlicensed staff prior to the start of employment and annually thereafter.
 - Results of the professional sanctions checks should not indicate any substantiated findings of abuse or neglect against the individual. This includes:
 - All applicable State licensing/certification Boards.

- All applicable state Nurse Aide Registries or Health Care Personnel Registries. A list of State entities can be found in the NCSBN Directory of Nurse Aide Registries at:
<https://www.ncsbn.org/725.htm>

Staff Training

- Providers are responsible for ensuring that all staff are appropriately trained, including subcontractors. Providers are responsible for the development and provision of training to their staff when alternative training is not available. Individuals who are qualified based on documented professional behavioral health experience, training or certification, and/or licensure, to conduct such training shall carry out the instruction.
- Providers are expected to operate within current best practices to ensure competence and quality performance of staff. Training is essential to the development of a competent workforce capable of providing quality RBHS.

Staff Monitoring/Supervision of Staff

- RBHS provided by licensed or certified professionals must follow supervision requirements as required by South Carolina State Law for each respective profession. The licensed professional needs to be licensed at the independent level.
- Staff must be supervised as follows:
- Services provided by any LMSW or MHP must be clinically supervised by an LPHA.
- Licensed clinical professionals have the responsibility of planning and guiding the delivery of services provided by unlicensed or uncertified professionals. These clinical professionals will evaluate and assess the beneficiary, as needed.
- When services are provided by an unlicensed or uncertified professional, the State agency or private organization must ensure the following:
 - The LPHA who monitors the performance of the unlicensed professional must provide documented consultation, guidance, and education with respect to the clinical skills, competencies, and treatment provided, at least every 30 days.
 - The supervising LPHA must maintain a log documenting supervision of the services provided by the unlicensed or uncertified professional to each beneficiary.
 - Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care and the individual beneficiary's progress. Issues relevant to an individual beneficiary will be documented in a service note in the clinical record.

- Case supervision and consultation does not supplant training requirements. The frequency of supervision should be evaluated on a case-by-case basis.

Who Can Confirm Medical Necessity?

- LPHAs must certify that the beneficiary meets the medical necessity criteria for each service. The LPHA must be enrolled in the South Carolina Medicaid Program. The following professionals are considered to be licensed at the independent level in South Carolina and can establish and/or confirm medical necessity:
 - Licensed Physician
 - Licensed Psychiatrist
 - Licensed Psychologists
 - Licensed Psycho-Educational Specialist
 - Licensed APRN
 - LISW-CP
 - Licensed PA
 - LPC
 - LMFT
 - Licensed Addiction Counselors – master’s and above
- When medical necessity for services is required to be established and/or confirmed, the professional must be licensed at the independent level in each respective state where the professional renders services to Medicaid beneficiaries outside of South Carolina, but within the SCMSA.
- A LMSW is considered a LPHA in South Carolina and can establish and/or confirm medical necessity when employed by a State Agency. For private Providers and LEAs, a LMSW must have the DA co-signed by an independently LPHA.
- LPHAs must be licensed in the state where they render services to the beneficiary.

Out-of-State LPHAs Confirming Medical Necessity

Out-of-State LPHAs must be enrolled in the South Carolina Medicaid Program. The professional must be licensed at the independent level in each respective state where the professional renders services within the SCMSA. The following professionals can establish and/or confirm medical

necessity within the state listed.

Supervision of Staff

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

At no time may the individual being supervised perform tasks when the supervisor cannot be reached by personal contact, phone, e-mail, pager or other immediate means. The supervisor must make provisions, in writing, for emergency situations including designation of another qualified provider who has agreed to be available on an as-needed basis to provide supervision and consultation to the individual when the supervisor is not available. All clinical service note entries made by a staff who requires supervision must be cosigned by the supervisor unless otherwise indicated for a specific Medicaid reimbursement service.

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

All supervisory staff licensed by Labor, Licensing and Regulation (LLR) must adhere to any provisions as required by LLR.

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COVERED SERVICES AND DEFINITIONS

In order to be covered under the Medicaid Program, a service must be medically necessary. Medical Necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is reasonably expected to relieve pain, improve and preserve health, or be essential to life. Services are not primarily for the benefit of the Provider and/or for the convenience of the beneficiary/family, caretaker or Provider. Services and treatment shall be rendered in a cost effective and in the least restrictive setting required by the beneficiary's condition. Services and treatment shall be consistent with generally accepted professional standards of practice as determined by the Medicaid Program, shall not be experimental or investigational in nature, and shall be substantiated by records including evidence of such medical necessity and quality.

All RBHS Providers shall ensure (1) that only the authorized units of services are provided and submitted to SCDHHS for reimbursement and (2) that all services are provided in accordance with all South Carolina Medicaid Program policy requirements.

Psychological Testing and Evaluation (PTE)

PTE services involve the use of formal testing procedures using reliable and valid instruments to measure the areas of intellectual, cognitive, adaptive, emotional and behavioral functioning, along with personality styles, interpersonal skills and psychopathology (e.g., Minnesota Multiphasic Personality Inventory [MMPI], Rorschach, and WAIS). Testing and evaluation must involve face-to-face interaction between a licensed/ certified psychologist and the beneficiary for the purpose of evaluating the beneficiary's intellectual, emotional and behavioral status. Tests must be standardized, and validated measures recognized by the scientific and professional community as a national standard for professional practice, and may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, motivations, and/or personality characteristics, as well as use of other non-experimental methods of evaluation.

PTE may be used for the purpose of diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning. When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnosis.

Prior to administering a battery of tests, it is important for the evaluating psychologist to review relevant clinical information from the most recent DA and/or medical, psychiatric and educational evaluations. The psychologist must consider historical clinical information, identify specific referral

questions to be addressed by the evaluation, and determine that the clinical questions cannot be addressed through a diagnostic interview with a skilled clinician.

When necessary or appropriate, consultation shall only include telephone or face-to-face contact by a psychologist to the family, school, or another health care Provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary. The psychologist is expected to render an opinion and/or advice. The psychologist must document the recommended course of action.

Staff-to-Beneficiary Ratio

PTE Services require one professional for each beneficiary.

Service Specific Medical Necessity for PTE

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of a mental health and/or SUD(s) are eligible for this service, provided that there is a clear, documented reason that the testing is needed (e.g., differential diagnosis, atypical symptomatology, prior/current mental health treatment is ineffective). Information should be provided in the documentation to explain why a DA was inconclusive and why testing is needed to clarify the diagnosis.

Behavioral Health Screening (BHS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The purpose of this service is to provide early identification of mental health and/or SUD(s) to facilitate appropriate referral for a focused assessment and/or treatment. BHS is designed to identify behavioral health issues and/or the risk of development of behavioral health problems and/or substance abuse.

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

GAIN — Global Appraisal of Individual Needs — Short Screener

DAST — Drug Abuse Screening Test

ECBI — Eyberg Child Behavior Inventory

SESBI — Sutter Eyberg Student Behavior Inventory

CIDI — Composite International Diagnostic Interview

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

Screenings should focus on patterns of behavior and associated factors such as legal problems, mental health status, educational functioning and living situation.

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

Prior to conducting the screening, attempts should be made to determine whether another screening had been conducted in the last 90 days. If a recent screening has been conducted, efforts should be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

Reimbursement for this service is only available for the interpretation and/or scoring of the screening tool and does not include time spent administering the tool.

Staff-to-Beneficiary Ratio

BHS requires one qualified clinical professional for each beneficiary served. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Service Specific Medical Necessity for BHS

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of a mental health and/or SUD(s) are eligible for this service.

CALOCUS-CASII Assessment — Community Support Services **This service only available for RBHS providers enrolled prior to July 1, 2022.*

SCDHHS requires the use of the CALOCUS-CASII as the standardized pre-admission criteria for all beneficiaries being considered for RBHS CSS. The assessment must be a face-to-face assessment with the beneficiary.

The CALOCUS-CASII must be administered by a LPHA or a master's level clinical staff with three years of experience. Providers who currently have approval from SCDHHS to administer the CALOCUS can also administer the CALOCUS-CASII. All new practitioners must have successfully completed training on CALOCUS-CASII and passed a competency test. The training can be obtained through any authorized provider, with the recommended training being from the American Academy of Child and Adolescent Psychiatry (AACAP). All certifications must then be submitted to SCDHHS for final approval prior to administering the instrument to beneficiaries.

The CALOCUS-CASII links a clinical assessment with standardized criteria that describes the level of intensity of services needed for a beneficiary. The CALOCUS-CASII rating can be done for any beneficiary in any setting, regardless of the diagnosis or service agency with which the beneficiary is involved.

The CALOCUS-CASII tool considers four distinct types of potential co-morbid areas: psychiatric, substance use, developmental and medical.

CALOCUS-CASII ranges from Level 1 to Level 6 where the frequency, intensity, location and duration of treatment are correlated to the severity of the child or adolescent's condition.

The level of care system can be viewed as a continuum ranging from medical maintenance or minimal treatment in a minimally restrictive environment to a Psychiatric Residential Treatment Facilities (PRTF), a more restrictive treatment environment.

The child or adolescent is evaluated and rated in the following six dimensions:

- Risk of Harm
- Functional Status
- Co-Morbidity
- Recovery
- Resiliency and Treatment History
- Treatment Acceptance and Engagement

Treatment and/or services are recommended based on the composite score of the dimensions and the corresponding level of care. Services may include a community mental health system, a private therapist, an interagency community-based system of care, or other Providers of mental, psychiatric or behavioral health services. It is always preferable to keep children in their communities, when this is an option, and clinical professionals should determine if enhanced community services could be provided to support the child and his or her family as an alternative to placement.

The levels of care are:

Level 1 — Recovery Maintenance and Health Management

Level 2 — Outpatient Services

Level 3 — Intensive Outpatient Services

Level 4 — Intensive Integrated Service without 24-Hour Psychiatric Monitoring

Level 5 — Non-Secure 24-Hour Services with Psychiatric Monitoring

Level 6 — Secure 24-Hour Services with Psychiatric Monitoring

When CALOCUS-CASII score indicates a Level 4, 5 or 6, residential placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered prior to consideration of residential placement.

Staff to Beneficiary Ratio

CALOCUS-CASII assessment requires one qualified clinical professional for each beneficiary served.

Diagnostic Assessment (DA) Services

The purpose of this face-to-face assessment is to determine the need for all services rendered and establish medical necessity, to confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and needs, and/or to assess progress in treatment and confirm the need for continued treatment. The assessment is also used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

DAs must include the following:

- An evaluation of the beneficiary for the presence of a mental illness and/or SUD.
- This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records
- Clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational records and history, including past psychological assessment report and records. Initial assessments must include a clinical summary that identifies recommendations for and the prioritization of mental health and/or other needed services.

If information obtained during the assessment results in a diagnosis, the assessment must identify the beneficiary's current symptoms or disorder via the current edition of the DSM or the ICD.

As a best practice, diagnoses should be updated as the condition of the beneficiary changes.

Once the initial assessment has been completed and services are deemed to be medically necessary, the development of the IPOC should be next-in the course of the treatment process.

Mental Health Comprehensive Assessment Follow-up

A Mental Health Comprehensive Assessment Follow-up occurs face-to-face with the beneficiary after an initial assessment to re-evaluate the status of the beneficiary, identify any significant changes in behavior and/or condition, and to monitor and ensure appropriateness of treatment. Follow-up assessments may also be rendered to assess the beneficiary's progress, response to treatment, the need for continued treatment and establish medical necessity for new or additional services to be added to the course of treatment.

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

Staff-to-Beneficiary Ratio

All assessments require one qualified clinical professional for each beneficiary. Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Service Specific Medical Necessity for DA Services

All Medicaid-eligible beneficiaries who have been identified as having or at-risk of mental health and/or SUD(s) are eligible for this service.

The following services can be rendered if a DA has been completed and medical necessity was determined. The only exception is the Crisis Management (CM) service. Two CM service encounters can be rendered to an individual prior to a DA being required. Following two CM service encounters, a DA (or Mental Health Comprehensive Assessment- Follow up if being rendered by DMH staff) must show medical necessity for more services to be authorized.

Psychotherapy

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

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

Psychotherapy Services are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability; improve their physical, mental, and emotional health; and cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities.

Psychotherapy Services should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues and may be provided in an individual, group or family setting. The assessments, plans of care, and CSNs must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality.

Providers of core treatment who are not employed by governmental entities must possess a license to practice in psychology, social work, professional counseling, marriage and family therapy, or medicine. Providers who are pursuing their independent license during a supervised period of clinical practice may also render core treatment services if they have an associate licensure, if applicable, and have a supervision contract submitted and approved by their applicable licensing Board.

All licensed professionals must be in conformance with the relevant practice act(s). By submitting claims to SCDHHS for reimbursement, licensed professionals attest that they are in conformance with the relevant practice act(s) and associate regulations. Any services performed by licensed professionals, to include supervisory relationships, that do not comport with the relevant practice act(s) and regulations are subject to recoupment by the Department, and a referral made to the appropriate Board at South Carolina Department of Labor, Licensing and Regulation.

Service Specific Medical Necessity Criteria for Psychotherapy Services

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

Individual Psychotherapy (IP)

The purpose of this face-to-face intervention is to assist the beneficiary in improving his or her emotional and behavioral functioning. The clinical professional assists the individual in identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.

IP is an interpersonal, relational intervention directed towards increasing an individual's sense of well-being and reducing subjective discomforting experience. IP may be psychotherapeutic and/or therapeutically supportive in nature.

IP involves planned therapeutic interventions that focus on the enhancement of a beneficiary's capacity to manage his or her emotions and behaviors through effective decision making, developing and acquiring coping skills, making better choices and decisions regarding co-occurring

substance abuse, achievement of personal goals, and development of self-confidence and self-esteem.

Treatment should be designed to maximize strengths and to reduce problems and/or functional deficits that interfere with a beneficiary's personal, family and/or community adjustment. Interventions should also be designed to achieve specific behavioral targets, such as improving medication adherence or reducing substance abuse.

Staff-to-Beneficiary Ratio

IP requires one qualified clinical professional to one beneficiary served.

Group Psychotherapy (GP)

GP is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician. The focus of GP is to assist beneficiaries with solving, emotional difficulties and to encourage the personal development of beneficiaries in the group.

The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure the process is productive for all members and focuses on identified therapeutic issues.

GP involves a small therapeutic group that is designed to produce behavior change. The group must be a part of an active treatment plan and the goals of GP must match the overall treatment plan for the individual beneficiary. GP requires a relationship and interaction among group members and a stated common goal. The focus of the psychotherapy sessions must not be exclusively educational or supportive in nature. The intended outcome of such group oriented, psychotherapeutic services is the management, reduction, or resolution of the identified behavioral health and/or substance abuse problems, thereby allowing the beneficiary to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from GP:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.
- Beneficiaries with the same or similar needs that may gain insight by being in a group with others with shared experiences.
- Beneficiaries who have a similar experience.
- Beneficiaries need to demonstrate a level of competency to function in a group.

Staff-to-Beneficiary Ratio

GP requires one qualified clinical professional and no more than eight beneficiaries (1:8). Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a Provider, regardless of whether or not the beneficiary is Medicaid-eligible.

Family Psychotherapy (FP)

The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning, with the functioning of his or her family unit. The therapist assists family members in developing a greater understanding of the beneficiary's psychiatric and/or behavioral disorder and the appropriate treatment for this disorder, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction.

FP involves interventions with members of the beneficiary's family unit (i.e., immediate or extended family or significant others) with or on behalf of a beneficiary to restore, enhance or maintain the family unit.

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

FP tends to be short-term treatment, with a focus on resolving specific problems such as eating disorders, difficulties with school, or adjustments to bereavement or geographical relocation. Treatment should be focused on changing the family dynamics and attempting to reduce and manage conflict. The family's strengths should be used to help them handle their problems.

FP helps families and individuals within that family understand and improve the way they interact and communicate with each other (i.e., transmission of attitudes problems and behaviors) and promote and encourage FS to help facilitate the beneficiary's improvement. The goal of FP is to get family members to recognize and address the problem by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include, but are not limited to, the identification and the resolution of conflicts arising in the family environment, including conflicts that may relate to substance use or abuse on the part of the beneficiary or family members, and the promotion of the family's understanding of the beneficiary's mental disorder, its dynamics, and treatment. Services may also include addressing ways in which the family can promote recovery for the beneficiary from mental illness and/or co-occurring SUDs.

Staff-to-Beneficiary Ratio

FP is one professional to one individual beneficiary and their family unit per encounter. Only one individual beneficiary can be billed for any one session of FP.

Multiple Family Group Psychotherapy (MFGP) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

MFGP treatment will allow beneficiaries and families with similar issues to meet face-to-face in a group with a clinician. The group's focus is to assist the beneficiary and family members in resolving emotional difficulties, encourage personal development and ways to improve and manage their functioning skills

The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other's behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified therapeutic issues.

MFGP involves a small therapeutic group that is designed to produce behavioral change. The goals of MFGP must match the overall treatment plan for the individual beneficiary. MFGP requires a relationship and interaction among group members and a stated common goal.

MFGP is directed toward the restoration, enhancement, or prevention of the deterioration of role performance of families. The psychotherapy allows the therapist to address the needs of several families at the same time and mobilizes group support between families. The process provides commonality of the MFGP experience; including experiences with behavioral health and or cooccurring SUDs and utilizes a complex blend of family interactions and therapeutic techniques, under the guidance of a therapist. The intended outcome of such family-oriented, psychotherapeutic services is the management, reduction, or resolution of the identified mental health problems, thereby allowing the beneficiary and family units to function more independently and competently in daily life.

Beneficiaries who meet the following criteria may benefit from MFGP:

- Beneficiaries with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting will allow the beneficiary to develop and practice new skills and focus on the factors that impact the beneficiary's symptoms.
- Beneficiaries with the same type of problem that may gain insight by being in a group with others.
- Beneficiaries who have a similar experience.
- Beneficiaries need to demonstrate a level of competency to function in a group.

Staff-to-Beneficiary Ratio

MFGP requires one qualified clinical professional for a minimum of two family units served (a minimum of four individuals) and a maximum of up to eight individuals which includes the beneficiaries and their families. Beneficiaries in excess of the allowed ratio should not be present

during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a Provider regardless of whether or not the beneficiary is Medicaid-eligible.

Service Specific Medical Necessity for MFGP

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

Service Plan Development (SPD) by Non-Physicians

The purpose of this service is to allow an LPHA, LMSW, or MHP to review, with other entities or support teams, the issues that are relevant to the needs of the beneficiary with the beneficiary or family member. Beneficiaries are actively involved in the development, revision, coordination, and implementation of the SPD.

The interdisciplinary team will establish the beneficiary's goals, objectives and identify appropriate treatment or services needed by the beneficiary to meet those goals via the development of the IPOC. Beneficiaries and their families must be involved in the planning, developing and choosing of needed services.

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

The interdisciplinary team is responsible for periodically reviewing progress made toward goals and modifying the IPOC as needed.

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

When the IPOC has been developed, a qualified clinical professional must review the IPOC with the beneficiary and/or family member or legal representation. The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LMSW must sign the final document.

Staff-to-Beneficiary Ratio

SPD requires at least one professional for each beneficiary.

Service Specific Medical Necessity

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or SUD. The results of the DA and/or screening tool must support the need for services.

Crisis Management (CM)

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

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

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

CM should therefore be immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual; CM is not a scheduled service.

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

- A preliminary evaluation of the beneficiary's specific crisis.
- Intervention and stabilization of the beneficiary.
- Reduction of the immediate personal distress experienced by the beneficiary.
- Development of an action plan that reduces the chance of future crises through the implementation of preventative strategies.
- Referrals to appropriate resources.
- Follow up with each beneficiary within 24-hours, when appropriate.
- Telephonic interventions are provided either to the beneficiary or on behalf of the beneficiary to collect an adequate amount of information to provide appropriate and safe services, stabilize the beneficiary, and prevent a negative outcome.

An evaluation of the beneficiary should be conducted promptly to identify presenting concerns, issues since last stabilization (when applicable), current living situation, availability of supports, potential risk for harm to self or others, current medications and medication compliance, current use of alcohol or drugs, medical conditions, and when applicable, history of previous crises including response and results.

Individuals in crisis who require this service may be using substances during the crisis. Substance use should be recognized and addressed in an integrated fashion, as it may add to risk, increasing the need for engagement in care. This coordination must be documented in the individual's plan of care.

Staff-to-Beneficiary Ratio

CM requires at least one qualified clinical professional for each beneficiary.

Service Specific Medical Necessity Criteria

Beneficiaries eligible for these services must have a diagnosis of a mental illness and/or SUD(s); experience acute psychiatric symptoms; or experience psychological and/or emotional changes that result in increased personal distress. Services are also provided to beneficiaries who are, at-risk for a higher level of care, such as hospitalization or other out-of-home placement.

Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning.

Two CM service encounters can be rendered to an individual prior to a DA being required. Following two CM service encounters, a DA (or Mental Health Comprehensive Assessment- Follow up if being rendered by DMH staff) must show medical necessity for more services to be authorized.

Community Support Services

CSS must be authorized for beneficiaries enrolled in an MCO prior to being rendered.

Psychosocial Rehabilitation Services (PRS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The purpose of this face-to-face service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the beneficiary's living, learning, social, and work environments. PRS is a skill building service, not a form of psychotherapy or counseling. PRS is intended to be time limited. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are based on medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the beneficiary's IPOC.

PRS include activities that are necessary to achieve goals in the IPOC in the following areas:

- Independent living skills development related to increasing the beneficiary's ability to manage his or her illness, illness, to improve his or her quality of life, and to live as actively and independently in the community as possible.

- Personal living skills development in the understanding and practice of daily and healthy living habits and self-care skills.
- Interpersonal ST that enhances the beneficiary's communication skills, ability to develop and maintain environmental supports, and ability to develop and maintain interpersonal relationships.

PRS is designed to improve the quality of life for beneficiaries by helping them assume responsibility over their lives, strengthen living skills, and develop environmental supports necessary to enable them to function as actively and independently in the community, as possible.

PRS must be provided in a supportive community environment. Each beneficiary should be offered PRS in a manner that is strengths-based and person-centered.

PRS must provide opportunities for the beneficiary to acquire and improve skills needed to function as adaptively and independently as possible in the community and facilitate the beneficiary's community integration.

Staff-to-Beneficiary Ratio

PRS can be provided individually, face-to-face with one beneficiary at a time.

PRS can be provided in small groups of no more than one staff to eight (1:8) adult beneficiaries and no more than one staff to eight (1:8) child and adolescent beneficiaries regardless of the payer source of the beneficiaries in the group. Only staff who meet the staff qualification requirements for PRS are considered for the 1:8 ratio. For example: If a group consists of nine children, two staff must be present and actively rendering the service. If two staff are not present and actively rendering the service, the Provider cannot be reimbursed for the service as the ratio exceeds 1:8.

Beneficiaries in excess of the allowed ratio should not be present during the delivery of the service. The ratio count applies to all beneficiaries receiving services by a Provider regardless of whether or not the beneficiary is Medicaid-eligible.

Service Specific Medical Necessity Criteria

A-I must be met to satisfy criteria for admission into PRS services:

- A. The beneficiary has received a DA, which includes a DSM diagnosis that requires and will respond to therapeutic interventions specific to the PRS service description.
- B. The beneficiary has a SPMI, serious emotional disturbance (SED) and/or SUD, and the symptom-related problems interfere with the individual's functioning and living, working, and/or learning environment. (Children under the age of seven may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).

C. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings and/or recreational setting.

D. Beneficiary meets three or more of the following criteria as documented on the DA:

- i. Is not functioning at a level that would be expected of typically developing individuals their age.
- ii. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement.
- iii. In the last 90-days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.
- iv. Experiences impaired ability to recognize personal or environmental dangers or significantly inappropriate social behavior.

E. The family/caregiver/guardian agrees to be an active beneficiary, which involves participating in interventions to better understand and care for the beneficiary for the purpose of maintaining progress during and after treatment.

F. Traditional mental health services (e.g., individual/family/group therapy, MM, etc.) alone are not clinically appropriate to prevent the beneficiary's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and that the benefits to receiving the treatment outweigh any potential harm.

G. The service is recommended by a LPHA acting within the scope of his/her professional licensure.

H. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for PRS (private providers only):

- i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the Parenting Stress Index (PSI).
- ii. For beneficiaries age 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the Child Behavior Check List (CBCL).
- iii. For beneficiaries 6–18 years, has been assigned a minimum CALOCUS-CASII composite score of 17.

Behavior Modification (B-MOD) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The service is provided to children and adolescents ages 0 to 21. The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his or her functioning within the home or community. Shadowing (following and observation) a beneficiary in any setting is not reimbursable under Medicaid. B-MOD is intended to be time-limited and the intensity of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease over time as the beneficiary's skills develop. Services are based upon a finding of medical necessity, shall be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the beneficiary's IPOC.

The goal of B-MOD is to alter patterns of behavior that are inappropriate or undesirable of the child or the adolescent. B-MOD involves the utilization of regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned techniques that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli.

B-MOD provides the beneficiary the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn life skills.

B-MOD involves the identification of precipitating factors that cause a behavior to occur. New, more appropriate behaviors are identified, developed, and strengthened through modeling and shaping. Intervention strategies that require direct involvement with the beneficiary must be used to develop, shape, model, reinforce and strengthen the new behaviors.

B-MOD techniques allow professionals to build the desired behavior in steps and reward those behaviors that come progressively closer to the goal and allow the beneficiary the opportunity to observe the professional performing the desired behavior.

Successful delivery of B-MOD should result in the display of desirable behaviors that have been infrequently or never displayed by the beneficiary. These desirable responses must be reflected in progress notes and show increasing frequency for ongoing B-MOD.

Staff-to-Beneficiary Ratio

B-MOD must be provided 1:1; B-MOD must not be provided in group settings.

Service Specific Medical Necessity Criteria

A–J must be met to satisfy criteria for admission into B-MOD services:

- A. The beneficiary is under 22 years of age.
- B. The beneficiary has received a DA, which includes a current DSM diagnosis that requires and will respond to therapeutic interventions and which documents the need for B-MOD.
- C. The beneficiary has a SPMI, SED and/or SUD, and must be engaging in one or more of the following behaviors: physical aggression, verbal aggression, object aggression, and/or self-injurious behavior that presents risk of harm to self or others (children under the age of seven may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).
- D. The beneficiary's behaviors interfere with three or more of the following areas: daily living, personal relationships, school/work settings and/or recreational setting.
- E. Beneficiary meets three or more of the following criteria as documented on the DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is deemed to be at-risk of psychiatric hospitalization or out-of-home placement.
 - iii. In the last 90-days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.
 - iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.
- F. The beneficiary's behavioral needs require interventions to decrease identified behaviors and to facilitate the beneficiary's success in his or her home and community.
- G. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the beneficiary's needs identified in the DA and IPOC, for the purpose of maintaining progress during and after treatment.
- H. Beneficiary is expected to benefit from the intervention and needs would not be better met clinically by any other formal or informal system or support.
- I. The service is recommended by a LPHA acting within the scope of his/her professional licensure.
- J. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for B-MOD (private providers only):

- i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the PSI.
- ii. For beneficiaries aged 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the CBCL.
- iii. For beneficiaries 6–18 years, has been assigned a minimum CALOCUS-CASII composite score of 17.

Family Support (FS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The service is provided to children and adolescents ages 0 to 21. The purpose of this face-to-face service is to enable the family or caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as an engaged member of the beneficiary’s treatment team and to develop and/or improve the ability of the family or caregiver(s) to appropriately care for the beneficiary. FS is intended to be time-limited and the intensity of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease over time as the beneficiary’s and family/caregiver’s skills develop. Services are based upon a finding of medical necessity, must be directly related to the beneficiary’s diagnostic and clinical needs, and are expected to achieve the rehabilitative goals specified in the beneficiary’s IPOC.

FS is intended to:

- Equip families with coping skills to independently manage challenges and crisis situations related to the beneficiary’s behavioral health and/or SUD.
- Educate families/caregivers to advocate effectively for the beneficiary in their care.
- Provide families/caregivers with information and skills necessary to allow them to be an integral and active part of the beneficiary’s treatment team.
- Model skills for the family/caregiver.

FS is a service with the primary purpose of treating the beneficiary’s behavioral health and/or SUD.

FS does not include case management activities nor does it include respite care or child care services of any kind.

Staff-to-Beneficiary Ratio

FS requires one qualified staff for each family unit served. If more than one child in a family has met medical necessity for FS they must be served separately.

Service Specific Medical Necessity Criteria

A–I must be met to satisfy criteria for admission into FS services:

- A. The beneficiary is under the age of 22.
- B. The beneficiary has received a DA, which includes a current DSM diagnosis and specific clinical needs that will respond to therapeutic interventions and which documents the need for FS.
- C. The beneficiary has a SPMI, SED and/or SUD, and the symptom-related problems interfere with the individual's functioning, living, working, and/or learning environment. Children under the age of seven may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM.
- D. As a result of the SED, SPMI or SUD, the beneficiary experiences moderate to severe functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings and/or recreational setting.
- E. Beneficiary meets three or more of the following criteria as documented on the DA:
 - i. Is not functioning at a level that would be expected of typically developing individuals their age.
 - ii. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement.
 - iii. In the last 90-days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.
 - iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.
- F. Family/caregiver agrees to be an active beneficiary in treatment; FS services should provide opportunities for the family/caregiver to acquire and improve skills needed to better understand and care for the needs of the beneficiary (e.g., managing crises, providing education about the beneficiary's diagnosis).
- G. Beneficiary is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.
- H. The service is recommended by a LPHA acting within the scope of his/her professional licensure.
- I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for FS (private providers only):

- i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the PSI.
- ii. For beneficiaries aged 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the CBCL.
- iii. For beneficiaries 6–18 years, has been assigned a minimum CALOCUS-CASII composite score of 17.

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UTILIZATION MANAGEMENT

All providers will ensure that only authorized amounts of services are provided and submitted to SCDHHS for reimbursement. The provider will ensure that all services are provided in accordance with all SCDHHS policy requirements. Reimbursement received in excess of authorized amount/duration is subject to recoupment.

COORDINATION OF CARE

It is the responsibility of all service Providers to coordinate care among all entities that render services to beneficiaries.

If a beneficiary is receiving treatment from multiple service Providers, there should be evidence of care coordination in the beneficiary's clinical record. Coordination of care serves to promote continuity of care and ensure there is no duplication in services or billing. Duplicated services cannot be reimbursed under Medicaid and Providers shall make every effort to contact other service Providers involved in the current course of treatment for the beneficiary to ensure services are complimentary to one another and not duplicative in nature. In the event separate RBHS Providers render services to the same beneficiary, coordination of care is essential to ensure the IPOCs are not in conflict with one another or the desired outcomes of the beneficiary.

MANAGED CARE ORGANIZATION

All RBHS services are covered under the managed care benefit package. If a beneficiary is enrolled with one of the State's contracted Managed Care Organizations (MCOs), all RBHS Providers must receive prior approval from the MCO. SCDHHS allows for MCOs to set PA rules and guidance. Please refer to the managed care policy and procedure manual at:

<https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp> for additional information regarding behavioral health and substance use treatment services.

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REPORTING AND DOCUMENTATION

DOCUMENTATION REQUIREMENTS

All RBHS Providers shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation sufficient to justify Medicaid participation and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. The absence of appropriate and complete records, as described below, may result in recoupment of payments by SCDHHS. All clinical records must be kept in a confidential and safeguarded manner as outlined in the Provider Administrative and Billing Manual.

An index as to how the clinical record is organized must be maintained and made available upon request. Each Provider shall have the responsibility of maintaining accurate, complete and timely records, and ensure the confidentiality of the beneficiary's clinical record.

The beneficiary's clinical record must include, at a minimum, the following:

- Comprehensive DA(s)
- Other assessments (as applicable)
- Assessment tool(s), administered and scored by a qualified clinician (as applicable):
 - PSI (birth to 1.5 years), or
 - The Child Behavior Check List (1.5–5 years), or
 - CALOCUS-CASII administered by a qualified clinical professional with a CALOCUS-CASII SCDHHS Provider certification (ages 6–18)

(Exclusion to assessment tools: State agencies directly rendering RBHS and all Providers directly rendering services to beneficiaries in foster care.)

- Parent/Caregiver/Guardian Agreement to Participate in CSS' form (as applicable)
- Signed, credentialed or functional titled, and dated IPOCs — initial, reviews and reformulations
- BMP, as applicable
- Signed, credentialed or functional titled and dated 90-day Progress Summaries

- Signed, credentialed or functional titled and dated CSNs
- RBHS State agency Referral Form (as applicable)
- Court orders, if applicable
- Copies of any evaluations and or tests, if applicable
- Signed releases, consents and confidentiality assurances for treatment
- Physician's orders, laboratory results, lists of medications and prescriptions (when performed or ordered)
- Copies of written reports (relevant to the beneficiary's treatment)
- Medicaid eligibility information, if applicable
- Other documents relevant to the care and treatment of the beneficiary

Consent to Examinations and Treatment

A consent form, dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor), or legal representative, must be obtained at the onset of treatment from all beneficiaries and placed in the beneficiary's file from each treatment Provider. If the beneficiary, parent, legal guardian or legal representative cannot sign the consent form due to a crisis and is accompanied by a next of kin or responsible party, that individual may sign the consent form. If the beneficiary is alone and unable to sign, a statement such as "beneficiary unable to sign and requires emergency treatment" must be noted on the consent form and must be signed by the LPHA and one other staff member. The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit. A new consent form should be signed and dated each time a beneficiary is readmitted to the system after discharge.

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

Release of Information

A Release of Information form must be signed by the child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims. This is required for requesting payment of government benefits on behalf of the child. This may be incorporated into a Consent for Treatment form.

Legibility

All clinical documentation must be filed in chronological order. All clinical records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order so they can be easily and clearly reviewed, copied and audited.

Original legible signature and credentials (e.g., RN, LPC, etc.), or functional title (if not licensed or in possession of a degree from a higher institution of learning [e.g., Human Service Professional]), of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service or co-signature, when required, are not acceptable. (See the Administrative and Billing Provider Manual for the use of electronic signatures and/or exceptions.)

Error Correction

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

- Draw one line through the error, and write “error”, “ER”, “mistaken entry”, or “ME” to the side of the error in parenthesis. Enter the correction, sign or initial, and date it.
- Errors cannot be totally marked through. The information in error must remain legible.
- No correction fluid may be used. If an explanation is necessary to explain the corrections, they must be entered in a separate CSN.

Late Entries

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

- 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, documentation shall be completed within 10 business days of the date of service.

Abbreviations and Symbols

Service Providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation. An abbreviation key must be maintained to support the use of abbreviations and symbols in entries. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

Documenting Medical Necessity

Medical necessity must be documented on a DA administered by a qualified LPHA. The LPHA's name, professional title, signature and date must be listed on the document to confirm medical necessity. If the LPHA is an LMSW, a co-signature by an independently licensed LPHA is required of private Providers.

The DA must be completed prior to any RBHS services being rendered with the exception of the Crisis Management (CM) service. Two CM service encounters can be rendered to an individual prior to a DA being required. Following two CM services, a DA must show medical necessity for more services to be authorized.

The DA must document the presence of a serious behavioral health disorder from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM or ICD criteria.

The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended. Additional required elements of the DA can be referenced in the DA Service description located in this manual.

Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative services.

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

The DA must be maintained in the Medicaid beneficiary's clinical record.

If SCDHHS or its designee determines that services were reimbursed when evidence of medical necessity, as outlined in this manual, was not documented and maintained in the beneficiary's record, payments to the Provider shall be subject to recoupment.

INDIVIDUALIZED PLAN OF CARE

The IPOC is an individualized comprehensive plan of care to improve the beneficiary's condition. The IPOC is developed in collaboration with the beneficiary, which may include an interdisciplinary team of the following: significant other(s), parent, guardian, primary caregiver, other State agencies and staff, or service Providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. While there may be certain treatment methodologies commonly utilized within a particular service, Providers must ensure that services are tailored to the beneficiary's individual needs and the service delivery reflects knowledge of the particular treatment issues involved.

The assessment of the beneficiary is used to identify problems and needs, develop goals and objectives, and determine appropriate Rehabilitative Services and methods of intervention for the beneficiary. The IPOC outlines the service delivery needed to meet the identified needs and improve overall functioning.

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

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

IPOC Documentation

Each Provider is responsible for developing the IPOC. When the State agency refers for services and does not provide the IPOC, the private organization must develop the IPOC.

When State agencies refer beneficiaries to private RBHS Providers for services, the private RBHS Providers must adhere to the recommendations for services and specific frequencies set forth by the respective State agency.

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

The IPOC must include the following components:

Beneficiary Identification Name
and Medicaid ID number.

Presenting Problem(s)

Statements that outline the beneficiary's specific needs that require treatment services. Statements that validate the need for treatment services based on medical necessity.

Psychiatric Diagnosis(es)

The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the DSM or the ICD.

For individuals who have more than one diagnosis regarding mental health, substance use and/or medical conditions, all diagnoses should be recorded.

Goals and Objectives

The IPOC should include a list of specific short-and long-term goals and objectives addressing the expected outcome of treatment. Goals and objectives should reflect input from the beneficiary and beneficiary's family, as applicable, and should be written so that they are observable, measurable, individualized (specific to the beneficiary's problems and/or needs) and realistic.

Goals are global statements that should reflect positive resolution to the beneficiary's identified needs and should include outcome measure(s) or expectation(s).

Objectives (short-term goals) are similar to and directly related to specified goals but are highly specific and reflect small attainable steps to achieve goals.

The beneficiary's culture, community, support systems, environmental factors, and developmental and intellectual factors should be considered in the formulation of objectives.

Specific Interventions

A list of specific therapeutic interventions (actions, activities, methods, etc.) used to meet the stated goals and objectives must be included. The identification of modalities to be used (e.g., CBT, DBT, Motivational Interviewing, Psychoeducation, etc.) should be included as part of the interventions.

Specific Services

All services to be rendered to beneficiaries and/or families must be identified on the IPOC (e.g., Individual Therapy, Group Therapy, Family Therapy, FS, etc.)

Frequency of Services

The frequency must be listed on the IPOC for each service. Each service should be listed by its name or approved abbreviation with an individualized and specific planned frequency. The frequency must be appropriate to the needs of the beneficiary and beneficiary's family, as applicable, and shall not exceed medical necessity.

- Example: PRS frequency should be identified as the following:
 - PRS — 3 hours per day/2 days per week or PRS — 12 units per day/2 days per week
 - Should not be listed as PRS — Up to 20 hours a week.

Criteria for Achievement

Outline how success for each goal and objective will be demonstrated. Criteria must be reasonable, attainable and measurable, must include target dates and must indicate a desired outcome to the treatment process.

Target Dates

A timeline for completion that is individualized to the beneficiary and their goals and objectives. Target dates should reflect projected incremental change over the course of a year, and should not uniformly reflect the annual expiration date of the IPOC.

Contact Information

Emergency contacts, including phone numbers, must be listed.

Discharge Plan

The IPOC must include a plan of action for discharge. This plan must include the anticipated date of discharge from services, beneficiary's and/or family's expected gains to be achieved through participation in treatment and services, and anticipated aftercare needed (if applicable).

Beneficiary Signature

The beneficiary and guardian must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC. The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LMSW must sign the final document.

Authorized Signature(s)

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

The IPOC must be signed, titled and signature dated by the LPHA, master's level qualified clinical professional or LMSW. The IPOC must be filed in the beneficiary's clinical record with any supporting documentation such as the DA.

Services Not Required on the IPOC

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

- DA
- CM
- SPD
- BHS

IPOC — CORE TREATMENT AND CSS**Duration:**

- The initial IPOC must be completed, signed, titled, and signature dated by the LPHA, master's level qualified clinical professional, or LMSW within 30 calendar days of the DA.
- Core Treatment Services may be rendered prior to the completion of the IPOC, provided the services are medically necessary.
- If the IPOC is not completed and signed within 30 days, services rendered are not Medicaid reimbursable.

Addendum:

When services are added or frequencies of services are changed in an existing IPOC, the addendum must include the signature and title of the clinician who formulated the addendum and the date it was formulated. All service changes must meet medical necessity criteria for each discrete service to be added.

- The IPOC must be signed and dated by the reviewing LPHA or master's level qualified clinical professional to confirm changes.
- When space is unavailable on the current IPOC, a separate sheet must be added and labeled as "Addendum IPOC" and the addendum must accompany the existing IPOC.
- If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary and other involved parties within 10 business days.

Reformulation:

- The maximum duration of the IPOC is 365 calendar days from the date of the signature of the LPHA, or master's level qualified clinical professional on the IPOC.
- Prior to termination or expiration of the treatment period, the LPHA or master's level qualified clinical professional must review the IPOC with the beneficiary and evaluate the beneficiary's progress with respect to each of the beneficiary's treatment goals and objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC.
- The signature of the LPHA or master's level qualified clinical professional responsible for the treatment is required.
- The IPOC must include the date of reformulation, the signature and title of the LPHA or master's level qualified professional authorizing services and the signature date.
- There should be evidence in the clinical record regarding the involvement of the beneficiary and the beneficiary's family, if applicable, in the reformulation of the IPOC.
- Copies of the reformulated IPOC must be distributed to all involved beneficiaries within 10 business days.

90 DAY PROGRESS SUMMARY

The 90-day Progress Summary is a periodic evaluation and review of a beneficiary's progress toward the achievement of goals and objectives, overall response to treatment services, the appropriateness of services rendered, and the need for the beneficiary's continued participation in the treatment.

The progress summary shall be completed at least every 90 calendar days from the signature date on the initial IPOC, and at least every 90 days thereafter.

The progress summary must be completed and signed by the LPHA, or other qualified clinical professional. The progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.

It is the responsibility of the current treatment Provider to complete the 90-day Progress Summary. If a beneficiary is transferred to a new Provider during the 90-day period, the discharging Provider must submit clinical documentation, including a discharge summary, to the receiving Provider to ensure a continuity of care.

The LPHA, or other qualified clinical professional will review and document the following:

- The beneficiary's name and Medicaid ID number.
- The beneficiary's progress toward treatment goals and objectives. Any barriers to progress should also be identified.
- The appropriateness and frequency of the services provided. Failure to provide the recommended services and their frequency should also be explained.
- The need for continued treatment.
- Recommendations for continued services or discharge of services as outlined in the success criteria for each objective.

CLINICAL SERVICE NOTES (CSN) **Clinical Service Notes (CSNs)**

The purpose of the CSNs is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions, and any changes in medical, behavioral or psychiatric status.

Evidence of rendering services must be documented on CSNs. A CSN is required for each contact or service, for each date of service, for each beneficiary (if service was rendered in a group setting) and must be written and signed by the qualified staff who provided the service. Each CSN must support both the type of service billed and the number of units billed. Every CSN must be individualized to reflect treatment/service and interventions with a specific beneficiary, for each date of service, for each service rendered to the beneficiary and/or family. The content of CSNs shall not be duplicated, be it among the records of beneficiaries served by the Provider and/or among dates of service for any one beneficiary served by the Provider. If CSNs are not completed and maintained in accordance with the requirements in this manual, payments to the Provider shall be subject to recoupment.

The CSN must include the following information:

- The beneficiary's name and Medicaid ID number.
- The date of service.
- The name of the rehabilitative service (or its approved abbreviation) and the corresponding procedure code.
- The number of units of service rendered.
- The date of service in a month, day and year format.
- Document the start time and end time for each service delivered.
- Location where the service was rendered. (Refer to the Billable Code/Location of Service section of this manual for additional information.)
- The manner in which the service was delivered: individual or group; if the service is provided in a group setting, the number of beneficiaries must be identified on the CSN.
- Be typed and/or handwritten — documentation must be legible.
- Be kept in chronological order.
- Abbreviations must be decipherable — if abbreviations are used, the Provider must maintain a list of abbreviations and their meanings and the list must be made available to SCDHHS upon request.
- Reference individuals by full name, title and agency or Provider affiliation at least once in each note, as applicable.
- Identification of other beneficiaries by name shall not be included.
- Be signed, credentialed or functional titled, and signature dated (month/date/year) by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with these standards.
- Billing modifiers must match the credentials of the individual rendering the service.
- Be completed and placed in the beneficiary's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service.

Providers must maintain adequate documentation to (1) support the number of units or encounters billed and to (2) support each service billed.

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative service conforms to the service description and authenticates the charges:

- The focus and/or reason for the session or interventions which should be related to treatment objective(s) and/or goal(a) on the IPOC, unless there is an unexpected event that needs to be addressed.
- The detailed summary of the interventions (e.g., action steps, tools used, techniques utilized, etc.) and involvement of qualified staff with the beneficiary and/or family during each contact or session/meeting (only time spent rendering the intervention or treatment can be billed — see the *Covered Services* section for additional information). Any use of an evidence-based practice should be clearly documented.
- The individualized response of the beneficiary and/or beneficiary's family, as applicable, to the interventions and/or treatment rendered at each contact or session/meeting.
- The general progress of the beneficiary to include observations of their conditions/mental status. Progress should reflect detailed individualized information about the beneficiary over the course of treatment and shall not reflect general categories of progress or general statements of progress in treatment (e.g., Phrases such as “moderate” or “not making progress”, without providing detailed information to support the identification of these will not meet this standard).
- The future plan for working with the beneficiary and the beneficiary's family, as applicable. This should reflect the plan of action for the next and foreseeable future sessions/meetings with the beneficiary (e.g., statements such as “will continue to meet with person as per IPOC” will not meet this standard).

Availability of Clinical Documentation

CSNs and other service documentation should be completed and placed in the clinical record immediately following the delivery of a service, but no later than five business days from the date of service. Any documentation completed and placed in the clinical records for any billed activity after this deadline shall be subject to recoupment.

Services must be documented in the clinical record and the documentation must justify the amount of reimbursement claimed to Medicaid.

Quality Improvement and Monitoring

All Providers should self-monitor adherence to applicable Federal and State Laws and Regulations and in accordance with the South Carolina Plan for Medical Assistance, alerts, bulletins, SCDHHS policies, procedures and Medicaid Provider Manuals. Any findings of non-compliance, as a result of self-monitoring activities shall be communicated to and monetarily remitted to SCDHHS.

SCDHHS, or its designees, will conduct reviews to ensure that Providers are in compliance with applicable laws, regulations and policies. Other authoritative entities may conduct reviews of RBHS Providers, including the State Auditor's Office, the South Carolina Attorney General's Office, United States Department of Health and Human Services, Government Accountability Office and/or their designees. Upon request, information must be furnished regarding any claim for payment to SCDHHS. All Providers must grant access to SCDHHS, or its designees, to records for reviews and/or investigations for the purposes of reviewing, copying and reproducing documents. Failure of the Provider to comply with this provision may result in the immediate termination of enrollment.

SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS

Psychological Testing and Evaluation (PTE)

Services must be documented on a CSN with a start time and end time. The CSN must include the purpose of the test, the results of the PTE and/or make reference to the completed test. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

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

Documentation must include:

- Beneficiary's name and Medicaid ID number.
- Name of the tests that were conducted (e.g., MMPI).
- Test results and interpretation.
- Identify recommendations or referrals based on test results.
- The diagnoses code and the diagnosis.
- Documentation must support the number of units billed.

Behavioral Health Screening (BHS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.

Services must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Documentation must:

- Include the outcome of the screening.

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

CALOCUS-CASII Assessment — Community Support Services **This service only available for RBHS providers enrolled prior to July 1, 2022.*

Assessments must be documented in a manner which addresses all of the necessary components and clearly establishes medical necessity. When submitting a claim for the CALOCUS-CASII assessment, documentation of the scoring instrument and supporting clinical documentation is required.

In addition to the CALOCUS-CASII Form itself, the service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Diagnostic Assessment (DA) Services

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

In addition to the assessment itself, the DA service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Psychiatric DA without Medical Services (Comprehensive DA)

The following components must be included in the Psychiatric DA without Medical Services (Comprehensive DA) include:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Beneficiary's demographic information:
 - Age
 - Date of birth
 - Phone Number
 - Address
 - Relationship/Marital Status
 - Preferred Language

- Beneficiary's cultural identification, including gender expression, sexual orientation, culture and practices, spiritual beliefs, etc.
- Presenting complaint, source of distress, areas of need, including urgent needs (e.g., suicide risk, personal safety, and/or risk to others).
- Risk factors and protective factors, including steps taken to address identified current risks (e.g., detailed safety plan).
- Mental/behavioral health history of beneficiary, including previous diagnoses, treatment (including medication) and hospitalizations.
- Psychological history including previous psychological assessment/testing measures, reports, etc.
- Substance use history including previous diagnoses, treatment (including medication) and hospitalizations.
- Exposure to physical abuse, sexual assault, antisocial behavior or other traumatic events.
- Physical health history, including current health needs and potential high-risk conditions.
- Medical history and medications, including history of past and current medications.
- Family history, including relationships with family members, and involvement of individuals in treatment and services, family psychiatric and substance use history.
- Mental status.
- Education and employment history.
- Housing/living situation.
- Diagnosis(es) of a serious behavioral health disorder (description and code must be identified for each) from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria.
- Initial start date of RBHS.
- Planned service type and frequency of each recommended rehabilitative service.
- Referrals for external services, support or treatment.

Mental Health Comprehensive Assessment Follow-up

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

Documentation must include the following components:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Include the outcome of the assessment
- Identify any referrals resulting from the assessment
- The diagnostic code and the diagnosis

In addition to the assessment itself, the diagnostic assessment service must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for clinical service notes.

Individual Psychotherapy (IP)

IP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

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

Group Psychotherapy (GP)

GP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

All psychotherapy services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Family Psychotherapy (FP)

FP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

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

Multiple Family Group Psychotherapy (MFGP)

MFGP must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary. Services must be documented on a CSN with a start time and end time. The CSN must document how the psychotherapy session applied to the identified beneficiary's treatment goals. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Service Plan Development (SPD) of the IPOC

Documentation should include the involvement of the clinical professional and/or team of professionals in the following:

- All individuals present for the service planning.
- The development, staffing, review and monitoring of the plan of care.
- Discharge criteria and/or achievement of goals.
- Confirmation of medical necessity and recommendations for services, including frequencies of services.
- Establishment of one or more diagnoses, including co-occurring SUD, if present.

The IPOC must include the date it was completed, the signature and title of the Physician, LPHA, or master's level qualified clinical professional, or LMSW signing the IPOC to authorize services. Refer back to the IPOC section to ensure all components are listed on the IPOC.

While attendance of multiple Provider representatives may be necessary, only one professional that is actively involved in the planning process from each Provider office may receive reimbursement. The Provider representative must have documentation of the invitation to the IPOC meeting in the clinical record.

Crisis Management (CM)

CM is not required to be listed on the IPOC.

Services must be documented on a CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs. A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and stop time, as well as the duration.
- All beneficiaries during the service.
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis.

- Content of the session, including safety risk assessment and safety planning.
- Active participation and intervention of the staff.
- Response of the beneficiary to the treatment.
- Beneficiary's status at the end of the session.
- A plan for what will be worked on with the beneficiary.
- Resolution of the crisis.

Psychosocial Rehabilitation Services (PRS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

PRS must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

The qualified staff providing the service is responsible for completing and signing the CSNs. The notes should clearly identify the specific goal(s) from the IPOC for which the delivery of PRS addresses. Services must be documented upon each contact with the beneficiary. Additionally, the CSNs and other documentation must meet all SCDHHS requirements.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

For beneficiaries age 0 through 15 years of age, the Parent/Caregiver/Guardian Agreement to Participate in CSS' form must be completed and maintained in the beneficiary's record. The Parent/Caregiver/Guardian Agreement form must be updated every ninety (90) calendar days. In the unlikely event that the beneficiary's family or caregiver is unable or unwilling to be an active beneficiary, this must be clearly documented in the clinical record.

Refer to the Clinical Service Note section of this manual regarding services being rendered in a group to ensure that requirements are met.

Behavior Modification (B-MOD) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The beneficiary's IPOC and treatment process must be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

B-MOD must be listed on the IPOC with a specific planned frequency to meet the identified individualized needs of the beneficiary.

The qualified staff providing the service is responsible for completing and signing the CSNs. The notes must clearly identify the specific goal(s) from the IPOC for which the delivery of B-MOD addresses. Services must be documented upon each contact with the beneficiary. Additionally, the CSNs and other documentation must meet all SCDHHS requirements, outlined in the Documentation Requirements section of this manual.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the need(s) of the beneficiary.

For beneficiaries aged 0 through 15, the Parent/Caregiver/Guardian Agreement to Participate in CSS form must be maintained in the beneficiary's record, completed and updated every ninety (90) calendar days .

Beneficiaries receiving B-MOD must have the Parent/Caregiver/Guardian Agreement Form signed prior to the initiation of B-MOD services.

- For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by the foster parent. In the event the foster parent changes during the 90-day authorization period, the new foster parent must sign the Parent/Caregiver/Guardian Agreement for the next 90-day authorization cycle. In the event there is a refusal or an inability to sign the agreement BMOD services must not be provided.
- In addition to general documentation requirements, service documentation for B-MOD must identify the presence of the inappropriate and/or undesirable and detail how the behavior was redirected by qualified staff.

In addition to the IPOC, a BMP must be included in the beneficiary's clinical record.

BEHAVIOR MODIFICATION PLAN (BMP)

A BMP addresses the beneficiary's specific behavioral challenge(s). The BMP supports the beneficiary in learning and utilizing positive behavioral interventions, strategies and supports. The BMP should focus on understanding why the behavior occurred, then focus on teaching an alternative behavior that meets the beneficiary's need(s).

The BMP must remain current and therefore must be amended when a new intervention, strategy or support is warranted or if no progress is being made. The BMP must be revised as needed and must always be current.

The BMP must be developed by a team consisting of the beneficiary, family/caregiver and B-MOD Provider. The BMP must be consistent with the beneficiary's goals outlined within the IPOC.

Components that must be included in BMP (including but not limited to):

- Name

- Medicaid Number
- Date of BMP and/or date of revision
- Target Behavior(s):
 - An operational definition of each problem behavior to be decreased.
 - An operational definition of each replacement behavior to be increased.
 - A measurable objective for each problem behavior and replacement behavior.
- Identify the desired behavioral change.
- Intervention Strategies: includes specific interventions and strategies to be implemented in addressing the target behavior(s)/goal(s).
- Environmental Changes: includes any changes to the setting or environment necessary to effectively implement the strategies and interventions.
- Timelines/Review Dates: includes segments of time during which specific portions of the BMP are to be addressed, as well as specific dates by which specific portions of the BMP are to be reviewed, with regard to progress.
- Behavioral Crisis Plan: How will a behavioral crisis be handled?
- Monitoring Progress/Evaluation Methods: includes a description of how progress toward achieving desired outcomes will be monitored and evaluated, including timeframes and data collection.
- Progress Review Date: the date the plan will be reviewed for effectiveness.
- Names of beneficiaries in the creation of the BMP.
- Signatures of persons who participated in the development of the plan (beneficiary, family/caregiver and B-MOD staff).

Family Support (FS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The qualified staff providing the service is responsible for completing and signing the CSNs. The notes should clearly identify the specific goals from the IPOC for which the delivery of FS addresses. Services must be documented upon each contact with the beneficiary and/or family/caregiver. Additionally, the CSNs and other documentation must meet all SCDHHS requirements, outlined in the Documentation Requirements section of this manual.

Documentation must clearly reflect the specific need of the beneficiary and the therapeutic interventions and support rendered to address the needs of the beneficiary.

Beneficiaries aged 0 through 15 must have the Parent/Caregiver/Guardian Agreement Form signed prior to the initiation of FS services.

For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by the foster parent and updated every ninety (90) calendar days. In the event the foster parent changes during the 90-day authorization period, the new foster parent must sign the Parent/Caregiver/Guardian Agreement for the next 90-day authorization cycle. In the event that there is a refusal or an inability to sign the agreement FS services must not be provided.

The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Discharge/Transition Criteria

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

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

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BILLING GUIDANCE

SERVICE UNIT CONTACT TIME

SCDHHS has adopted the Medicare 8 Minute Rule for services. This means that when indicated by any discrete RBHS service, a Provider may not bill for a service of less than eight minutes. The actual minutes billed by any one Provider in a day shall not exceed the daily unit limits. If any RBHS 15-minute service is performed for seven minutes or less on any day, the service is not reimbursable. The expectation is that a Provider’s direct beneficiary contact time for each unit will average 15 minutes in length. If a Provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

UNITS	TIME
1	Equal to 8 minutes but less than 23 minutes
2	Greater than/equal to 23 minutes, but less than 38 minutes
3	Greater than/equal to 38 minutes, but less than 53 minutes
4	Greater than/equal to 53 minutes, but less than 68 minutes
5	Greater than/equal to 68 minutes, but less than 83 minutes
6	Greater than/equal to 83 minutes, but less than 98 minutes
7	Greater than/equal to 98 minutes, but less than 113 minutes
8	Greater than/equal to 113 minutes, but less than 128 minutes
9	Greater than/equal to 128 minutes, but less than 143 minutes
10	Greater than/equal to 143 minutes, but less than 158 minutes
11	Greater than/equal to 158 minutes, but less than 173 minutes
12	Greater than/equal to 173 minutes, but less than 188 minutes
13	Greater than/equal to 188 minutes, but less than 203 minutes
14	Greater than/equal to 203 minutes, but less than 218 minutes
15	Greater than/equal to 218 minutes, but less than 233 minutes

16

Greater than/equal to 233 minutes, but less than 248 minutes

USE OF Z-CODES

The use of Z-codes is allowed but this is considered a temporary diagnosis for ages 7 and older. The use of Z-codes is not time limited for children ages 0 to 6 of age. Z-codes can be used in any diagnosis field on the claim form.

BILLABLE CODE/LOCATION OF SERVICE

The Place of Service code needed for school based RBHS is:

03 — School

Reference the School-Based RBHS Fee schedule for approved modifiers to include on all claims.

SERVICE-SPECIFIC BILLING GUIDANCE

Psychological Testing and Evaluation (PTE)

PTE is billed as a 60-minute unit with a limit of ten units billed within a week and a limit of 20 units billed per year.

Billable Place of Service

Services must be administered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

The evaluating psychologist should inquire about and review any prior testing (e.g., psycho-educational, psychological, developmental and/or neuropsychological) that may have been administered, and request copies for review prior to conducting a new battery. If prior testing cannot be reviewed, the Provider should document their attempts to access the information and offer an explanation pertaining to the clear medical necessity for a new assessment. Attempts should be made to determine when tests were previously administered to ensure that test exposure is not a factor in the outcome of the evaluation. If an assessment has been conducted in the last 90 days, an assessment should be repeated only if a significant change in behavior or functioning has been noted. A repeated assessment must be added to the clinical records.

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

The PTE and DA can be billed on the same day. The assessments must be billed separately.

Behavioral Health Screening (BHS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

BHS is billed in 15-minute units for a maximum of two units per day.

Billable Place of Service

Services must be administered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

BHS shall not be billed on the same date of service as Psychiatric Diagnostic Evaluation without Medical (Comprehensive DA — Initial) and/or CALOCUS-CASII.

CALOCUS-CASII Assessment — Community Support Services **This service only available for RBHS providers enrolled prior to July 1, 2022.*

The CALOCUS-CASII assessments are billed as an encounter. One encounter can be reimbursed every six months.

Billable Place of Service

CALOCUS-CASII assessments must be administered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Diagnostic Assessment (DA) Services

The initial and follow-up DAs are billed as an encounter.

The initial assessment may be rendered once every six months.

The follow-up assessment may be rendered up to 12 times in a year.

Billable Place of Service

Services must be administered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

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

Efforts should be made to determine whether another DA has been conducted in the last 90 days and information should be updated as needed. If a DA has been conducted within the last 90 days, efforts should be made to access those records.

Individual Psychotherapy (IP)

IP is billed as an encounter. There are three encounter ranges based on amount of time spent with the beneficiary. There can be one encounter per day with a limit of six encounters per month. Six sessions in any combination can be billed in a month.

Billable Place of Service

Services must be rendered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Group Psychotherapy (GP)

GP is billed as an encounter. A session must last a minimum of an hour. More than one session can be billed per day, with a limit of eight sessions per month.

Billable Place of Service

Services must be rendered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Family Psychotherapy (FP)

FP is billed as an encounter and can only be rendered once per day. A session must last a minimum of an hour. FP with the beneficiary can be rendered four sessions per month; FP without the beneficiary can be rendered four sessions per month.

Billable Place of Service

Services must be rendered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

When multiple members of a family are identified beneficiaries, reimbursement for FP shall be for only one of the beneficiaries present in the session, not all beneficiaries.

Multiple Family Group Psychotherapy (MFGP) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

MFGP is billed as an encounter. A session must last a minimum of an hour and more than one session can be billed per day, with a limit of eight sessions per month.

Billable Place of Service

Services must be rendered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality. Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Service Plan Development (SPD)

SPD by a non-Physician is billed in a 15-minute unit.

Special Restrictions Related to Other Services

State agencies that refer SPD to qualified Providers may designate and authorize the Provider to develop the plan of care. Providers should ensure that other health and human service agencies or Providers involved with the beneficiary receive a copy of the IPOC.

Assessment services cannot be billed on the same date of service as SPD services. The assessment must be completed prior to the development of the IPOC.

Crisis Management (CM)

CM is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Excluded settings: acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Special Restrictions Related to Other Services

Services provided to children must include coordination with family or guardians and other systems of care as appropriate.

Psychosocial Rehabilitation Services (PRS) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

PRS is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

PRS is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same-Day Service Restrictions

CSS' are defined as the following five services: Psychosocial Rehabilitation, B-MOD, CIS, TCC and FS services.

SCDHHS will only reimburse for one RBHS CSS per day. For example, FS — B-MOD will not be reimbursed on the same-day as PRS or FS.

Exception: Individual (1:1) PRS may be provided on the same day as CIS.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

For services rendered to beneficiaries that are residing in a community residential care facility or substance abuse facility, activities must be above and beyond structured activities required daily by the South Carolina Department of Health and Environmental Control (DHEC) licensure requirements. This delineation must be clearly defined, documented and accessible in the beneficiary record.

Behavior Modification (B-MOD) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

B-MOD is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a setting that is convenient for the beneficiary, affords an adequate therapeutic environment and protects the beneficiary’s rights to privacy and confidentiality.

B-MOD is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions and residential settings of any type of more than 16 beds and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same-Day Service Restrictions

CSS are defined as the following five services: Psychosocial Rehabilitation, B-MOD, FS Services CIS and TCC.

SCDHHS will only reimburse for one RBHS CSS per day. For example, B-MOD will not be reimbursed on the same-day as PRS or FS.

Exceptions to any same-day service restrictions are noted under the specific service.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

Family Support (FS) (0–21) **This service only available for RBHS providers enrolled prior to July 1, 2022.*

FS is billed in 15-minute units.

Billable Place of Service

Services must be rendered in a setting that is convenient for the beneficiary, affords an adequate therapeutic environment and protects the beneficiary’s rights to privacy and confidentiality.

FS is not Medicaid reimbursable if it is provided in the following places of service: acute care hospitals, inpatient psychiatric hospitals, PRTF, institutions and residential settings of any type of more than 16 beds, and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).

Same-Day Service Restrictions

CSS are defined as the following five services: Psychosocial Rehabilitation, B-MOD, FS Services, CIS, and TCC.

SCDHHS will only reimburse one RBHS CSS per day. For example, B-MOD will not be reimbursed on the same-day as PRS or FS.

Exceptions to any same-day service restrictions are noted under the specific service.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.

Services provided on the behalf of the beneficiary must include coordination with family/caregiver and other systems of care as appropriate. FS must not be rendered with more than one family unit at a time.

Children in foster care, TFC, and those served by the Continuum of Care are exempt from the same-day service restriction.