SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

PSYCHIATRIC HOSPITAL SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PART I - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

PROGRAM OVERVIEW

The purpose of this manual is to provide pertinent information to Inpatient Psychiatric Service providers for successful participation in the South Carolina Medicaid Program. Part One of this manual provides a comprehensive overview of the program standards and policies and procedures for Medicaid Psychiatric Residential Treatment Facilities (PRTFs).

PRTF level of care is reserved for members whose immediate treatment needs require a structured 24-hour inpatient residential setting that provides all services (including educational) onsite.

To receive reimbursement for these services, providers must meet the facility requirements in this manual. The South Carolina Department of Health and Human Services (SCDHHS) designated Quality Improvement Organization (QIO) will prior authorize admission and continued stays in a PRTF.

PRTFs provide Inpatient Psychiatric Services to children under 21 who do not require acute inpatient psychiatric care but need a structured environment with intensive treatment services.

Medicaid reimbursement for PRTFs will continue to be based upon a per diem rate. The services covered by the per diem rate and provided to a Medicaid-eligible member residing in a PRTF will include the cost of institutional care as well as the cost associated with their psychiatric diagnosis, excluding all medications (including psychiatric medications) and other ancillary services. Additional information relating to the South Carolina Medicaid payment methodology for PRTFs can be found in Attachment 4.19-A of the South Carolina Medicaid State Plan.

CERTIFICATION OF NEED (CON)

The Code of Federal Regulations, 42 CFR 441.151, states that Inpatient Psychiatric Services must be certified as necessary, in writing, for the setting in which the services will be provided in accordance with CFR 441.152.

42 CFR 441.153 mandates that either an independent review team or the facility-based interdisciplinary team certify a member’s admission to an inpatient psychiatric facility by completing the Certificate of Need (CON) form.

The CON must certify the following admission requirements:

- Documentation of a comprehensive assessment conducted within the previous 10 business days by a Licensed Practitioner of the Healing Arts (LPHA) has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms and risk assessment.
- Mental health, substance use disorder and/or health care resources available in the community do not meet the treatment needs of the member.
- The proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- Services can reasonably be expected to improve the member's condition, prevent further regression, and/or prepare the child and family for the child's return home so that inpatient psychiatric services will no longer be needed.

Refer to the Documentation Requirements section for guidelines on how to complete the form.

Team Completing the CON

The member's admission status dictates whether an independent review team or the facility-based interdisciplinary team is responsible for certifying the member's need for admission to acute inpatient services.

Independent Review Team

An independent review team is a group of professionals who are not affiliated with the receiving inpatient psychiatric facility and have no financial, employment, or consultant relationship with the admitting facility. The independent review team is responsible for completing the CON when an individual is a Medicaid recipient. The independent review team must consist of professionals in accordance with 42 CFR 441.153.

Interdisciplinary Team

An interdisciplinary team is a team of professionals within the PRTF. PRTF-based interdisciplinary teams are responsible for CON for members who become Medicaid eligible after admission. All team members must sign the CON form. The interdisciplinary team must consist of professionals in accordance with 42 CFR 441.153.

PRTF Admission Types

There are two types of Medicaid admissions to PRTFs:

1. Urgent admission: The member meets the CON criteria but is not presenting immediate danger that would cause death, serious impairment to the health of the member or bodily harm to another person by the member. An independent team that meets the requirements noted above will complete the CON form for urgent admissions to PRTFs. The form must be signed and dated by at least one physician and one other team member.

2. Post-admission eligibility: The member becomes eligible for Medicaid after admission to the PRTF. The facility's interdisciplinary team will complete the CON form for members which must cover any period before the Medicaid application and relevant claims.

The PRTF Scope of Services and Performance Standards have been guided by best practice and seek to emphasize:

- Individualized, culturally and linguistically competent, strength/resiliency-based, trauma-informed services with a focus on skill building;
- Standardized behavioral approaches to prevent aggression, which can lead to elimination of restrictive procedures within the PRTF;
- Youth/family voice and choice in all treatment, support, and program decisions;
- Permanent connections for youth without identified permanency plans;
- Comprehensive and immediate family engagement and partnerships to support sustained, successful outcomes for youth with their families in the home and community following PRTF treatment in accordance with the following family-driven, youth-guided principles:

  - Children must be treated within the context of their family systems. PRTF providers shall work with the child and family team (i.e., the member, his or her parents, legal guardians, or others in whose care he or she will be released after discharge) to implement services that are congruent with the child's family culture and environment.
  - PRTF providers must engage and support family members/caregivers to be actively and meaningfully involved in all aspects of the child's care. The primary planning entity for each child will be a team with the family and child at its center, community and facility-based service providers, referring agencies, and other supportive individuals invited by the child and family to participate. A case manager or care coordinator shall orchestrate and facilitate the work of the team. As key members of the team, families and identified caregivers and stakeholders must be included in the assessment process, in setting and prioritizing treatment goals, in ongoing care, discharge planning, and transition activities.
  - Treatment and support must be highly individualized to the needs of each child and family. Therapeutic interventions must target the behaviors, symptoms and concerns that may have limited the child's successes to date. Programming must address each child's specific needs, reflect each child's preference and unique capabilities, and must be adaptable and transferable to each family's situation.

  - PRTFs must prioritize the youth's existing relationships with family, friends, teachers and neighbors. Phone calls, family visits, and other experiences shall not be earned nor restricted unless there is clear clinical justification and strategic goals outlined in the service plan for doing so.

- Therapeutic activities shall be mindfully planned to allow children to practice skills and behaviors that will help them succeed in family, school, and other community settings. Children must be able to appropriately personalize their environment to reflect their tastes, culture, preferences, and interests.
- Participation in family-focused therapy shall be a primary objective in PRTF placements.
- Discharge plans must build on identified strengths and cultural priorities and incorporate families' natural supports, as well as necessary professional services.
- A family's supported level of involvement must be considered a treatment priority and addressed in the service plan. Families must be actively engaged and sometimes re-engaged.
- PRTF providers must collaborate with community providers (e.g., outpatient, community service agency) to deliver family-focused therapy and ensure continuity of care.
- Family involvement and engagement efforts must be clearly supported by documentation in the treatment record and by interview results from family members.
- PRTF providers shall not diminish the services afforded to children whose families might be unable or unwilling to participate in their care. Instead, providers must continually pursue an effective level of engagement with the family, at times even extending to other relatives beyond the immediate family.
    - Some children referred to a PRTF do not reside with biological families. SCDHHS expectations and requirements for family involvement, family voice, and choice extend to the wide diversity of primary caregivers including biological, adoptive, foster, or fictive kin residing together in which adults perform the duties of parenthood for the children. ("Home" refers to the residences of those families.)
    - Older youth who may not have an identified family to return to must be assisted in developing ties to their community, to non-family resources upon which they can depend for assistance, and with caregivers who can help to meet their relationship needs.

Quality Assurance and Improvement Plan

- PRTFs must engage in continuous quality assurance and improvement activities centered around mitigating risk and improving outcomes.
- PRTFs must maintain or develop and document standards of care to be assessed through internal quality assurance activities.

- PRTF standards of care must emphasize timely access to treatment for all youth including those with complex, challenging, or high-risk behaviors, average length of stay associated with optimal success, sustained family and community reintegration, and restraint reduction for youth as major goals of PRTF care.

Purpose

This level of care is required only if the member's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Research shows that effective home and community-based services can provide the best health, mental health, and functional life outcomes for children, youth, and their families. Providers must actively strive to expand the variations of service they provide and integrate them with community-based programs to effectively stabilize and strengthen family home and community living options for members.

SCDHHS recognizes a primary goal of a PRTF is to prepare the member and family, as quickly as possible, for the member's return to home and community. A member's underlying behavioral problems must be addressed in order to accomplish this goal, and therapeutic interventions must target the behaviors and symptoms that have limited the member's successes. Service planning and programming, including therapeutic strategies and provision of active treatment, must reflect this goal, and must be focused on teaching members how to successfully function in the context of the setting to which they will be returning—not the placement in which they are receiving services.

The member's underlying behavioral problems need not be fully resolved before the member can successfully transition back home as the most appropriate setting for therapeutic work is the environment in which the member will be living and functioning, i.e. their home and community.

Transitions from PRTFs must be designed to provide member's families with sufficient referrals and resources to feel confident about meeting the challenges at home. These resources should include home and community-based supports (formal and informal) that can adequately address the member's needs, including any familial and community safety supports.

PRTFs shall be regarded as a treatment level in a larger continuum of care and not as residential placements.

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

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Population Covered

Medicaid reimbursement is available for Inpatient Psychiatric Services in PRTFs provided to the following:

- Medicaid members under the age of 21. If the child receives services immediately before he or she reaches age 21, services may continue until the earlier of the date the individual no longer requires the services or the date the individual reaches age 22.

If the member is enrolled with one of the state's contracted MCOs, all PRTF providers must receive prior approval and claim reimbursement directly from the member's MCO. Please refer to the managed care policy and procedure manual for more information. The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website for additional information regarding MCO coverage.

Admission Criteria

In addition to the elements required for the Certificate of Need, a member must meet the following criteria for admission into a PRTF:

- The member demonstrates symptomatology consistent with a current DSM diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
- The member is experiencing emotional or behavioral problems in the home, community or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.
- The member demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development and medication compliance training.
    - The member has a history of multiple hospitalizations or other treatment episodes, or a recent inpatient stay with a history of poor treatment adherence or outcome necessitating a step down from acute inpatient setting.
- Less restrictive or intensive levels of treatment have been tried and were unsuccessful or are not appropriate to meet the member's needs.

- The member's functioning is such that the member cannot currently remain in the home environment and receive community-based treatment.

Prior to placing a member in a PRTF, the referring agent must submit a CON, along with all pertinent documentation, to the facility for their clinical record.

Continued Stay Criteria

A member must meet the following criteria for continued stay at a PRTF:

- There is a need for continued active psychiatric treatment by a multidisciplinary team at a PRTF level of care as evidenced by information obtained in the most recent Individualized Plan of Care, treatment team notes, including updated discharge plan and any Therapeutic Home Time documentation.
- Clinical evidence indicates at least one of the following:
  - The problems that caused the admission continue to meet criteria for PRTF level of care, or
  - The emergence of additional problems that meet the admission criteria both in severity of need and intensity of service needs, or
  - The disposition planning and/or attempts at therapeutic re-entry into the community have resulted in exacerbation of the psychiatric illness to the degree that would necessitate continued member treatment. Subjective opinions without objective clinical information or evidence are NOT sufficient to meet severity of need based on justifying the expectation that there would be decompensation.
- Objective, measurable and time-limited therapeutic clinical goals are determined to be most appropriately met at a PRTF level of care before the patient can return to a new or previous living situation.
- Psychiatric symptoms and precipitating psychosocial stressors are interfering with the member's ability to return to a less-intensive level of care.

Please review the Prior Authorization section to identify the criteria and requirements for admission and continued stay requests.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Psychiatric Residential Treatment Facility providers must comply with provisions of 42 CFR Section 483.350 to 483.376.

In order to participate in the South Carolina Medicaid program, providers of Inpatient Psychiatric Services must meet the appropriate state/federal requirements and licensure, certification and enrollment guidelines as outlined below.

All facilities that wish to enroll, or are currently enrolled, in the South Carolina Medicaid program must meet the following minimum requirements:

- A psychiatric facility accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities with the Behavioral Health Inpatient Treatment program standards, or the Council on Accreditation of Services for facilities providing services to families and children.
- Facilities must contract with SCDHHS.
- Facilities must submit a written facility description, a request for participation, and cost information to:

  SCDHHS Office of Behavioral Health
  Post Office Box 8206
  Columbia, SC 29202-8206

  OR emailed to:

  Behavioralhealth004@scdhhs.gov.

  Note: The request for participation must include a copy of your TJC, CARF, or COA accreditation and licensing.

- Facilities seeking to obtain specialization in ASD services must email this request to behavioralhealth004@scdhhs.gov. Specialization will require submission of the following:
  - A detailed program description and treatment philosophy encompassing approach to Assessment/Psychological Evaluation and Treatment.
  - Staff training program description and information encompassing the educational component of the program that is geared towards those with special needs.

- Outline of staffing to, at a minimum, include the following disciplines: Clinical Program Director, Board Certified Behavioral Analysts (BCBAs), Registered Behavioral Technicians (RBTs), Master's Level Therapists, Music Therapists, Behavioral Nurses, Recreational Therapists, a Registered Dietician, Speech Language Pathologists, and Occupational Therapists.
- Required credentials of staff at each level of intervention (i.e., unit staff, therapists, ancillary providers, etc.) and justification of staffing ratios.

If the above information is approved, the SCDHHS will send the provider two copies of the contract, a Provider Enrollment Form, the Ownership and Disclosure Statement, a W-9 Form and a Provider Agreement. The provider will sign the contracts, complete the enrollment forms and return all other documents to the Contracts Division. The Director of SCDHHS then signs the contract and sends one copy to the provider.

Please refer to the Provider Enrollment manual for detailed instructions regarding enrollment.

Facility Modifications

Existing Facilities

PRTF service providers requesting any modification to their facility are required to notify SCDHHS or its designee in writing 60 days in advance of the modification and must receive written approval for facility modifications from SCDHHS or its designee prior to claiming Medicaid reimbursement. Facility modifications that impact the facility licensure must be approved by Department of Public Health (DPH) prior to notifying SCDHHS.

Facility modification shall be defined by any of the following conditions:

- Changes and revisions to policies and procedures enacted since the provider was enrolled or since the last comprehensive review was completed.
- An existing provider intends to add the same service but to serve a different population (*e.g.,* age, gender, etc.).
- An existing facility is sold, or ownership is transferred to a different entity.
- An existing provider changes its facility director or other operational changes.
- An existing provider intends to increase its bed capacity, or to reorganize services through diversification of programming (*e.g.,* respite, crisis stabilization) and/or deployment of staff to reflect the facility's role as a community resource and not a "placement".
- An existing provider changes address/physical location.

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

- A provider is currently under a formal corrective action plan from SCDHHS or its designee and/or DPH Licensing. If the facility is under a corrective action plan, modification(s) will be considered on a case-by-case basis. The modification(s) would be considered only after the corrective action plan is completed.

- The provider has experienced substantial recoupment as a result of a post-payment review by Medicaid Program Integrity/QIO within the last two years and has failed to show evidence of correcting compliance issues. If during the process to modify, a post-payment review occurs and preliminary results indicate issues of concern, the process could be delayed.

- The provider does not demonstrate fiscal responsibility/accountability of its existing facilities as evidenced by review of annual financial reports submitted to the Division of Ancillary Reimbursements.

- The provider has failed to maintain the facility's license and/or accreditation.

Licensure and Certification

In-state facilities must be licensed by DPH and meet and maintain compliance with all requirements as set forth by both the Centers for Medicare and Medicaid (CMS) and SCDPH Regulation Number 61.103, as amended.

Out-of-state facilities must be licensed and certified by that state's appropriate licensing authority and meet the inpatient psychiatric benefit in-state requirement, including all requirements as set forth by CMS.

Attestation Requirements

Each PRTF that provides Inpatient Psychiatric Services for Children Under Age 21 must attest in writing to SCDHHS that the facility is in compliance with the conditions of participation on an annual basis. Letters of attestation of compliance must be issued by each PRTF prior to July 21st of each year. Attestation letters should be mailed to:

SCDHHS Bureau of Quality
Attention: PRTF Attestation
Post Office Box 8206
Columbia, SC 29202-8206

OR emailed to:

quality@scdhhs.gov

Letters of attestation must include the following information:

- Facility General Characteristics:
  - Name
  - Address
  - Telephone Number
  - Fax Number
  - Medicaid Provider Number and NPI

- Facility Specific Characteristics:
  - Bed Size
  - Number of children currently served within the PRTF who receive services based on their eligibility for the Medicaid Inpatient Psychiatric Services for Children Under Age 21 benefits.
  - Number of children, if any, whose Medicaid Inpatient Psychiatric Services for Children Under Age 21 benefits are paid for by any state other than South Carolina.
  - A list of all states from which the PRTF has ever received Medicaid payment for providing Inpatient Psychiatric Services for Children Under Age 21.
  - Signature of the Facility Director
  - Date the attestation was signed
  - A statement certifying that the facility currently meets all the requirements under 42 CFR Subpart G § 483 governing the use of restraint and seclusion.
  - A statement acknowledging the right of SCDHHS, DPH (or its agents or the appropriate State Health Licensing agent) and, if necessary, CMS, to conduct an onsite survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility or to investigate serious occurrences.
  - An annual statement and acknowledgement that the facility will submit a new attestation of compliance in the event that the individual who has the legal authority to obligate the facility is no longer in such a position.

- A statement certifying that the facility currently meets the Certification of Need requirements as identified under 42 CFR § 441 governing Subpart D – Inpatient Psychiatric Services for Children Under Age 21 in Psychiatric Facilities.

- A copy of the facility's mission statement, approach to practice, quality assurance plan, and safety or risk mitigation plans.

- A copy of any assigned corrective action plans with updates.

- A copy of the employee agreement with the physician who has assumed professional responsibility for directing all treatment provided in the PRTF.

Note: PRTF staff ("Other Licensed Practitioner", i.e., physician, physician assistant, or an advanced practice registered nurse [APRN] with prescriptive authority, as per 42 CFR Section 483.358) involved with utilization of seclusion and/or restraint must adhere to the applicable scope of practice limits and definitions under state law. A model attestation letter can be found in the Forms section of this manual.

Staffing Requirements

Facilities must be appropriately staffed to meet the needs of all members in their care. The facility must ensure there is an adequate number of multidisciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each child.

Inpatient Psychiatric Services must be provided under the direction of a licensed physician. The facility must have an employment agreement with a physician who has assumed professional responsibility for directing all treatment provided in the PRTF. The physician must be licensed to practice medicine in the state of South Carolina or in the state where the facility is located. The physician must meet all training and staff qualification requirements in this manual.

Licensed mental health professionals shall be available to ensure that the facility can meet the stated active treatment requirements. The overall program structure and staffing plan must have flexibility built in to address the individual strengths, challenges, needs, cultures, and home schedules of each youth and family served. Direct care staff include professionals who possess a current South Carolina license to practice, such as licensed physician assistant, licensed advanced practice registered nurse, licensed psychologist, licensed marriage and family therapist, licensed professional counselor, licensed master's social worker, licensed independent social worker – clinical practice, registered nurse or other appropriately trained professionals as approved by SCDHHS. Supervision and/or direction must be provided by professionals licensed to practice independently and facilities must retain copies of all supervision contracts that reflect the supervisory chain of command. A minimum of one (1) licensed professional with supervisory capacity must be onsite at all times, 24 hours per day, 7 days per week.

Employment Background Check Requirements

Employees and contractors granted clinical privilege, who have regular, direct access to members, or their personal, financial or medical information must have a full background check completed. The background check must include the following:

- Criminal Records
- Child Abuse and Neglect Central Registry
- Sex Offender Registry
- Motor Vehicle Licensure & Record (if the employee's position description requires that she/he transport members, a copy of the individual's motor vehicle record (MVR) will be kept in the individual's personnel record; the facility must also adhere to any other State or Federal regulations regarding transportation of members as applicable, e.g., "Jacob's Law".)
- Nurse Aide Registry / SCLLR Licensee Look-up
- Medicaid Exclusion List
- These checks are required prior to initial hire and at least annually thereafter. The results must be kept in the employee's personnel file.

Staff Development and Training Requirements

The facility is responsible for hiring and maintaining a qualified workforce.

The facility must require its clinicians, technicians, support staff, and other professionals to have the following education and training:

- **Basic Orientation**
  - Basic orientation includes but is not limited to standards as outlined in the DPH regulations.
- **CPR** (Excludes physicians)
  - Staff must receive certification in the use of cardiopulmonary resuscitation, including periodic recertification, as required. Staff must demonstrate competencies in cardiopulmonary resuscitation on an annual basis.
- **Emergency Safety Intervention (ESI)**
  - Staff must demonstrate knowledge of the following:

› Techniques to identify staff and member behaviors, events and environmental factors that may trigger emergency safety situations;

› The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations; and

› The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in members who are restrained or in seclusion.

– Staff must be trained and demonstrate competency before participating in an emergency safety intervention. Staff training must include training exercises in which staff members successfully demonstrate, in practice, the techniques they have learned for managing emergency safety situations.

– Staff must demonstrate their competencies in identification techniques, nonphysical intervention skills and the safe use of restraint and seclusion on a semiannual basis. Continuing education must be scheduled for seasoned staff to ensure they maintain these competencies.

- **Facility mission, goals, and values to include approach to care**
- **Facility Organizational Culture Model**
- **Facility Crisis Prevention and Intervention Plan**
- **Facility Debriefing Protocol**
- **Facility Quality Assurance Plan and Relevant Committees**
  - **Staff must be trained and demonstrate understanding of the Quality Assurance Plan and any staff and/or resident committees dedicated to performance improvement**
- **Clinical Overview**
  - Staff must demonstrate knowledge of the following through initial and annual trainings:
    - Growth and Development
    - Family Dynamics
    - Group Dynamics
    - Common Behavioral Health Disorders

- Therapeutic Boundaries
- Grief and Loss Issues
- Cultural Diversity (to include transgender competency)
- Psychosexual Issues
- Suicide Screening, Assessment, and Crisis Intervention (such as AMSR, Suicide2Hope)
    - Mental Health First Aid (Excludes individuals with a master's degree in a behavioral health or related field and licensed/certified in their respective profession)
- Compassion Fatigue and Recognizing Burnout

– Training must include key principles and approaches essential to a coordinated system of care and other ongoing professional development.

Training must be provided by individuals who are qualified by education, training and experience or approved by SCDHHS.

The facility must document in the staff personnel records that the training and demonstration of competencies were successfully completed. Documentation must include the date training was completed and the names of persons certifying the completion of training. All trainings and materials used by the facility must be available for review by CMS, SCDHHS and the State survey agency. Maintenance of Staff Credentials. **A credentials folder shall be maintained for each PRTF employee and includes the following:**

- Resumes or equivalent application form;
- Official transcripts and/or copies of diplomas from an accredited university or college;
- Proof of licensure for LPHA;
- Signature Sheet; and
- Training files, which include documentation of participation in the required orientations, certifications and re-certifications.

Staff to Client Ratio

All PRTFs must be staffed appropriately to meet the needs of all children in their care. The facility must also ensure there is an adequate number of staff to carry out the goals and objectives of the facility, and to ensure the delivery of individualized treatment to each child as detailed in their plan of care.

The ratio of direct care staff to children shall be a minimum of one staff member to five members during facility hours in each residence or unit. Facility hours are defined as those times when the child is expected to be awake and receiving services. The minimum ratio of direct care staff shall be immediately available.

During sleeping hours, the ratio of staff to member shall be a minimum of one staff member to seven members. At least one direct care staff member of the same sex as the member shall be present, awake and available to the member at all times. If both male and female members are present in the facility, at least one male and one female direct care staff member shall be present, awake and available. The minimum ratio of direct care staff shall be immediately available in a connecting area to the sleeping rooms. A minimum of one (1) licensed professional with supervisory capacity must be onsite 24/7 and may be considered in the staffing ratios.

Electronic supervision shall not replace the direct care staffing requirements. Youth shall always remain in sight and sound observation range of staff. Staff shall conduct periodic visual welfare checks of all children at intervals not to exceed every 15 minutes; documentation of welfare checks, which denote the time and observations made, must be maintained in a log in each residential unit

For youth on suicide protocols, the level of in-person supervision necessary is based on the level of assessed suicidal risk. Facilities must have policy and procedure outlining various levels of suicide monitoring based on assessed risk (such as close monitoring [low risk], observation [moderate risk], 1:1 staffing ratio [high risk], etc.). At a minimum, continuous one-to-one visual, line-of-sight, within sound range, and within arms' reach monitoring is required for any child on the highest level of suicide watch until cleared. Electronic supervision must never be used as an alternative to in-person monitoring.

Risk of suicide must be assessed by a physician or licensed clinician using an evidence-based suicide screener such as the Columbia Suicide Severity Rating Scale (C-SSRS); the assessing clinician must also document outcome of screening and assessment, level of suicide watch required, and identify any specific risks for the individual of which staff must be aware and continue to monitor. A copy of this documentation must be provided to all staff working with the youth for the duration of the suicide protocol and placed in the youth's chart.

Before removing a youth from suicide protocols, a clinician must reassess suicide risk level.

Additional staff shall be available in the facility on all shifts to supplement the staff-to-client ratio, to provide immediate assistance in case of an emergency, and to periodically check on the status of the beneficiaries. An interdisciplinary team member must be available at all times.

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COVERED SERVICES AND DEFINITIONS

ACTIVE TREATMENT

Inpatient Psychiatric Services must involve “active treatment,” which means implementation of a professionally developed and supervised Individual Plan of Care (IPOC) that establishes treatment goals and treatment services to reach those goals. Goals and services are designed to address the member’s needs and result in the member’s safe discharge from inpatient status and return to family, home, school and community at the earliest possible time. Active treatment is a clinical process involving ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning and preparation for discharge; this includes services and activities directed towards engagement of the member, identification and development and adaptive use of strengths, continuous assessment of needs, goal planning, execution of planned strategies and advocacy.

Members must be engaged in active treatment.

PRTFs must provide services and support that change to continually meet the child’s needs, including for stability and avoidance of multiple placements. As a child’s needs may change, support and services must also adapt to continue to support the child during placement.

The child and family team should anticipate crises that might develop and devise specific strategies to prevent and address them through the child’s individualized Crisis Prevention and Intervention Plan.

All individual plans of care will include crisis plans that will address alternatives to law enforcement involvement and the avoidance of restraints and seclusions. If a PRTF placement is interrupted by hospitalization or arrest, the provider will pursue every opportunity to ensure the child’s return to that same facility in accordance with the child’s IPOC. Please refer to the Reports/Documentation section for requirements regarding the IPOC.

The determination that active treatment is being implemented will be based on the following criteria:

- Examination of the plan of care should reflect interdisciplinary involvement, including that of outpatient treatment provider(s).
- Observation of communication with the member should indicate that the components of the plan of care are being delivered.
- Review of progress notes are consistent with the plan of care and indicate reasonable improvement in the members’ condition.

- Documentation of participation in facility services as required in the Program Overview section of this manual.

Clinical documentation of active treatment should be consistent with ongoing efforts to support full and active involvement of the family and/or guardian, any referring state agency, and the member's outpatient treatment providers in planning for and delivering services and speak to goals and success criteria.

Services rendered in a PRTF will not be reimbursed for stays during which active treatment related to the member's diagnostic needs is not provided or the member no longer meets criteria for inpatient psychiatric treatment.

Psychiatric Evaluations

A psychiatric evaluation must be administered by the facility physician/psychiatrist within 60 hours of admission for each member. The evaluation must identify factors related to or cause for admission to include diagnosis, summary of medical condition, behaviors, and social status of the member. The physician/psychiatrist must document the type of services needed, make a recommendation concerning need for inpatient treatment, evaluate medications the member is on and make adjustments or changes as needed. Each member must have at least one face-to-face contact monthly with the facility psychiatrist.

Assessment/Reassessment

A new diagnostic assessment must be administered face-to-face to the member and completed at a minimum of every 6 months, or as necessary, to determine the need for continued treatment.

Reassessments shall be completed by LPHAs. The following professionals are considered to be licensed at the independent level in South Carolina:

- Licensed Physician;
- Licensed Psychiatrist;
- Licensed Advanced Practice Registered Nurse;
- Licensed Physician Assistant;
- Licensed Psychologists;
- Licensed Psycho-Educational Specialist;
- Licensed Independent Social Worker-Clinical Practice;
- Licensed Professional Counselor;
- Licensed Marriage and Family Therapist;

- Licensed Addiction Counselor (LAC); and
- Licensed Master Social Worker*.

*A Licensed Master Social Worker must have the DA co-signed by an independently LPHA.

When reassessments are completed, the results shall be shared with the expanded child and family team members, including family, outpatient treatment provider(s), and referring agencies, within 10 calendar days, to ensure all children in placement continue to meet acute inpatient level of care requirements. All shared information must comply with HIPAA regulations.

The initial clinical assessment must include a biopsychosocial history; the initial and any follow-up assessments must also describe the following:

- The presence of co-occurring condition(s);
- Stressors in the natural environment;
- Current support system;
- Present behavioral triggers and mitigation strategies;
- The need for and availability of social supports;
- Resiliency and recovery;
- Engagement;
- Treatment barriers;
- Strengths and needs;
- Preferences in services (cultural, location, etc.); and
- Barriers to accomplishing goals and objectives.

Psychological Evaluations

A psychological evaluation must be completed by a qualified professional of the facility within 30 days of the date of admission for each member. This comprehensive psychological evaluation includes a psychological diagnostic interview, assessment and appropriate testing with a written report. The comprehensive psychological evaluation must include history; current mental status; disposition and appropriate psychometric, projective, and/or developmental testing; consultation with referral sources and others; evaluation/interpretation of hospital records or previous psychological reports; other accumulated data for diagnostic purposes which results in a written report with a diagnostic impression that documents the evaluation, interpretation of results, and

detailed treatment recommendations. Only a licensed psychologist shall select and interpret the results of psychological tests. The psychologist must personally interview the patient when a diagnosis is made or requested. The written report must be approved and signed by the psychologist. The comprehensive psychological evaluation and resulting report are one component of the total diagnostic evaluation necessary to establish and manage the treatment plan for inpatient psychiatric care. Re-evaluations must be conducted as needed or continued treatment.

NOTE: This evaluation must be independent of the DA, and while the DA may be used for gathering collateral information during records review, it is not indicative of a completed psychological evaluation. The final report should include a list of all tests provided, and where appropriate and indicated, should include measures of IQ (where a current IQ measure is not provided or available) and projective testing to assist with diagnosis.

Therapy Services

Therapy services are therapeutic interventions that address both the member's presenting behaviors and underlying behavioral health issues. Therapy must be provided by licensed or master's level direct care staff as defined in the Staffing Requirements section and as allowed by state law. PRTFs must advise youth and families, as well as community stakeholders, of all evidence-based practice modalities utilized in therapy.

Individual Psychotherapy

Face-to-face goal-oriented interventions with the child. Individual Psychotherapy should be provided as often as needed, but at least 90 minutes per week.

Group Psychotherapy

Face-to-face, planned interventions with a group of members, not to exceed one staff to eight members. Group Psychotherapy must be individually documented for each member. A member should receive at least three Group Psychotherapy sessions, lasting 45 minute or longer, per week.

Family Psychotherapy

Face-to-face interventions between clinical staff and the member's family unit or significant others, which must be conducted at least twice a month. Work with families should foster enhanced relationships and communication to promote improved functioning in the family system and improved functioning following PRTF interventions. Family education and skill-building regarding the youth's behaviors in the context of their mental health, trauma, and other needs, and strategies supporting self-regulation and addressing the youth's emotional and behavioral needs from this perspective, must be provided. Work with families should provide opportunities to discuss youth time at home, address strengths and challenges, replicate skill practices that are occurring in the PRTF setting, and incorporate skill practice specific to supporting a successful permanent return home. When applicable, documentation must include the reason for non-involvement and/or reasonable attempts (e.g., instrumental support, use of communications technologies) to involve the family and/or significant others.

Medical Services

Services include medication management and dispensing of medication, as appropriate. Each member must have at least one face-to-face contact per month with the physician, or as medically necessary.

Medication Management

The facility must have written policy to ensure medications are secure and not accessible to members. The medication shall be under a double lock system. The physician order must be on file to support the administering of medication. Qualified staff shall dispense all medication. A medication log shall be maintained to document dispensing of medication to include the member's name, name of the medication, dosage, time and date the medication was dispensed, and the signature of the staff member along with their title.

Prescribers are encouraged to use best practice when ordering medications. In addition, providers should limit the use of standing PRN prescriptions and provide evidence-based rationale when prescribing duplicate medications in the same class.

Crisis Management

The facility must have a written suicide prevention policy and document annual training of all staff in suicide prevention and suicide attempt response measures. Crisis intervention services will be documented and provided immediately following abrupt or substantial changes in the member's functioning and/or marked increase in personal distress.

Rehabilitative Psychosocial Services

Services designed to improve or preserve the member's level of physical cognitive, social, emotional, and behavioral functions; promotion of social skills and age-appropriate training; and developing supports and skills for the member that promote healthy functioning in family, home, school and community. These services should be offered daily.

Engagement Services and Activities

- Engaging the member in a purposeful, supportive, and helping relationship, addressing basic needs, that include determining the supports the member needs, the productive and leisure activities in which the member desires to participate that are informed by appropriate expectations in the post-discharge family, home, school and community settings.

- Understanding the member's personal history and the member's satisfaction or dissatisfaction with services and treatments, including medications that have been provided or prescribed in the past.

Strength Assessment Services and Activities

Services and activities include identifying and assessing the member's wants and needs, the member's aspirations for the future, resources that are or might be available to that member and their family, sources of motivation available to the member, and strengths and capabilities the member possesses. Services also include identifying and researching what educational, vocational and social resources are or might be available to the member to inform and facilitate the member's treatment, and identifying, researching, and understanding cultural factors that might have affected or that might affect the member's experience with receiving treatment and other services. Providers should also examine the effects that these factors might have on the treatment process, and the ways in which these factors might be best used to support the member's treatment.

Goal-Oriented Services and Activities

- Helping the member to identify, organize, and prioritize his/her personal goals and objectives regarding treatment, education, and training and community involvement.
- Assisting and supporting the member in choosing and pursuing activities consistent with achieving his/her goals and objectives at a pace consistent with the member's capabilities and motivation.
- Instructing the member on goal-setting and problem-solving skills, independent living skills, social skills, and self-management skills, acknowledging the need to devise methods and strategies to promote generalization and adaptation of acquired skills to the family, home, school and community settings where they will be used after discharge.
- Identifying critical stressors that negatively affect the member's mental status and the interventions, coping strategies, and supportive resources that have been successful or helpful in addressing or relieving those stressors in the past.
- Developing relapse prevention strategies, including wrap-around plans that the member and family team may utilize.

Advocacy Services and Activities

Services and activities that involve coordinating the treatment and support efforts and advocating for the member, as appropriate, in developing goals and objectives within the member's individualized treatment plan during the course of treatment and assisting in acquiring the resources necessary for achieving those goals and objectives.

Therapeutic Home Time (THT)

THT is an opportunity to assess the ability of the youth to successfully transition to a less restrictive level of care. Fourteen days is the maximum benefit allowed per youth per fiscal year. THT is considered a reimbursable component of the service under the all-inclusive rate.

A notification to SCDHHS is required at least 24 hours prior to the youth leaving the facility for the THT. This notification shall be communicated via secure email to behavioralhealth004@scdhhs.gov for fee-for-service members. If the youth is in an MCO, a notification must be sent to the respective health plan.

THT must support a therapeutic plan to transition the youth to a less restrictive level of care. The following information must be (1) documented in the treatment record and (2) must be included with any submissions for continued stay requests:

- Documented progress toward identified treatment goals;
- Documentation that the youth has been prepared for THT, as evidenced by a written crisis plan and a written plan for provider contact with the youth and legal representative during the visit; and
- A viable written discharge plan; and documentation of youth achievements and/or regressions during and following THT.

Leave of Absence (LOA)

A facility may place a member on a Leave of Absence (LOA) when readmission is expected and the member does not require services in a PRTF during the interim period. Leave of Absence are separate from THT and may be used for periods of time including when a youth is in the hospital, or if all 14 days of THT have been utilized. Charges for the LOA days, if any, must be shown as non-covered.

Discharge Criteria

Discharge planning should start no later than the day of admission. A member is considered discharged if the member:

- Is formally released from a PRTF;
- Is transferred to another psychiatric facility;
- Is discharged to a long-term care or step-down facility;
- Dies; or
- Leaves against medical advice.

PRTFs must ensure the following are met before discharge:

- Member has ability to function appropriately in a non-PRTF setting;
- Member is stable on current type and dosage of prescribed medication;

- Substantial progress has been made on treatment goals;
- No changes in the comprehensive psychiatric evaluation, formulation, diagnosis, treatment goals, and/or treatment plan in the previous 14 days; and
- An appropriate lower level of care has been identified and secured by the team.

5

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Quality Improvement Organization (QIO) Prior Authorization

All admissions for Fee-for-Service members must be prior authorized through the SCDHHS designated QIO.

For admissions, the PRTF must submit the request for prior authorization using the Acentra Health fax form along with the completed CON and the most recent diagnostic assessment to Acentra Health. Also, the member must meet the admissions criteria identified within the Admission Criteria section.

Initial stays in PRTFs will be limited to 30 calendar days.

If continued placement is needed, the provider must submit a continued stay request to Acentra by the 21st day in the facility. The provider must also submit an IPOC, the monthly treatment team notes, including discharge plan updates, and any THT documentation to Acentra Health prior to expiration of the current authorization. The IPOC and monthly treatment team note(s) must be completed by an interdisciplinary team that should include the member, family/caregiver, member's case manager/care coordinator and member's outpatient service provider. Additionally, Acentra will evaluate adherence to manual service requirements to approve or deny continued stay requests. Continued placement in a PRTF should be based on the progress of the member. Continued stays will be limited to 30 days.

The QIO will review the need for continued services on an annual basis using InterQual® criteria.

Acentra will use InterQual® Behavioral Health criteria to approve or deny the admission, based on medical necessity. Unless indicated through policy, all requests for approvals and denials will be sent to the provider via fax within two business days.

Requests must be submitted using one of the following methods:

Fax: 1-855-300-0082

Web Portal: http://scdhhs.kepro.com

If additional information is needed to process the request, the request will be pended, and the provider will have two business days to respond to Acentra. Providers will have only one time to respond to Acentra after additional information is requested.

Acentra will submit via fax the approval or denial authorization to provider within two business days. The approval will provide the Prior Authorization number needed for billing.

The provider is responsible for receiving and retaining proper prior authorization forms.

Providers are encouraged to visit the Acentra Web site listed above for additional information on the process.

Quality of Care Guidelines

SCDHHS utilizes the CMS Psychiatric Quality of Care Guidelines for Psychiatric Hospital Services. Psychiatric Hospital Services must meet the Quality-of-Care guidelines, which include, but are not limited to the following:

- The member's psychiatric evaluation must be completed within 60 hours of admission and must contain the pertinent clinical information.
- A complete multidisciplinary intake evaluation shall be completed.
- Each member's treatment plan must be based on an inventory of the member's strengths and disabilities, including the pertinent clinical information and should be discussed with the member.
- The facility must provide ongoing monitoring and evaluation of the member's status to identify conditions or changes in conditions that could lead to harm and/or deterioration.
- The facility must ensure adequate and appropriate use of medications and provide medication monitoring at all times.
- The facility must provide adequate monitoring, supervision and intervention by staff to prevent harm and/or trauma to the member while in the psychiatric hospital.
- The facility must ensure proper use of restraints and/or seclusion during crisis management.
- The facility must ensure that appropriate, safe discharge planning occurs.

Psychiatric Quality of Care Surveys

The QIO,SCDHHS Bureau of Quality, or SCDHHS designee may review the medical records of South Carolina Medicaid members who receive services in residential treatment facilities.

The QIO, SCDHHS Bureau of Quality, or SCDHHS designee has the authority to act on behalf of SCDHHS to deny Medicaid claims if they determine that a facility has not complied with applicable requirements.

SCDHHS contracts hospital utilization review services to a QIO or the SCDHHS designee.

There are two types of reviews conducted by the QIO or the SCDHHS designee:

- Pre-discharge Reviews
- Retrospective Reviews

These reviews are accomplished through a medical record evaluation of selected cases. The medical record review focuses on compliance with federal and state procedural requirements, provides assurance that Inpatient Psychiatric Hospital Services are medically necessary and verifies that active treatment is being provided. The review staff completes the medical record evaluation and cases that do not meet criteria are referred to a physician consultant. Findings of a review can also be referred to SCDHHS' Division of Program Integrity if there is a suspicion of fraud, waste or abuse.

Retrospective reviews determine whether the care rendered meets acceptable standards of Inpatient Psychiatric Hospital Services. QIO or the SCDHHS designee will conduct periodic reviews of the level of care determinations.

OTHER SERVICE/PRODUCT LIMITATIONS

Out-of-State Facilities — Admissions

members If an exhaustive search for in-state PRTF placement is unable to meet the treatment needs of a beneficiary, SCDHHS will engage in an out-of-state placement search. Out-of-state facilities that enter into contract to provide services must be enrolled as a SC Medicaid provider and comply with relevant federal, state, and contractual guidelines. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

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REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

Medicaid reimbursement is directly related to the delivery of services. Each member shall have a medical record that includes sufficient documentation to support the services rendered and billed. Clinical documentation of the treatment services provided to the member, his or her responsiveness to treatment, and the interaction and involvement of the staff should justify the services billed to Medicaid and the member's continued stay.

The medical record must be arranged in a logical order to facilitate the review and audit of the clinical information and the course of treatment. Records must be individualized to the member and support the level of care.

Records shall contain at a minimum the following:

- The member's history (to include whether or not this is a first PRTF admission);
- Evaluation reports;
- Clinical documentation (to include treatment plans and reviews);
- Service documentation;
- Person-centered care plan;
- Family engagement, participation, and readiness for the youth's discharge;
- Strengths (as identified by youth, families, and staff);
- Youth identified goals- for both treatment and the life course;
- Behavioral triggers;
- Level of engagement in all services provided;
- Progress notes;
- Discharge plan;
- Medications;

- Documentation of all incidents of restraint and seclusion; and
- CON form; and
- All other required and/or relevant forms.

All documentation must be appropriately signed and dated and labeled with the beneficiary's full name and Medicaid number. .

Providers are reminded that the medical record must contain sufficient documentation to demonstrate that the member's signs and/or symptoms were severe enough to warrant the need for PRTF-level inpatient psychiatric treatment and speak to progress and discharge plan goals.

Documentation must include sufficient, accurate information to 1) support the diagnosis, 2) justify the treatment/procedures, 3) document the course of care as evidenced by measurable, timebound goals and treatment plans that are captured in the individualized plan of care, and 4) identify treatment/diagnostic test results. Documentation must be placed in the beneficiary's medical record to clearly justify medical necessity for the service and the setting billed. Documentation must be reported in accordance with licensure/certification practice standards.

Certification of Need Form

Providers must utilize the following guidelines to complete the CON form:

- The CON form must be completed, signed and dated by a minimum of two team members.
- The CON form must be completed only once per member per admission. If a member is discharged and readmitted, a new CON form must be completed.
- The CON form is valid for 45 days when completed prior to the admission of a member. Although the form is valid for 45 days, it must accurately reflect the member's state of health on the date of admission.
- The CON form must be submitted to the QIO and placed in the member's clinical case record.
- A new CON form is required when a member is discharged from one facility and admitted to another PRTF.

Note: Any inpatient service days paid by Medicaid that are not covered by a properly completed CON form are subject to recoupment in a post-payment or retrospective review.

Individual Plan of Care (IPOC)

In the context of services rendered in a PRTF, an IPOC is a written plan developed for each member by a child and family team and the facility-based interdisciplinary team of professionals

specified in 42 CFR § 441.156 to improve his or her condition and/or the capacities and confidence of his or her family/caregivers to the extent that a PRTF level of care is no longer necessary.

Each member must have a written IPOC, which is goal-oriented, time-limited, and specific, describing the service to be provided.

The plan of care must meet all the following requirements:

- Be developed, written and implemented no later than 14 days after admission;
- Be signed, dated, and professionally titled by at least two members of the interdisciplinary team, one of which must be a physician;
- Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the member's situation and reflects the need for PRTF level care;
- Be designed to achieve the member's discharge from inpatient status at the earliest possible time;
- Based on an inventory of the member's strengths and needs, the member's aspirations for the future, resources that are or might be available to that member and their family, sources of motivation available to the member and capabilities the member possesses;
- State treatment goals/objectives primarily designed to prepare the member and family for the member's return home; and prescribe integrated therapies, activities, and experiences designed to meet the objectives;
- Be reviewed at a minimum of every 30 calendar days;
- Be reformulated at a minimum of every 60 calendar days. A reformulation will address any changes, any new identified needs, and any previously identified needs and reflect the need for continued treatment;
- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the member's family, school and community upon discharge; and
- The plan of care must include the following:
  - Diagnoses, symptoms, complaints and complications indicating the need for the member's admission to include any behavioral triggers/responses;
  - A description of the functional level of the member;

- Goals and objectives for the member that are primarily designed to prepare the member and family for the member's return home, address any behavioral triggers/responses, address any barriers to success, and are specific, measurable, and time-limited;
- Services to be provided, including evidence-based practice modalities, frequency of the services, professionals to provide the services, and title of the professional to provide the services;
- Any orders for medications, treatment, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
- Plans for continuing care, including review and modification to the member's plan of care;
- Plans for the member's discharge. Discharge plans should be made to facilitate transition and discharge from the facility at the earliest time possible. Discharge plans should include recommendations for continuity of necessary services and supports, the transition process, considerations around permanency, safety, discharge and aftercare; and
- Be signed, dated, and professionally titled by at least two members of the interdisciplinary team, one of which must be a physician.

Note: Please ensure the treatment plan includes updates to address any newly identified conditions, failure to respond to treatment, regression in behaviors, dangerous behaviors. If a member is not making progress, it is expected that the PRTF will adjust the treatment plan and interventions to address this immediately.

Thirty Day Review and Treatment Team Meetings

The plan of care must be reviewed every 30 days by the team specified to determine that services provided are or were required and to recommend changes in the plan as indicated by the member's overall adjustment during the PRTF stay. If a member is not making progress, it is expected that the PRTF will adjust the treatment plan and interventions to address this immediately.
Any changes in the member's care plan must be documented in the thirty-day review. The PRTF must invite the member's outpatient treatment provider(s) and other members of the child and family team to participate in these reviews. The PRTF must notify community partners (i.e., family/caregivers, behavioral health treatment providers, involved state agencies, and SCDHHS/Managed Care Organizations [MCOs]) two weeks in advance of each member's monthly treatment team meeting. If there are any changes to the scheduled meeting following submission of notification the facility is required to notify all relevant parties no later than 24 hours prior to the meeting. The notification to SCDHHS should be sent via secure email to behavioralhealth004@scdhhs.gov.

A written report of each review must be entered in the member's record. The review must be signed and dated by the team members.

Both the plan of care and the thirty-day review must reflect the continued need for PRTF services and/or specify steps toward transition of the member back to his/her family, home, school and community.

Discharge Plan

Discharge planning should start no later than the day of admission. Services include the development of a comprehensive discharge plan. Comprehensive discharge plans should include:

• Member name, DOB and Medicaid ID number;

- Date of admission;
- Presenting condition/problem;
- Diagnosis at admission;
- Strengths, needs, abilities, behavioral triggers/response strategies, and preferences at admission;
- Medications at admission;
- Services provided and progress on recovery at time of discharge/transition;
- Identify and speak to level of engagement by family or other natural supports;
- Date of discharge/transition;
- Reason for discharge/transition;
- Diagnosis at discharge/transition;
- Plan for diagnosis management post-discharge;
- Strengths, needs, abilities, behavioral triggers/response strategies, and preferences at discharge/transition;
- Medications at discharge;
- Plan for PRTF follow-up/support;
- Staff signature/title/date; and

- Member signature/date.

REPORTING REQUIREMENTS

Emergency Safety Intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, the member's chronological and developmental age, size, gender, physical, medical, and psychiatric condition, and personal history (including any history of physical or sexual abuse, both to inform treatment goals and methods to avoid re-traumatization of children).

Application of Time Out

Youth must be allowed to safely and without consequence take a time out as a de-escalation technique when necessary. A staff-directed time out must never be used as a punishment or physically prevent the youth's movement from the time out area.

Time out may take place away from the area of activity or from other members, such as in the member's room (exclusionary), or in the area of activity or other members (inclusionary).

Staff must monitor the member while he or she is in time out, whether initiated by the youth or staff. Documentation in the unit log of activity must indicate the start and end time of every time out.

Please reference the Notification of Parent(s) or Legal Guardian(s) section below for notification and documentation requirements.

Conditions of Participation — Use of Restraints or Seclusion

Inpatient Psychiatric Service providers must comply with provisions of 42 CFR Subpart G § 483.350 to 483.376 regarding conditions of participation, restraint and seclusion and must maintain a current attestation of compliance with SCDHHS. The rule 42 CFR 483.350 *et. seq.* establishes a Condition of Participation for the use of restraint or seclusion that providers must meet in order to provide or continue to provide Medicaid Inpatient Psychiatric Services for Children Under Age 21.

Guidance for Restraint or Seclusion

PRTFs must develop behavior support and teaching techniques that are strength-based, that promote self-regulation and self-monitoring, that foster critical thinking and personal responsibility, and that are able to be generalized in less restrictive family, home, school and community environments.

Conversely, Inpatient Psychiatric Hospitals and PRTFs should strive to eliminate coercion and coercive interventions (*e.g.,* seclusion, restraint, response-cost and other aversive practices), and maintain clinical excellence by providing high quality care that is trauma-informed, incorporates state-of-the-art evidence-based approaches, and uses relevant data and feedback in rigorous processes of continuous improvement.

In accordance with Federal regulation 42 CFR §483.352, the following definitions apply for restraint or seclusion:

A **drug** used as a restraint is defined as any drug that:

- Is administered to manage a member's behavior in a way that reduces the safety risk to the member or others;
- Has the temporary effect of restricting the member's freedom of movement; and
- Is not a standard treatment for the member's medical or psychiatric condition.

Definitions

An **emergency safety intervention** is defined as the use of restraint or seclusion as an immediate response to an emergency safety situation.

An **emergency safety situation** is defined as unanticipated member behavior that places the member or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

A **mechanical restraint** is defined as any device attached to or adjacent to the member's body that he or she cannot easily remove that restricts the freedom of movement or the normal access to his or her body.

A **minor** means a minor as defined under State law and, for the purpose of this subpart, includes a member who has been declared legally incompetent by the applicable State court.

A **personal restraint** is defined as the application of physical force without the use of any device for the purposes of restraining the free movement of a member's body. The term personal restraint does not include briefly holding, without undue force, a member in order to calm or comfort him or her or holding a member's hand to safely escort a member from one area to another.

A **Psychiatric Residential Treatment Facility** is defined as a facility, other than a hospital, that provides psychiatric services, as described in 42 CFR Subpart D of Part 441, to individuals under age 21, in an inpatient setting.

A **restraint** is defined as a "personal restraint," a "mechanical restraint," or a "drug used as a restraint" as defined in this section.

Seclusion is defined as the involuntary confinement of a member alone in a room or an area from which the member is physically prevented from leaving.

A **serious injury** is defined as any significant impairment of the physical condition of the member as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations,

bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff is defined as those individuals with responsibility for managing a member's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time or contract basis.

A **time out** is defined as the restriction of a member for a period of time to a designated area from which the member is not physically prevented from leaving, for the purpose of providing the member an opportunity to regain self-control.

Protection of Members
The Restraint and Seclusion policy of the 42 CFR 483.356 Subpart G provides the following guidelines for the protection of members:

- Each member has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience or retaliation.
- An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
- Restraint or seclusion must not result in harm or injury to the member and must be used only to ensure the safety of the member or others during an emergency safety situation; and until the emergency safety situation has ceased and the member's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
- Restraint and seclusion must not be used simultaneously.

Notification of Facility Policy

At admission, the facility must inform both the incoming member and, in the case of a minor, the member's parent(s) or legal guardian(s) of the following policy:

Communicate its policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the member is in the facility.

- Communicate its restraint and seclusion policy in a language that the member, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators. The facility's policy must provide contact information, including the phone number and email/mailing address, for the Disability Rights South Carolina organization and the Department of Children's Advocacy (DCA).
- The requirement to obtain an acknowledgment, in writing, from the member, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's

policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the member's record.

- The requirement to provide a copy of the facility's restraint and seclusion policy to the member and in the case of a minor, to the member's parent(s) or legal guardian(s).

Orders for the Use of Restraint and Seclusion

Inpatient Psychiatric Services furnished in a PRTF must satisfy all requirements as set forth in Subpart G of Section 483 of the Code of Federal Regulations governing the use of restraint and seclusion.

Restraint and seclusion shall be used only to ensure the immediate safety of the individual or others when no less restrictive intervention has been or is likely to be effective in averting danger.

Restraint and seclusion shall never be used for coercion, retaliation, humiliation, as a threat or form of punishment, in lieu of adequate staffing, as a replacement for active treatment, for staff convenience or for property damage not involving imminent danger.

Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and the facility to order (restraint or seclusion) and trained in the use of emergency safety interventions. The Code of Federal Regulations, 42 CFR §441.451, require that Inpatient Psychiatric Services for Children Under Age 21 be provided under the direction of a physician. Other orders for the use of restraint and seclusion are as follows:

- If the member's treatment team physician is available, only he or she can order restraint or seclusion.
- A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
- If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff, such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the member's record. The physician or other licensed practitioner (*i.e.,* physician assistant or APRN with prescriptive authority) permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

- Each order for restraint or seclusion must be limited to no longer than the duration of the emergency safety situation and must under no circumstances exceed two hours for members ages 18 to 21, one hour for members ages 9 to 17 or one-half hour for members under age 9.
- Within one hour of the initiation of the emergency safety intervention, a physician or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well-being of the member must conduct a face-to-face assessment of the physical and psychological well-being of the member including, but not limited to:
  - The member's physical and psychological status;
  - The member's behavior;
  - The appropriateness of the intervention measures; or
  - Any complications resulting from the intervention.

Each order for restraint must include:

- The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;
- The date and time the order was obtained;
- Each incident must include time in and time out; and
- The emergency safety intervention ordered, including the length of time for which the physician, or other licensed practitioner permitted by the state and the facility to order restraint and seclusion, authorized its use.

Staff must document the intervention in the member's record. The documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends.

The documentation must include all of the following:

Each order for restraint and seclusion;

- The time the emergency safety intervention actually began and ended;
- The time and results of the one-hour assessment required in order number 5 above.

The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes; and

The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the member's record as soon as possible.

Consultation with Treatment Team and Physician
If a physician or other licensed practitioner permitted by the state and the facility to order restraint and seclusion orders the use of restraint or seclusion, that person must contact the member's treatment team physician, unless the ordering physician is in fact the member's treatment team physician. The person ordering the use of restraint or seclusion must do both of the following:

- Consult with the member's team physician as soon as possible and inform the team physician of the emergency safety situation that required the member to be restrained or placed in seclusion.

- Document in the member's record the date and time the team physician was consulted.

Monitoring of the Member in and Immediately After Restraint
All PRTF clinical staff must be trained in the use of emergency safety interventions. In addition, staff must adhere to the following:

- Staff must be physically present, continually assessing and monitoring the physical and psychological well-being of the member and the safe use of restraint throughout the duration of the emergency safety intervention.

- If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as licensed practitioner permitted by the state, must immediately contact the ordering physician to receive further instructions.

- A physician or other licensed practitioner permitted by the state and the facility to evaluate the member's well-being and trained in the use of emergency safety interventions must evaluate the member's well-being immediately after the restraint is removed.

Monitoring of the Member in and Immediately After Seclusion
All PRTF clinical staff must be trained in the use of emergency safety interventions. In addition, staff must adhere to the following:

Staff must be physically present in or immediately outside the seclusion room continually assessing and monitoring the physical and psychological well-being of the member and the safe use of seclusion throughout the duration of the emergency safety intervention.

- A room for seclusion must allow staff full view of the member in all areas of the room and be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets. Video monitoring of the member in seclusion will not meet this requirement because such

monitoring cannot determine if a member is experiencing a medical emergency such as cardiac arrest or asphyxiation.

- If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practitioner permitted by the state, must immediately contact the ordering physician to receive further instructions.

- A physician or other licensed practitioner permitted by the state and the facility to evaluate the member's well-being and trained in the use of emergency safety interventions must evaluate the member's well-being immediately after the member is removed from seclusion.

Notification of Parent(s) or Legal Guardian(s)
If the member is a minor as defined by State law, the following actions must be taken:

- The facility must notify the parent(s) or legal guardian(s) of the member who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

- The facility must document in the member's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

Post-Intervention Debriefings
All of the following must occur during post intervention debriefings:

- Within 24 hours after the use of restraint and seclusion, staff involved in an emergency safety intervention and the member must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the member. Other staff and member's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility.

- The facility must conduct such discussion in a language that is understood by the member's parent(s) or legal guardian(s). The facility must provide both the member and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the member or others that could prevent the future use of restraint or seclusion.

  Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of:

  – The emergency safety situation that required the intervention;

  – The precipitating factors that led up to the intervention;

  - Alternative techniques that might have prevented the use of the restraint or seclusion;
  - Procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
  - The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

- Staff must document in the member's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the member's treatment plan that result from debriefings.

Medical Treatment for Injuries Resulting from an Emergency Safety Intervention
Staff must immediately obtain medical treatment from qualified medical personnel for a member injured as a result of an emergency safety intervention. In addition, the Psychiatric Residential Treatment Facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that:

- A member will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care.
- Medical and other information needed for care of the member in light of such a transfer will be exchanged between the institutions in accordance with the State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting.
- Services are available to each member 24 hours a day, 7 days a week.
- Staff must document in the member's record all injuries that occurred as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.
- Staff involved in an emergency safety intervention that results in an injury to a member or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Quarterly Reports of Seclusion or Restraint
Facilities are required to submit quarterly reports of seclusion or restraint occurrences to SCDHHS. These reports must include the following:

- Medicaid ID;
- Staff involved;

- Name and credentials of ordering physician or other licensed practitioner as permitted by the state and facility;
- Date and time of intervention;
- Identify type of intervention (Seclusion or Restraint); and
- Reason for intervention.

Reports must be submitted electronically in a secure format to 803-255-8204. The deadline for submitting reports is 30 days after the end of the quarter.

Facility Reporting of Serious Occurrences

Serious occurrences that must be reported include, but are not limited to, the following:

- Member's death
- Serious injury to a member
- Suicide attempt by a member
- Crimes against/or by a member
- Confirmed or suspected cases of abuse, neglect, or exploitation
- Medication error with adverse reaction
- Hospitalizations as a result of an accident and/or incident
- Severe injury involving the use of restraints
- Fire
- Member left without notification or elopement
- Incidents requiring emergency community response, such as police or paramedics.

A **serious injury** is defined as any significant impairment of the physical condition of the member as determined by qualified medical personnel. This includes but is not limited to burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

The facility must report each serious occurrence to both SCDHHS and the State-designated Disability Rights system as well as the Department of Children's Advocacy and shall also report such occurrences to the referring state agency.

Staff must report any serious occurrence involving a member to SCDHHS, Disability Rights South Carolina, and DCA no later than close of business the next business day after a serious occurrence. The report must include the name of the member involved in the serious occurrence, a detailed description of the occurrence, corrective action taken, and the name, street address and telephone number of the facility. A standardized fax form for reporting serious occurrences is located in the Forms section of this manual.

- In the case of a minor, the facility must notify the member's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

- Staff must document in the member's record that the serious occurrence was reported to both SCDHHS, Disabilities Rights South Carolina, and DCA, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the member's record, as well as in the incident and accident logs maintained by the facility.

For reporting purposes, the South Carolina Disability Rights contact information is:

Disability Rights South Carolina
3710 Landmark Drive, Suite 208
Columbia, SC 29204
Toll Phone: 1-866-275-7273
TTY: 1-866-232-4525
Fax: 1-803-790-1946

The South Carolina Department of Health and Human Services contact information is:

SCDHHS Bureau of Quality
Attention: PRTF Serious Occurrences
Post Office Box 8206
Columbia, SC 29202-8206
Telephone: 803-898-2565

Fax: 803-255-8204

The South Carolina Department of Children's Advocacy contact information is:

S.C. Department of Children's Advocacy
1205 Pendleton Street, Suite 471A
Columbia, SC 29201
Office: 803-734-3176
Toll-Free Complaint Line: 1-800-206-1957

The following may warrant an onsite visit and/or corrective action plan:

- Quantity of occurrences;

- Seriousness of occurrence;

- Incomplete/missing documentation;

- Untimely reports;

- Non-reported incidents.

This list is non-exhaustive of occurrences that may result in an onsite visit and/or CAP. In addition to an onsite visit and/or CAP, a Root Cause Analysis and/or additional documentation may be requested.

Facility Reporting of Deaths

Facilities must report deaths to SCDHHS' Bureau of Quality, and the CMS Regional Office no later than close of business the next business day after a death. Staff must document in the member's record that the death was reported to the CMS Regional Office.

Facilities must report deaths to parents/guardians at the time of the member's death. Facilities shall report deaths to referring or involved state agencies.

Facilities must use the Death Reporting Worksheet found in the Forms Section of this manual to report deaths to CMS.

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BILLING GUIDANCE

When a new facility enrolls in Medicaid, a statewide rate will be assigned to the new provider.

FEE-FOR-SERVICE

Medicaid reimbursement is available for services provided in acute inpatient facilities if the member is under the age of 21.

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PART II — ACUTE INPATIENT PSYCHIATRIC SERVICES

PROGRAM OVERVIEW

The purpose of this manual is to provide pertinent information to Inpatient Psychiatric Hospital Service providers for successful participation in the South Carolina Medicaid Program. Part Two of this manual provides a comprehensive overview of the program standards and policies and procedures for Medicaid acute inpatient services in a freestanding psychiatric hospital. An Acute Inpatient Psychiatric Hospital is defined as a hospital that provides psychiatric services, as described in 42 CFR Subpart E §482.60-§482.62, to individuals in an inpatient hospital section.

To receive reimbursement for these services, providers must meet the program requirements in this manual.

The SCDHHS-designated QIO will authorize admission(s) to acute inpatient psychiatric hospitals. All admissions to acute inpatient facilities require prior authorization by the SCDHHS-designated QIO or the respective MCO. Please refer to the Utilization Management section of this manual for processes, procedures, and requirements regarding prior authorization.

Certification of Need for Services (CON)

The Code of Federal Regulations, 42 CFR 441.151, states that Inpatient Psychiatric Services must be certified as necessary, in writing, for the setting in which the services will be provided, in accordance with CFR 441.152.

It is also mandated (42 CFR 441.153) that an independent review team or the facility-based interdisciplinary team certify a member's admission to an inpatient psychiatric setting by completing the CON form.

The CON must certify the following admission requirements:

- Documentation of a comprehensive assessment conducted within the previous week by an LPHA has been reviewed and includes information pertaining, but not limited to, prior treatment history, diagnostic history, mental status examination, current symptoms, and risk assessment.
- Mental health, substance use disorder, and/or health care resources available in the community do not meet the treatment needs of the member.
- The proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.

- Services can reasonably be expected to improve the member's condition, prevent further regression, and/or prepare the child and family for the child's return home so that inpatient psychiatric services will no longer be needed.

- Certification of need for inpatient care must be authorized by a physician.

Refer to the Documentation Requirements section for guidelines on how to complete the form.

Team Completing the CON

The member's admission status dictates whether an independent review team or the facility-based interdisciplinary team is responsible for certifying the member's need for admission to acute inpatient services.

Independent Review Teams

An independent review team is comprised of individuals who are not affiliated with the receiving inpatient psychiatric facility and do not have any financial, employment, or consultant relationship with the admitting facility. An independent review team must complete the CON. The independent review team must consist of professionals in accordance with 42 CFR 441.153.

Interdisciplinary Teams

An interdisciplinary team is a group of professionals within the facility. The CON must be completed by the interdisciplinary team for an individual who applies for Medicaid while in the facility or for an emergency admission. All team members must sign the CON form. The interdisciplinary review team must consist of professionals in accordance with 42 CFR 441.153.

Acute Inpatient Psychiatric Services Settings

Acute inpatient services are normally provided to Medicaid-eligible members in one of two settings:

- Short-Term: Short-Term Psychiatric Hospitals are facilities whose South Carolina Medicaid average length of stay is 25 days or less. The date of admission should be reflected in the Authorization.

- Long-Term: Long-Term Psychiatric Hospitals are facilities whose South Carolina Medicaid average length of stay is determined to be greater than 25 days. Interim claims may be submitted.

Categories of Admissions for Acute Inpatient Hospitals

There are three types of Medicaid admissions to Psychiatric Hospitals:

Emergency Admission

An emergency admission is one in which the immediate admission is necessary to prevent death, cause serious impairment of the member's health, or harm to another person by the member.

An emergency admission must relate to the nature of the member's condition. Neither the need for placement (regardless of hour) nor the presence of a court order alone justifies an emergency admission in the absence of other qualifying factors. In addition, the facility-based interdisciplinary team must complete the CON form within 14 days of the emergency admission. In all cases, it is the facility's responsibility to receive and retain the proper CON form. Any days paid by Medicaid not covered by an appropriate CON form will be recouped in a retrospective or post-payment review.

Emergency admissions must be well-documented in the clinical record. The CON or Physician's Certification must be present in the member's records, but it is not solely sufficient to substantiate the need for emergency admission. The psychiatric hospital's clinical records for each Medicaid member admitted under emergency procedures must support the claim that the admission was actually an emergency.

Urgent Admission
An urgent admission is one which the member meets the CON criteria but is not presenting immediate danger that would cause death or serious impairment to the health of the member or bodily harm to another person by the member (21 and under only).

The independent team must complete the CON form for all members seeking urgent admission to private psychiatric hospitals.

Post Admission Eligibility
The hospital completes the CON form for members who apply for Medicaid while in the facility (21 and under only). The facility-based interdisciplinary team must approve the certification. The CON form should cover any period before the Medicaid application was submitted.

Purpose

Care in an acute inpatient psychiatric hospital is required only if the member's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. The primary goal of an inpatient psychiatric hospital is to stabilize, restore, and prepare the member and family, as quickly as possible, for the member's return to home and community.

Programming must be individualized to the needs of each member and his or her family to maximize individual functioning. Services must be therapeutic and identifiable as structured programming and consistent with the treatment needs of the member. The provider is expected to appropriately treat a member, document the delivery of services and responses to treatment, and provide or obtain all services the member needs while in the facility. It is also expected that therapeutic services be provided at a time that is conducive for the involvement of the member and his or her family.

Each provider must ensure that a structure exists that clearly supports stabilization, restoration, and preparation of the member and family for a timely return to the home and the community. Service planning and programming, including therapeutic strategies and provision of active treatment, must

reflect this goal, and must be focused on teaching members how to successfully function in the context of the setting to which they will be returning—not the placement in which they are receiving services.

A member's underlying behavioral problems must be addressed in order to accomplish this goal, and therapeutic interventions must target the behaviors and symptoms that have limited the member's successes. The member's underlying behavioral problems need not be fully resolved before the member can successfully transition back to a less restrictive setting. The most appropriate setting for long term therapeutic work is the environment in which the member will be living and functioning (i.e., their home and community).

Transitions from acute inpatient facilities to less restrictive settings are not contingent upon when the member and family have surmounted every problem or challenge. Transitions from acute inpatient facilities must adequately address the member's needs, including any familial and community safety supports.

Acute inpatient psychiatric services should be regarded as a treatment level in the larger continuum of care and not as "placements." Providers should actively strive to expand the variations of service they provide and integrate them with community-based programs to effectively stabilize and strengthen family, home, and community living options for members.

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

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Population Covered

Medicaid reimbursement is available for Acute Inpatient Psychiatric Services provided to the following:

- Medicaid members under the age of 21. If the child receives services immediately before he or she reaches age 21, services may continue until the date the individual no longer requires the services or the date the individual reaches age 22.
- Medicaid members 65 and older.

Medicaid reimbursement is not available for members between 22 and 64 in institutions for mental disease (IMDs) for Fee-for-Service members.

MCOs may opt to cover acute inpatient services for members between 22-64 years of age. If the member is enrolled with one of the state's contracted MCOs, all hospital providers must receive prior approval and claim reimbursement directly from the member's MCO. Please refer to the managed care policy and procedure manual for more information. The policy herein does not cover services under an MCO. Providers are encouraged to visit the SCDHHS website for additional information regarding MCO coverage.

Admission Criteria

Inpatient care is required only if the member's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Factors that may result in an inconvenience to a member or family do not, by themselves, justify inpatient admission. Some factors that providers should consider when making the decision to admit or for continued treatment include:

- The severity of the signs and symptoms exhibited by the member;
- The medical predictability of something adverse happening to the member;
- The need for diagnostic studies; and
- The availability of diagnostic procedures at the time when and at the location where the member presents.

Severity of Illness

An admission occurs when the Severity of Illness/Intensity of Service criteria is met, and the physician expects the member will remain in the hospital longer than 24 hours. Only Medicaid eligible members who are admitted for psychiatric hospital care can receive Medicaid reimbursable services. The facility must demonstrate that members are appropriate for this level of care by documenting that the following admission criteria have been met:

- A CON form has been completed;
- At the time of admission, the member exhibits at least one of the following signs and/or symptoms defined in the Psychiatric Criteria utilized by SCDHHS (or its designated utilization review contractor):

  – **Impaired Safety**

    Impaired Safety can be characterized by one or more of the following signs and symptoms:

    › Depressed mood;

    › Recent suicide attempt;

    › Substance abuse;

    › Seizures (withdrawal or toxic);

    › Assaultive behavior;

    › Self-mutilating behavior; or

    › Severe maladaptive or disruptive behavior.

  – **Impaired Thought Process**

    Impaired Thought Process can be characterized by one or more of the following signs and symptoms:

    › Verbal and behavioral disorganization;

    › Thought disorganization (hallucinations, paranoid ideation, phobias, etc.);

    › Impaired reality testing;

    › Bizarre or delusional behavior;

› Disorientation or memory impairment to the degree that it endangers the member's welfare; or

› Severe withdrawal or catatonia.

– **Alcohol and Drug Detoxification**

The need for Alcohol and Drug Detoxification can be characterized by evidence of withdrawal syndrome or effects of alcohol and/or drugs with one or more of the following signs and symptoms:

› Marked tremor;

› Uncontrolled agitation or anxiety;

› Hallucinations accompanied by fright;

› Changing mental state (marked confusion and disorientation as to time/place);

› High risk for seizures;

› High risk for delirium tremens;

› History of alcohol/drug intake sufficient to produce withdrawal manifestations when the alcohol/drug is discontinued, and there is a history of member withdrawal problems;

› Drinking/drug ingestion within past 48 hours with impairment of judgment or reality testing which presents significant risk to the safety of self and others;

› Inability to stop drinking/drug abuse with potential for medical complications;

› Dual diagnosis; or

› Diagnosis of codependency.

– **Other factors that may require inpatient treatment**

Other factors or situations relevant to support a temporary need for inpatient treatment can include:

› Failure of outpatient therapy;

› Failure of social or family functioning which places the member at increased risk;

› Treatment in a less restricted environment not feasible due to the member's behavior;

› Need for intensive inpatient evaluation;

› Need for 24-hour skilled and intensive observation;

› Need for evaluation of drug tolerance;

› Recurrence of psychosis not responding to outpatient treatment;

› Toxic effects from therapeutic psychotropic drugs; and

› Blood/urine positive for barbiturates, narcotics, alcohol or other toxic agents in a member displaying physical symptoms.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

In order to participate in the South Carolina Medicaid program, providers of Acute Inpatient Psychiatric Services must meet the appropriate licensure, certification and enrollment guidelines as outlined below.

Acute inpatient psychiatric service providers must comply with and meet the following requirements:

- Licensed by DPH;
- Services provided under the direction of a SC licensed Physician; AND
- Participation in Medicare as a psychiatric hospital as specified in 482.60, OR
- Accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS;
- Accreditation standards as set forth in CFR 441.151 (if serving members ages 0-21); and
- Contract with SCDHHS.

In addition to the requirements above facilities must submit the following:

  - A written facility description with their electronic provider enrollment application. Provider enrollment can be found at: https://providerservices.scdhhs.gov/ProviderEnrollmentWeb/;
  - W-9 Form;
  - A copy of the facility's active accreditation documentation;
  - DPH license;
  - The Ownership and Disclosure Statement; and
  - A Provider Agreement.

If the above information is approved, SCDHHS will send the provider two copies of the contract, the Provider Enrollment Form, the Ownership and Disclosure Statement, a W-9 Form and a Provider Agreement. The provider will sign the contracts, complete the enrollment forms and return all other

documents to the Contracts Division. The Director of SCDHHS then signs the contract and a copy is sent to the provider.

Please refer to the Provider Enrollment manual for detailed instructions regarding enrollment.

Facility Modifications

Existing Facilities

Acute Inpatient Psychiatric service providers requesting any modification to their facility are required to notify SCDHHS or its designee in writing 60 days in advance of the modification and must receive written approval for facility modifications from SCDHHS or its designee prior to claiming Medicaid reimbursement. Facility modifications that impact the facility licensure must be approved by DPH prior to notifying SCDHHS.

Facility modification shall be defined by any of the following conditions:

- Changes and revisions to policies and procedures enacted since the provider was enrolled or since the last comprehensive review was completed.
- An existing provider intends to add the same service but to serve a different population; *e.g.*, age, gender, etc.
- An existing facility is sold, or ownership is transferred to a different entity.
- An existing provider changes its facility director or other operational changes.
- An existing provider intends to increase its bed capacity, or to reorganize services through diversification of programming (*e.g.,* respite, crisis stabilization) and/or deployment of staff to reflect the facility's role as a community resource and not a "placement".
- An existing provider changes address/physical location.

Exceptions

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

- A provider is currently under a formal corrective action plan from SCDHHS or its designee and DPH Licensing. If the facility is under a corrective action plan, modification(s) will be considered on a case-by-case basis. The modification(s) would be considered only after the corrective action plan is completed.
- The provider has experienced substantial recoupment as a result of a post-payment review by Medicaid Program Integrity/QIO within the last two years and has failed to show evidence of correcting compliance issues. If during the process to modify, a post-payment review occurs and preliminary results indicate problems, the process could be delayed.

- The provider does not demonstrate fiscal responsibility/accountability of its existing facilities as evidenced by review of annual financial reports submitted to the Division of Ancillary Reimbursements.

- The provider has failed to maintain the facility's license and/or accreditation.

Licensure and Certification

In-state facilities must be licensed by the DPH and meet and maintain compliance with all requirements as set forth by SCDPH Regulation Number 61.103, as amended.

Out-of-state facilities must be licensed and certified by that state's appropriate licensing authority and meet the inpatient psychiatric benefit in-state requirement, including all requirements as set forth by CMS.

Staffing Requirements

All acute inpatient psychiatric hospitals must be appropriately staffed to meet the needs of all members in their care and ensure that the facility can meet the stated active treatment requirements. Each facility must have a licensed physician and nurse. The facility must ensure there is an adequate number of multidisciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each member.

Acute inpatient psychiatric services must be provided under the direction and supervision of a licensed physician. The facility must have an employment agreement with a physician who has assumed professional responsibility for directing all treatment provided in the acute inpatient setting. The physician must be licensed to practice medicine in the state of South Carolina or in the state where the facility is located.

Licensed mental health professionals shall be available to ensure that the facility can meet the stated active treatment requirements. Direct care staff include professionals who possess a current South Carolina license to practice, such as licensed physician assistant, licensed advanced practice registered nurse, licensed psychologist, licensed marriage and family therapist, licensed professional counselor, licensed master's social worker, licensed independent social worker – clinical practice, registered nurse or other appropriately trained professionals.

Supervision or direction must be provided by licensed professionals.

Employment Background Check Requirements

Employees and contractors granted clinical privilege, who have regular, direct access to members, or their personal, financial or medical information must have a full background check completed. The background check must include the following:

- Criminal Records;

- Child Abuse and Neglect Central Registry;
- Sex Offender Registry;
- Motor Vehicle Licensure & Record (if the employee's position description requires that he/she transport members, a copy of the individual's MVR will be kept in the individual's personnel record; the facility must also adhere to any other State or Federal regulations regarding transportation of members as applicable, e.g., "Jacob's Law".);
- Nurse Aide Registry; and
- Medicaid Exclusion List.

These checks are required prior to initial hire and at least annually thereafter. The results must be kept in the employee's personnel file.

Staff Development and Training Requirements

The acute inpatient psychiatric service provider is responsible for hiring and maintaining a qualified workforce.

The facility must require Mental Health Technicians, support staff and professionals receive ongoing education, training and demonstrated knowledge of the following:

- **Basic Orientation**

– Basic orientation includes but is not limited to standards as outlined in the DPH regulations.

- **CPR** (Excludes physicians)

  – Staff must receive certification in the use of cardiopulmonary resuscitation, including periodic recertification, as required. Staff must demonstrate competencies in cardiopulmonary resuscitation on an annual basis.

- **ESI**

  – Staff must demonstrate knowledge of the following:

    › Techniques to identify staff and member behaviors, events and environmental factors that may trigger emergency safety situations;

    › The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations; and

    › The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in members who are restrained or in seclusion.

  - Staff must be trained and demonstrate competency before participating in an emergency safety intervention. Staff training must include training exercises in which staff members successfully demonstrate, in practice, the techniques they have learned for managing emergency safety situations.

  - Staff must demonstrate their competencies in identification techniques, nonphysical intervention skills, and the safe use of restraint and seclusion on a semiannual basis.

- **Mental Health First Aid** (Excludes individuals with a master's degree in a behavioral health or related field, and licensed/certified in their respective profession).

Training must include key principles and approaches essential to a coordinated system of care, and other ongoing professional development.

Technicians, support staff and professionals who treat youth ages 12 and above must be trained in the age-appropriate Mental Health First Aid training.

Training must be provided by individuals who are qualified by education, training and experience.

The facility must document in the staff personnel records that the training and demonstration of competencies were successfully completed. Documentation must include the date training was completed and the names of persons certifying the completion of training. All trainings and materials used by the facility must be available for review by CMS, SCDHHS and the State survey agency.

Maintenance of Staff Credentials

A credentials folder shall be maintained for each acute inpatient psychiatric hospital employee and includes the following:

- Resumes or equivalent application form;
- Official transcripts and/or copies of diplomas from an accredited university or college;
- Proof of licensure for LPHA;
- Signature Sheet; and
- Training files, which include documentation of participation in the required orientations, certifications, and re-certifications.

Staff to Client Ratio

All Inpatient Psychiatric Hospital Facilities must be staffed appropriately to meet the needs of all children in their care. The facility must also ensure there is an adequate number of staff to carry out the goals and objectives of the facility, and to ensure the delivery of individualized treatment to each child as detailed in their plan of care.

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COVERED SERVICES & DEFINITIONS

Intensive Outpatient (IOP) and Partial Hospitalization Programs (PHP):
IOP and PHP are covered services for licensed hospitals enrolled to deliver outpatient hospital services. Programmatic guidelines and requirements, service codes, and additional policy information may be found in the Hospital Services provider manual.

ACTIVE TREATMENT

Acute inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised IPOC designed to achieve the member's discharge from inpatient status and return to family, home, school and community at the earliest possible time. Active treatment is a clinical process involving ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning and preparation for discharge; this includes services and activities directed towards engagement of the member, identification and development and adaptive use of strengths, continuous assessment of needs, goal planning, execution of planned strategies and advocacy.

Members must be engaged in active treatment.

Acute inpatient psychiatric facilities must provide services and support that change to continually meet the member's needs, including for stability and avoidance of multiple admissions.

The expanded interdisciplinary team should anticipate crises that might develop and devise specific strategies to prevent and address them.

The determination that active treatment is being implemented will be based on the following criteria:

- Examination of the plan of care should reflect interdisciplinary involvement, including that of outpatient treatment provider(s).
- Observation of communication with the member should indicate that the components of the plan of care are being delivered.
- Review of progress notes are consistent with the plan of care and indicate reasonable improvement in the members' condition.
- Documentation of participation in facility services as required in the Program Overview section of this manual.

Clinical documentation of active treatment should be consistent with ongoing efforts to support full and active involvement of the family and/or guardian, any referring state agency, and the member's outpatient treatment providers in planning for and delivering services. Providers must have written documentation of the service(s) rendered and must enter the service(s) documentation in the member's record.

Medicaid reimbursement for services rendered in an acute inpatient psychiatric facility will not be available for stays during which active treatment related to the member's diagnostic needs is not provided or the member no longer requires acute inpatient psychiatric treatment due to his or her psychiatric condition.

Psychiatric Evaluations

A psychiatric evaluation must be administered by the facility physician/ psychiatrist within 60 hours of admission for each member. The evaluation must identify factors related to or cause for admission to include diagnosis, summary of medical condition, and social status of the member. The physician/psychiatrist must document the type of services needed, make a recommendation concerning the need for inpatient treatment, evaluate medications the member is on and make adjustments or changes as needed. Each member must have face-to-face contact with the facility psychiatrist as needed.

A new psychiatric diagnostic evaluation must be completed as needed to determine the need for continued treatment.

Reassessments shall be completed by LPHAs. The following professionals are considered to be licensed at the independent level in South Carolina:

- Licensed Physician;
- Licensed Psychiatrist;
- Licensed Advanced Practice Registered Nurse;
- Licensed Physician Assistant;
- Licensed Psychologists;
- Licensed Psycho-Educational Specialist;
- Licensed Independent Social Worker-Clinical Practice;
- Licensed Professional Counselor;
- Licensed Marriage and Family Therapist; and

- Licensed Master Social Worker*.

*A Licensed Master Social Worker must have the DA co-signed by an independently LPHA.

When reassessments are completed, the results should be shared with the expanded child and family team members, including family, outpatient treatment provider(s) and referring agencies, within 10 calendar days, to ensure all children in placement continue to meet acute inpatient level of care requirements. All shared information must comply with HIPAA regulations.

Clinical assessment must describe the following:

- The presence of a co-morbid condition(s);
- Stressors in the natural environment;
- The need for and availability of social supports;
- Resiliency and recovery;
- Engagement;
- Treatment barriers;
- Strengths and needs;
- Preferences in services (cultural, location, etc.); and
- Barriers to accomplishing goals and objectives.

Psychological Evaluations

A psychological evaluation must be completed by a qualified professional of the facility within 30 days of the date of admission for each member. This comprehensive psychological evaluation includes a psychological diagnostic interview, assessment and appropriate testing with a written report. The comprehensive psychological evaluation must include history; mental status; disposition and may include psychometric, projective and/or developmental tests; consultation with referral sources and others; evaluation/interpretation of hospital records or psychological reports; and other accumulated data for diagnostic purposes which results in a written report that documents the evaluation and interpretation of results. Only a licensed psychologist shall select and interpret the results of psychological tests. The psychologist must personally interview the patient when a diagnosis is made or requested. The written report must be approved and signed by the psychologist. The comprehensive psychological evaluation and resulting report are one component of the total diagnostic evaluation necessary to establish and manage the treatment plan for inpatient psychiatric care. Re-evaluations must be conducted as needed periodically for continued treatment

Therapy Services

Therapeutic interventions should address both the member's presenting behaviors and underlying behavioral health issues. Therapy must be provided by licensed or master's level direct care staff as defined in the Staffing Requirements section and as allowed by state law. Therapeutic interventions should directly relate to specific issues identified in the assessment and treatment plan. If the treating psychiatrist determines are any behaviors or underlying issues that should not be addressed in the acute setting that must be documented in the treatment plan.

If the member is not stable enough to benefit and attend therapy sessions the reason must be documented and presented within the member's record. The document must be signed off by the servicing psychiatrist/physician.

Group Psychotherapy

Face-to-face, planned interventions with a group of members, not to exceed one staff to eight members. Group Psychotherapy must be individually documented for each member. A member should receive at least three 45 minute or more Group Psychotherapy sessions per week.

Family Psychotherapy

Face-to-face interventions between clinical staff and the member's family unit or significant others must be conducted at least once a week. If parents are unable to attend the face-to-face session they may join telephonically or via a secure video teleconference. When applicable, documentation must include the reason for non-involvement and/or reasonable attempts (e.g., instrumental support, use of communications technologies) to involve the family and/or significant others.

Medical Services

Services include medication management and dispensing of medication, as appropriate. Each member must have at least one face-to-face contact per month with the physician, or as medically necessary.

Medication Management

The facility must have written policy to ensure medications are secure and are not accessible to members. The medication shall be under a double lock system. The physician order must be on file to support the administering of medication. Qualified staff shall dispense all medication. A medication log shall be maintained to document dispensing of medication to include the member's name, name of the medication, dosage, time and date the medication was dispensed, and the signature of the staff member along with their title.

Prescribers are encouraged to use best practice when ordering medications. In addition, providers should limit the use of standing PRN prescriptions and provide evidence-based rationale when prescribing duplicate medications in the same class.

Crisis Management

Services provided immediately following abrupt or substantial changes in the member's functioning and/or marked increase in personal distress.

The clinician must assist the member 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.

Engagement Services and Activities

Services and activities include:

- Engaging the member in a purposeful, supportive, and helping relationship, addressing basic needs, that include determining the supports the member needs, the productive and leisure activities in which the member desires to participate that are informed by appropriate expectations in the post-discharge family, home, school and community settings.

- Understanding the member's personal history and the member's satisfaction or dissatisfaction with services and treatments, including medications that have been provided to or prescribed in the past.

Strengths Assessment Services and Activities

Services and activities include identifying and assessing the member's wants and needs, the member's aspirations for the future, resources that are or might be available to that member and their family, sources of motivation available to the member, and strengths and capabilities the member possesses. Services also include identifying and researching what educational, vocational and social resources are or might be available to the member to inform and facilitate the member's treatment, and identifying, researching, and understanding cultural factors that might have affected or that might affect the member's experience with receiving treatment and other services. Providers should also examine the effects that these factors might have on the treatment process, and the ways in which these factors might be best used to support the member's treatment.

Goal-Oriented Services and Activities

- Assisting and supporting the member in choosing and pursuing activities consistent with achieving his/her goals and objectives at a pace consistent with the member's capabilities and motivation.

- Instructing the member on goal-setting and problem-solving skills, independent living skills, social skills, and self-management skills, acknowledging the need to devise methods and strategies to promote generalization and adaptation of acquired skills to the family, home, school and community settings where they will be used after discharge.

- Identifying critical stressors that negatively affect the member's mental status and the interventions, coping strategies, and supportive resources that have been successful or helpful in addressing or relieving those stressors in the past.

- Developing relapse prevention strategies, including wrap-around plans that the member and family team may utilize.

Advocacy Services and Activities

Services and activities that involve coordinating the treatment and support efforts and advocating for the member, as appropriate, in developing goals and objectives within the member's individualized treatment plan during the course of treatment and assisting in acquiring the resources necessary for achieving those goals and objectives.

Discharge Criteria

A member is considered discharged if the member:

- No longer meets acute inpatient level of care/medical necessity as determined by the treatment team facility;
- Is transferred to another psychiatric facility;
- Is discharged to a long-term care or step-down facility;
- Dies; or
- Leaves against medical advice.

Acute inpatient Psychiatric Hospitals must document in the clinical record the following criteria before discharge:

- Member has ability to function appropriately in a non-psychiatric hospital setting;
- Member is stable on current type of dosage and prescribed medication;
- Substantial progress has been made on treatment goals;
- No changes in the comprehensive psychiatric evaluation, formulation, diagnosis, treatment goals and treatment plan in the previous 14 days; and
- An appropriate lower level of care has been identified and secured by the team.

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UTILIZATION MANAGEMENT

PRIOR AUTHORI ZATION

The admitting acute inpatient psychiatric service provider must submit the request for prior authorization along with the CON (for members under 21) and the most recent diagnostic assessment to the SCDHHS QIO. The QIO will use InterQual® Behavioral Health criteria to approve or deny the admission based on medical necessity. Unless indicated through policy, all requests for approvals and denials will be sent to the provider via fax within two business days. If approved, the QIO will provide the Prior Authorization number needed for billing.

The admitting provider must submit the request for prior authorization using the QIO fax form for Inpatient Prior Authorization Request Form. Requests must be submitted using one of the following methods:

Fax: 1-855-300-0082

Web Portal: http://scdhhs.acentra.com

If additional information is needed to process the request, the request will be pended, and the provider will have two business days to respond to the QIO. Providers will have only one time to respond to the QIO after additional information is requested.

The QIO or the SCDHHS designee may review the medical records of South Carolina Medicaid members who receive services in residential treatment facilities.

The QIO or the SCDHHS designee has the authority to act on behalf of SCDHHS if they determine that a facility has not complied with applicable requirements.

UTILIZATION REVIEW

SCDHHS contracts hospital utilization review services to a QIO or the SCDHHS designee.

There are two types of reviews conducted by the QIO or the SCDHHS designee:

- Pre-discharge Reviews
- Retrospective Reviews

These reviews are accomplished through a medical record evaluation of selected cases. The medical record review focuses on compliance with federal and state procedural requirements, provides assurance that Inpatient Psychiatric Hospital Services are medically necessary, and verifies that active treatment is being provided. The review staff completes the medical record evaluation and initial screening. Cases that do not meet criteria are referred to a physician consultant. Findings of a review can also be referred to SCDHHS' Division of Program Integrity if there is a suspicion of fraud, waste or abuse.

Retrospective reviews determine whether the care rendered meets acceptable standards of Inpatient Psychiatric Hospital Services. QIO or the SCDHHS designee will conduct periodic reviews of the level of care determinations.

Prior Authorization for Members in an MCO

The admitting acute inpatient psychiatric facility must submit the request for prior authorization along with the required clinical documentation to the MCO directly.

In all cases, the provider is responsible for receiving and retaining proper prior authorization forms. Additionally, all acute inpatient authorizations for members under 21 require a CON Form. The completed CON must be submitted to the MCO before admission is authorized.

OTHER SERVICE/PRODUCT LIMITATIONS

Out-of-State Facilities — Admissions

South Carolina law requires referring agencies seeking admission for Medicaid members to out-of-state facilities to contact the Office of the Governor, Constituent Services, at (803) 734-2100. It is recommended that, prior to seeking enrollment with South Carolina Medicaid, the referring agency contact CS to ensure that placement is imminent. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

Notice of Non-Coverage

The South Carolina Medicaid Notice of Non-Coverage for Inpatient Psychiatric Hospital Care Form should be used to notify Medicaid members that a facility has determined that inpatient psychiatric care is no longer medically necessary. Refer to the Forms section of this manual for a sample of this form.

This determination may occur at the time of admission or after the member is admitted for Psychiatric Hospital Services.

If the member or legally responsible party disagrees with the facility's decision to discharge, he or she may request a review by SCDHHS' contracted QIO. If the member or legally responsible party decides to remain in the facility and the QIO determines that psychiatric hospital care is no longer medically necessary, the member will be responsible for payment.

The completed copy of the Non-Coverage Form should be forwarded to the Medicaid member, attending physician, legal guardian, authorized referral entity (the agency that authorized the referral), SCDHHS' Division of Behavioral Health and QIO.

The Non-Coverage Form should be used when the Admission Criteria, Continued Stay Criteria, and Discharge Criteria do not apply to a member.

When a member is transferred from one facility to another, this is considered a regular discharge and would not constitute issuance of a Non-Coverage Form.

Note: South Carolina Medicaid will accept records and clinical service notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 et seq.). Reviewers and auditors will accept electronic documentation as long as they can access them, and the integrity of the document is maintained.

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REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

Medicaid reimbursement is directly related to the delivery of services. Each member shall have a medical record that includes sufficient documentation to support the services rendered and billed. Clinical documentation of the treatment services provided to the member, his or her responsiveness to treatment, and the interaction and involvement of the staff should justify the services billed to Medicaid and the member's continued stay.

The medical record must be arranged in a logical order to facilitate the review and audit of the clinical information and the course of treatment. Records must be individualized to the member and support the level of care.

Records shall contain at a minimum the following:

- The member's history;
- Evaluation reports;
- Clinical documentation (to include treatment plans and reviews);
- Service documentation;
- Progress notes;
- Discharge plan;
- Medications;
- Documentation of all incidents of restraint and seclusion; and
- CON form, and all other required and/or relevant forms.

All documentation must be appropriately signed and dated.

Providers are reminded that the medical record must contain sufficient documentation to demonstrate that the member's signs and/or symptoms were severe enough to warrant the need for acute-inpatient psychiatric treatment.

Documentation must include sufficient, accurate information to 1) support the diagnosis, 2) justify the treatment/procedures, 3) document the course of care, and 4) identify treatment/diagnostic test

results. Documentation must be placed in the member's medical record to clearly justify medical necessity for the service and the setting billed.

Certification of Need Form

Providers must utilize the following guidelines to complete the CON form:

- The CON form must be completed, signed, and dated by a minimum of two team members.
- The CON form must be completed only once per member per admission. If a member is discharged and readmitted, a new CON form must be completed.
- The CON form is valid for 45 days when completed prior to the admission of a member. Although the form is valid for 45 days, it must accurately reflect the member's state of health on the date of admission.
- The CON form must be submitted to the QIO and placed in the member's clinical case record.
- A new CON form is required when a member is discharged from one facility and admitted to another acute inpatient psychiatric facility.

Note: Any inpatient service days paid by Medicaid that are not covered by a properly completed CON form are subject to recoupment in a post-payment or retrospective review.

Individual Plan of Care

In the context of services rendered in an acute inpatient psychiatric facility, an IPOC is a written plan developed for each member by an expanded child and family team, to improve his or her condition and/or the capacities and confidence of his or her family/caregivers to the extent that acute inpatient level of care is no longer necessary.

Each member must have a written individual plan of care, which is goal-oriented and specific, describing the service to be provided. If the member is unable to engage in active treatment services (e.g. psychotherapy services) the physician must document why active treatment intervention is not appropriate and have this reflected in the IPOC.

The plan of care must meet all the following requirements:

- Be developed, written and implemented no later than 14 days after admission;
- Be signed, dated, and professionally titled by at least two members of the interdisciplinary team, one of which must be a physician;
- Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation and reflects the need for acute inpatient level care;

- Be developed by the expanded member and family team – that is, the member, his or her parents, family members, legal guardians, or others in whose care he or she will be released after discharge; and the facility-based interdisciplinary team of professionals specified in 42 CFR § 441.156;
- Be developed for the member to improve his or her condition and/or the capacities of in his or her family/caregivers to the extent that acute inpatient level care is no longer necessary, and psychiatric services are no longer necessary or can be provided in home and community-based settings; and designed to achieve the member's discharge from inpatient status at the earliest possible time;
- State treatment objectives primarily designed to prepare the member and family for the member's return home; and prescribe integrated therapies, activities and experiences designed to meet the objectives;
- Be reviewed at a minimum of every 30 calendar days;
- Be reformulated at a minimum of every 30 calendar days. A reformulation will address any changes, any new identified needs, and any previously identified needs, and reflect the need for continued treatment;
- Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the member's family, school, and community upon discharge; and
- The plan of care must include the following:
  - Diagnoses, symptoms, complaints and complications indicating the need for the member's admission;
  - A description of the functional level of the member;
  - Goals and objectives for the member that are primarily designed to prepare the member and family for the member's return home, and are measurable and time limited;
  - Services to be provided, frequency of the services, professionals to provide the services and title of the professional to provide the services;
  - Any orders for medications, treatment, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
  - Plans for continuing care, including review and modification to the member's plan of care;

- Plans for the member's discharge. Discharge plans should be made to facilitate transition and discharge from the facility at the earliest time possible. Discharge plans should include recommendations for continuity of necessary services and supports, the transition process, discharge and aftercare; and
- Be signed, dated, and professionally titled by at least two members of the interdisciplinary team, one of which must be a physician.

Note: Please ensure the treatment plan includes updates to address any newly identified conditions, failure to respond to treatment, regression in behaviors, dangerous behaviors. If a member is not making progress, it is expected that the acute inpatient psychiatric facility will adjust the treatment plan and interventions to address this immediately.

Discharge Plan

Discharge planning should start no later than the day of admission. Services include the development of a comprehensive discharge plan. Comprehensive discharge plans should include:

- Member name, DOB and Medicaid ID number;
- Date of admission;
- Presenting condition/problem;
- Diagnosis at admission;
- Strengths, needs, abilities, and preferences at admission;
- Medications at admission;
- Services provided and progress on recovery at time of discharge/transition;
- Participation of natural supports;
- Date of discharge/transition;
- Reason for discharge/transition;
- Diagnosis at discharge/transition;
- Strengths, needs, abilities, and preferences at discharge/transition;
- Medications at discharge;
- Recommendations for follow-up/support;
- Staff signature/title/date; and

- Member signature/date.

EMERGENCY SAFETY INTERVENTIONS & REPORTING REQUIREMENTS

Emergency Safety Intervention

An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the member's chronological and developmental age, size, gender, physical, medical, and psychiatric condition, and personal history (including any history of physical or sexual abuse, both to inform treatment goals and methods and to avoid re-traumatization of members).

Application of Time Out

A member in time out must never be physically prevented from leaving the time out area.

Time out may take place away from the area of activity or from other members, such as in the member's room (exclusionary), or in the area of activity or other members (inclusionary).

Staff must monitor the member while he or she is in time out.

Please reference the Notification of Parent(s) or Legal Guardian(s) section below for notification and documentation requirements.

Conditions of Participation — Use of Restraints or Seclusion

Acute inpatient psychiatric hospital service providers must comply with CFR regarding conditions of participation, restraint and seclusion, and must maintain a current attestation of compliance with SCDHHS. The rules 42 CFR 483.350 et. seq. & 482.13 et seq. establishes Condition of Participation for the use of restraint or seclusion that providers must meet in order to provide or continue to provide Medicaid Inpatient Psychiatric Services.

Guidance for restraint or seclusion

Acute inpatient psychiatric facilities must develop behavior support and teaching techniques that are strength-based, that promote self-regulation and self-monitoring, that foster critical thinking and personal responsibility, and that are able to be generalized in less restrictive family, home, school and community environments.

Acute inpatient psychiatric facilities should strive to eliminate coercion and coercive interventions (e.g., seclusion, restraint, response-cost and other aversive practices), and maintain clinical excellence by providing high quality care that is trauma-informed, incorporates state-of-the-art evidence-based approaches, and uses relevant data and feedback in rigorous processes of continuous improvement.

In accordance with Federal regulation 42 CFR §483.352, the following definitions apply for restraint or seclusion:

A drug used as a restraint is defined as any drug that:

- Is administered to manage a member's behavior in a way that reduces the safety risk to the member or others;
- Has the temporary effect of restricting the member's freedom of movement; and
- Is not a standard treatment for the member's medical or psychiatric condition.

Definitions

A **restraint** is defined as a "personal restraint," a "mechanical restraint," or a "drug used as a restraint" as defined in this section.

Seclusion is defined as the involuntary confinement of a member alone in a room or an area from which the member is physically prevented from leaving.

An **emergency safety situation** is defined as unanticipated member behavior that places the member or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

An **emergency safety intervention** is defined as the use of restraint or seclusion as an immediate response to an emergency safety situation.

A **mechanical restraint** is defined as any device attached to or adjacent to the member's body that he or she cannot easily remove that restricts the freedom of movement or the normal access to his or her body.

A **personal restraint** is defined as the application of physical force without the use of any device for the purposes of restraining the free movement of a member's body. The term personal restraint does not include briefly holding, without undue force, a member in order to calm or comfort him or her, or holding a member's hand to safely escort a member from one area to another.

A **time out** is defined as the restriction of a member for a period of time to a designated area from which the member is not physically prevented from leaving, for the purpose of providing the member an opportunity to regain self-control.

A **serious injury** is defined as any significant impairment of the physical condition of the member as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

A **minor** means a minor as defined under State law and, for the purpose of this subpart, includes a member who has been declared legally incompetent by the applicable State court.

Staff is defined as those individuals with responsibility for managing a member's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time or contract basis.

Protection of Members

The Restraint and Seclusion policy of the 42 CFR 483.356 Subpart G provides the following guidelines for the protection of members:

- Each member has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience or retaliation.
- An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
- Restraint or seclusion must not result in harm or injury to the member and must be used only to ensure the safety of the member or others during an emergency safety situation; and until the emergency safety situation has ceased and the member's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
- Restraint and seclusion must not be used simultaneously.

Notification of Facility Policy

At admission, the facility must inform both the incoming member and, in the case of a minor, the member's parent(s) or legal guardian(s) of the following policy:

- Communicate its policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the member is in the facility.
- Communicate its restraint and seclusion policy in a language that the member, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.
- The requirement to obtain an acknowledgment, in writing, from the member, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the member's record.
- The requirement to provide a copy of the facility's restraint and seclusion policy to the member and in the case of a minor, to the member's parent(s) or legal guardian(s).

Orders for the Use of Restraint and Seclusion

Services furnished in an acute inpatient psychiatric setting must satisfy all requirements as set forth in 42 CFR 482.13 seq. eq. governing the use of restraint and seclusion.

For the purposes of this manual, “restraint” is defined as any type of physical intervention (including mechanical, personal, drug used as a restraint and therapeutic holds) that reduces or restricts an individual’s freedom of movement and is administered without the individual’s permission. For the purposes of this manual, “seclusion” is defined as the involuntary confinement of a member alone in a room or an area from which the member is physically prevented from leaving.

Restraint and seclusion shall be used only to ensure the immediate safety of the individual or others when no less restrictive intervention has been or is likely to be effective in averting danger.

Restraint and seclusion shall never be used for coercion, retaliation, humiliation, as a threat or form of punishment, in lieu of adequate staffing, as a replacement for active treatment, for staff convenience, or for property damage not involving imminent danger.

Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and the facility to order (restraint or seclusion) and trained in the use of emergency safety interventions. The Code of Federal Regulations, 42 CFR §483.358 & §482.13 require that inpatient psychiatric services be provided under the direction of a physician. Other orders for the use of restraint and seclusion are as follows:

- If the member’s treatment team physician is available, only he or she can order restraint or seclusion.
- A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
- If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff, such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the member’s record. The physician or other licensed practitioner (i.e., physician assistant or APRN with prescriptive authority) permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.
- Each order for restraint or seclusion must be limited to no longer than the duration of the emergency safety situation and must under no circumstances exceed four hours for members ages 18 or older, two hours for members ages 9 to 17, or one hour for members under age 9.

- Within one hour of the initiation of the emergency safety intervention, a physician or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well-being of the member must conduct a face-to-face assessment of the physical and psychological well-being of the member including, but not limited to:
  - The member's physical and psychological status;
  - The member's behavior;
  - The appropriateness of the intervention measures; and
  - Any complications resulting from the intervention.
- Each order for restraint must include:
  - The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;
  - The date and time the order was obtained;
  - Each incident must include time in and time out; and
  - The emergency safety intervention ordered, including the length of time for which the physician, or other licensed practitioner permitted by the state and the facility to order restraint and seclusion, authorized its use.
- Staff must document the intervention in the member's record. The documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends.

  The documentation must include all of the following:
  - Each order for restraint and seclusion; and
  - The time the emergency safety intervention actually began and ended.
- The time and results of the one-hour assessment required in order number 5 above.

  The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

- The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the member's record as soon as possible.

Consultation with Treatment Team and Physician

If a physician or other licensed practitioner permitted by the state and the facility to order restraint and seclusion orders the use of restraint or seclusion, that person must contact the member's treatment team physician, unless the ordering physician is in fact the member's treatment team physician. The person ordering the use of restraint or seclusion must do both of the following:

- Consult with the member's team physician as soon as possible and inform the team physician of the emergency safety situation that required the member to be restrained or placed in seclusion.

- Document in the member's record the date and time the team physician was consulted.

Monitoring of the Member During and Immediately After Restraint

All acute inpatient clinical staff must be trained in the use of emergency safety interventions. In addition, staff must adhere to the following:

- Staff must be physically present, continually assessing and monitoring the physical and psychological well-being of the member and the safe use of restraint throughout the duration of the emergency safety intervention.

- If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as licensed practitioner permitted by the state, must immediately contact the ordering physician to receive further instructions.

- A physician or other licensed practitioner permitted by the state and the facility to evaluate the member's well-being and trained in the use of emergency safety interventions must evaluate the member's well-being immediately after the restraint is removed.

Monitoring of the Member During and Immediately After Seclusion

All Acute inpatient clinical staff must be trained in the use of emergency safety interventions. In addition, staff must adhere to the following:

- Staff must be physically present in or immediately outside the seclusion room continually assessing and monitoring the physical and psychological well-being of the member and the safe use of seclusion throughout the duration of the emergency safety intervention.

A room for seclusion must allow staff full view of the member in all areas of the room and be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets. Video monitoring of the member in seclusion will not meet this requirement because such monitoring

cannot determine if a member is experiencing a medical emergency such as cardiac arrest or asphyxiation.

- If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practitioner permitted by the state, must immediately contact the ordering physician to receive further instructions.

- A physician or other licensed practitioner permitted by the state and the facility to evaluate the member's well-being and trained in the use of emergency safety interventions must evaluate the member's well-being immediately after the member is removed from seclusion.

Notification of Parent(s) or Legal Guardian(s)

If the member is a minor as defined by State law, the following actions must be taken:

- The facility must notify the parent(s) or legal guardian(s) of the member who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

- The facility must document in the member's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

Post-Intervention Debriefings

All of the following must occur during post intervention debriefings:

- Within 24 hours after the use of restraint and seclusion, staff involved in an emergency safety intervention and the member must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the member. Other staff and member's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility.

The facility must conduct such discussion in a language that is understood by the member's parent(s) or legal guardian(s). The facility must provide both the member and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the member, or others that could prevent the future use of restraint or seclusion.

- Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of:

  – The emergency safety situation that required the intervention;

  – The precipitating factors that led up to the intervention;

  - Alternative techniques that might have prevented the use of the restraint or seclusion;
  - Procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
  - The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

- Staff must document in the member's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the member's treatment plan that result from debriefings.

Medical Treatment for Injuries Resulting from an Emergency Safety Intervention

If a patient is injured as a result of an emergency safety intervention, Staff must immediately obtain medical treatment from qualified medical personnel for them. In addition, the acute inpatient facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that:

- A member will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care.
- Medical and other information needed for care of the member in light of such a transfer will be exchanged between the institutions in accordance with the State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting.
- Services are available to each member 24 hours a day, 7 days a week.
- Staff must document in the member's record all injuries that occurred as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.
- Staff involved in an emergency safety intervention that results in an injury to a member or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Facility Reporting of Deaths

In addition to the reporting requirements contained in the above section, facilities must report deaths to SCDHHS' Division of Behavioral Health, and the CMS Regional Office no later than close of business the next business day after a serious occurrence. Facilities should also report deaths to referring state agencies and parent/guardian within the same time frames. Staff must document in the member's record that the death was reported to the CMS Regional Office. Facilities must use the Death Reporting Worksheet found in the Forms Section of this manual to report deaths.

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BILLING GUIDANCE

REIMBURSEMENT: PAYMENT METHODOLOGY

Inpatient psychiatric hospitals will be reimbursed using a per diem rate methodology.

FEE-FOR -SERVICE

Medicaid reimbursement is available for services provided in acute inpatient facilities if the member is under the age of 21 or 65 and over. Medicaid reimbursement is not available for members between the ages of 22 and 64 in IMDs. If the member receives services immediately before he or she reaches age 21, services may continue until the date the individual no longer requires the services or the date the individual reaches age 22.

MANAGED CARE

Medicaid reimbursement is available for services provided in acute inpatient facilities for members between the ages of 0-21. MCOs may opt to cover acute inpatient services for members between 22-64 years of age. If the member is enrolled with one of the state's contracted MCOs, all hospital providers must receive prior approval and claim reimbursement directly from the member's MCO.

Please refer to the managed care policy and procedure manual at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care-organizations-mco/policy-and-procedure-pp for more information. The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care for additional information regarding MCO coverage.