

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



PSYCHIATRIC HOSPITAL SERVICES PROVIDER MANUAL

JANUARY 1, 2020

South Carolina Department of Health and Human Services

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PART I — PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

2

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 beneficiaries 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 program requirements in this manual. The South Carolina Department of Health and Human Services (SCDHHS) designate Quality Improvement Organization (QIO) will prior authorize admission and continued stays in a PRTF.

PRTFs are facilities, other than a hospital, that provide psychiatric services as further specified in this manual to children under age 21 in an inpatient setting. PRTFs provide Inpatient Psychiatric Services to children under 21 who do not need acute inpatient psychiatric care but need a structured environment with intensive treatment services.

Medicaid reimbursement for PRTFs will continue to be based upon a prospective per diem rate. The services covered by the per diem rate and provided to a Medicaid-eligible beneficiary 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

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 beneficiary'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 week by an 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 beneficiary.
- The proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- Services can reasonably be expected to improve the beneficiary'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 beneficiary's admission status dictates whether an independent review team or the facility-based interdisciplinary team is responsible for certifying the beneficiary's need for admission to acute inpatient services.

Independent Review Team

An independent review team is a team that is not affiliated with the receiving inpatient psychiatric facility and no member has a 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 to 42 CFR 441.153.

Interdisciplinary Teams

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

PRTF Admission Types

There are two types of Medicaid admissions to PRTFs:

1. Urgent admission – is one in which the beneficiary meets the CON criteria but is not presenting immediate danger that would cause death, serious impairment to the health of the beneficiary or bodily harm to another person by the beneficiary. An independent team meeting the requirements for CON teams 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 facility’s interdisciplinary team will complete the CON form for beneficiaries who become Medicaid eligible after their admission to a PRTF. The completed CON form must cover any period before the Medicaid application and relevant claims.

PRTF Family-Driven and Youth-Guided Care

SCDHHS has adopted the core principles of family-driven, youth-guided care to align with best practice approaches to ensure the provision of treatment and services to youth and families. The following are family-driven, youth-guided principles that have been adopted:

- Children must be treated within the context of their family systems. PRTF providers should work with the child and family team (i.e., the beneficiary, his or her parents, legal guardians, or others in whose care he or she will be released after discharge) team to implement services that are congruent with the child’s family culture and environment.
- Family and ethnic/racial culture should be assessed and considered in the formulation of a treatment approach, especially for children who are from cultures where out of home treatment is seen as shameful or stigmatizing. PRTF providers should reach out to cultural guides (e.g., other team members) to help tailor accommodations to such cultural norms.
- PRTF providers must encourage 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 should 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 should orchestrate and facilitate the work of the team. As key members of the team, families must be included in the assessment process, in setting and prioritizing treatment goals, in ongoing care, discharge planning and transition activities.
- Each family should be encouraged to use the child’s treatment in a PRTF as a transition period, helping the family as a whole to start on a new path, developing new skills, a renewed sense of confidence, competence and optimism as parents, siblings and other members prepare to reunite as a family.
- 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.
- PRTF program settings must provide a natural and home-like environment. In general, children should be placed in service settings that sustain their existing relationships with family, friends, teachers and neighbors. Phone calls, family visits and other experiences should not have to be earned and should not be restricted unless there is clear clinical justification and strategic goals outlined in the service plan for doing so. Therapeutic activities should be mindfully planned to

allow children to practice skills and behaviors that will help them to succeed in family, school and other community settings. Children should be able to appropriately personalize their environment to reflect their tastes, culture, preferences and interests.

- Participation in family-focused therapy should be a primary objective in PRTF placements.
- Discharge plans should build on identified strengths and cultural priorities and should incorporate families' natural supports as well as 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 reengaged.
- PRTF providers must collaborate with community (e.g., outpatient, community service agency) providers to deliver family-focused therapy and to 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 should 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.

Purpose

Care in a PRTF setting is required only if the beneficiary'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 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 beneficiaries.

The primary goal of a PRTF is to prepare the beneficiary and family, as quickly as possible, for the beneficiary's return to home and community. A beneficiary'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 beneficiary's successes. Service planning and programming, including therapeutic strategies and provision of active treatment, must reflect this goal, and must be focused on teaching beneficiaries 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 beneficiary's underlying behavioral problems need not be fully resolved before the beneficiary can successfully transition back home as the most appropriate setting for therapeutic work is the environment in which the beneficiary will be living and functioning, i.e. their home and community.

Transitions from PRTFs must be designed to provide beneficiary'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 beneficiary's needs, including any familial and community safety supports.

PRTF programs should be regarded as a treatment level in 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 beneficiaries 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 beneficiary 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 at https://msp.scdhhs.gov/managed_care/site-page/mco-contract-pp for more information. The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at https://msp.scdhhs.gov/managed_care/ for additional information regarding MCO coverage.

Admission Criteria

A beneficiary must meet the following criteria for admission into a PRTF:

- The beneficiary demonstrates symptomatology consistent with a current DSM diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
- The beneficiary 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 beneficiary 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 beneficiary has a history of multiple hospitalizations or other treatment episodes, or a recent inpatient stay with a history of poor treatment adherence or outcome.
- Less restrictive or intensive levels of treatment have been tried and were unsuccessful or are not appropriate to meet the beneficiary's needs.
- The beneficiary's functioning is such that the beneficiary cannot currently remain in the home environment and receive community-based treatment.

Prior to placing a beneficiary 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 beneficiary 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 beneficiary 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 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 beneficiary'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 program providers must comply with provisions of 42 CFR Section 483.50 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 in the South Carolina Medicaid program must meet the following minimum requirements:

- Be a psychiatric facility and is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities 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 program description, a request for participation, and cost information to:

SCDHHS Division of Behavioral Health
Attention: Psychiatric Hospital Services Program Manager
Post Office Box 8206
Columbia, SC 29202-8206

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

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.

Program Modifications

Existing Programs

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

Program 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 program 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 program'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 DHEC 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 programs as evidenced by review of annual financial reports submitted to the Division of Ancillary Reimbursements.
- The provider has failed to maintain the facility's license and/or accreditation.

Licensure and Certification

In-state facilities must be licensed by the DHEC and meet and maintain compliance with all requirements as set forth by SCDHEC 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.

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 Division Behavioral Health
Attention: Attestation
Post Office Box 8206
Columbia, SC 29202-8206

Letters of attestations 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 DHEC (or its agents or that State Health Licensing agent) and, if necessary, Centers for Medicare and Medicaid Services (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 Programs.

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 beneficiaries 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 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 program 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 beneficiaries, 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 beneficiaries, a copy of the individual’s motor vehicle record (MVR) will be kept in the individual’s personnel record; the program must also adhere to any other State or Federal regulations regarding transportation of beneficiaries as applicable, e.g., “Jacob’s Law”.)
- Nurse Aide Registry
- 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 technicians, support staff and professionals to have the following education and training:

- **Basic Orientation**
 - Basic orientation includes but is not limited to standards as outlined in the DHEC 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 beneficiary 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 beneficiaries 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 age 12 and above must be trained in the age-appropriate Mental Health First Aid training by July 1, 2018.

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 training programs 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 beneficiaries during program hours in each residence or unit. Program 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 beneficiary shall be a minimum of one staff member to seven beneficiaries. At least one direct care staff member of the same sex as the beneficiary shall be present, awake and available to the beneficiary at all times. If both male and female beneficiaries 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.

Electronic supervision shall not replace the direct care staffing requirements. Children 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.

The level of supervision necessary while a child is on suicide watch is based on the level of assessed suicidal risk. Continuous one-to-one visual, line-of-sight monitoring is required.

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. However, an interdisciplinary team member must be available in case of an emergency.

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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 beneficiary’s needs and result in the beneficiary’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 beneficiary, identification and development and adaptive use of strengths, continuous assessment of needs, goal planning, execution of planned strategies and advocacy.

Beneficiaries must be engaged in active treatment.

PRTF programs must provide services and supports that change to continually meet the child’s needs, including for stability and avoidance of multiple placements. As a child’s needs may change, supports and services must also change 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.

In recognition of the Palmetto Coordinated System of Care’s principled commitment to avoiding delinquency, 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 program in accordance with the child’s IPOC. Please refer to the Reports/Documentation 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 beneficiary 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 beneficiaries’ condition.

- Documentation of participation in programs of services as required in the Program Content 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 beneficiary's outpatient treatment providers in planning for and delivering services.

Medicaid reimbursement for services rendered in a PRTF will not be available for stays during which active treatment related to the beneficiary's diagnostic needs is not provided or the beneficiary no longer requires 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 beneficiary. The evaluation must identify factors related to or cause for admission to include diagnosis, summary of medical condition and social status of the beneficiary. The physician/psychiatrist must document the type of services needed, make a recommendation concerning need for inpatient treatment, evaluate medications the beneficiary is on and make adjustments or changes as needed. Each beneficiary 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 beneficiary and completed at a minimum of every 6 months, or as necessary, to determine the need for continued treatment.

Reassessments shall be completed by qualified professionals.

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 assessments 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 beneficiary. 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 or continued treatment.

Therapy Services

Therapy services are therapeutic interventions that address both the beneficiary'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.

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 beneficiaries, not to exceed one staff to eight beneficiaries. Group Psychotherapy must be individually documented for each beneficiary. A beneficiary 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 beneficiary's family unit or significant others, which must be conducted at least once a month. 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 beneficiary 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 beneficiaries. 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 beneficiary'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 beneficiary's functioning and/or marked increase in personal distress.

Rehabilitative Psychosocial Services

Services designed to improve or preserve the beneficiary'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 beneficiary that promote healthy functioning in family, home, school and community.

Engagement Services and Activities

- Engaging the beneficiary in a purposeful, supportive, and helping relationship, addressing basic needs, that include determining the supports the beneficiary's needs, the productive and leisure activities in which the beneficiary desires to participate that are informed by appropriate expectations in the post-discharge family, home, school and community settings.
- Understanding the beneficiary's personal history and the beneficiary's satisfaction or dissatisfaction with services and treatments, including medications that have been provided to or prescribed in the past.

Strength Assessment Services and Activities

Services and activities include identifying and assessing the beneficiary's wants and needs, the beneficiary's aspirations for the future, resources that are or might be available to that beneficiary and their family, sources of motivation available to the beneficiary, and strengths and capabilities the beneficiary possesses. Services also include identifying and researching what educational, vocational and social resources are or might be available to the beneficiary to inform and facilitate the beneficiary's treatment, and identifying, researching, and understanding cultural factors that might have affected or that might affect the beneficiary'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 beneficiary's treatment.

Goal-Oriented Services and Activities

- Helping the beneficiary to identify, organize, and prioritize his/her personal goals and objectives regarding treatment, education, and training and community involvement.
- Assisting and supporting the beneficiary in choosing and pursuing activities consistent with achieving his/her goals and objectives at a pace consistent with the beneficiary's capabilities and motivation.
- Instructing the beneficiary 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 beneficiary'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 beneficiary and family team may utilize.

Advocacy Services and Activities

Services and activities that involve coordinating the treatment and support efforts and advocating for the beneficiary, as appropriate, in developing goals and objectives within the beneficiary'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. If the youth is in an MCO, a notification must also be sent to the respective 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

A facility may place a beneficiary on a Leave of Absence when readmission is expected and the beneficiary 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 beneficiary is considered discharged if the beneficiary:

- 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:

- Beneficiary has ability to function appropriately in a non-PRTF setting;
- Beneficiary 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 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 AUTHORIZATION

Quality Improvement Organization (QIO) Prior Authorization (KEPRO)

All admissions for Fee-for-Service beneficiaries must be prior authorized through the SCDHHS designated QIO (KEPRO).

For admissions, the PRTF must submit the request for prior authorization using the KEPRO fax form along with the completed CON and the most recent diagnostic assessment to KEPRO. Also, the beneficiary 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 KEPRO 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 KEPRO 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 beneficiary, family/caregiver, beneficiary's case manager/care coordinator and beneficiary's outpatient service provider. Additionally, KEPRO 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 beneficiary. Continued stays will be limited to 30 days.

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

KEPRO 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 KEPRO. Providers will have only one time to respond to KEPRO after additional information is requested.

KEPRO 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 KEPRO Web site listed above for additional information on the process.

Quality Improvement Organization

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 beneficiary'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 beneficiary's treatment plan must be based on an inventory of the beneficiary's strengths and disabilities, including the pertinent clinical information and should be discussed with the beneficiary.
- The facility must provide ongoing monitoring and evaluation of the beneficiary'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 beneficiary 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 discharge planning occurs.

Psychiatric Quality of Care

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

The QIO or the 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 program 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:

1. Pre-discharge Reviews

2. 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.

Prior Authorization for Beneficiaries in an MCO

The admitting PRTF or Inpatient Psychiatric Hospital provider must submit the request for prior authorization along with the required clinical documentation to the MCO directly. The MCO will use established 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 within seven calendar days.

OTHER SERVICE/PRODUCT LIMITATIONS

Out-of-State Facilities — Admissions

South Carolina law requires referring agencies seeking admission for Medicaid beneficiaries 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 Constituent Services 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.

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REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

Medicaid reimbursement is directly related to the delivery of services. Each beneficiary 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 beneficiary, his or her responsiveness to treatment, and the interaction and involvement of the staff should justify the services billed to Medicaid and the beneficiary'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 beneficiary and support the level of care.

Records shall contain at a minimum the following:

- The beneficiary'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 beneficiary's signs and/or symptoms were severe enough to warrant the need for PRTF-level 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 beneficiary'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 beneficiary per admission. If a beneficiary 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 beneficiary. Although the form is valid for 45 days, it must accurately reflect the beneficiary's state of health on the date of admission.
- The CON form must be submitted to the QIO and placed in the beneficiary's clinical case record.
- A new CON form is required when a beneficiary 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

In the context of services rendered in a PRTF, an IPOC is a written plan developed for each beneficiary 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 beneficiary must have a written IPOC, which is goal-oriented 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 beneficiary's situation and reflects the need for PRTF level care;
- Be designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time;

- Based on an inventory of the beneficiary's strengths and needs, the beneficiary's aspirations for the future, resources that are or might be available to that beneficiary and their family, sources of motivation available to the beneficiary and capabilities the beneficiary possesses;
- State treatment goals/objectives primarily designed to prepare the beneficiary and family for the beneficiary's return home; and prescribe an integrated program of 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, 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 beneficiary'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 beneficiary's admission;
 - A description of the functional level of the beneficiary;
 - Goals and objectives for the beneficiary that are primarily designed to prepare the beneficiary and family for the beneficiary'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 beneficiary;
 - Plans for continuing care, including review and modification to the beneficiary's plan of care;
 - Plans for the beneficiary'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 PRTF will adjust the treatment plan and interventions to address this immediately.

Thirty Day Review

The plan of care must be reviewed every 30 days by the team specified to determine that services being provided are or were required and to recommend changes in the plan as indicated by the beneficiary'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 beneficiary's care plan must be documented in the thirty-day review. The PRTF must invite the beneficiary'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 beneficiary'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 beneficiary'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 beneficiary 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:

- Beneficiary 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
- Beneficiary 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, and the resident'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 children).

Application of Time Out

A beneficiary 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 beneficiaries, such as in the beneficiary's room (exclusionary), or in the area of activity or other beneficiaries (inclusionary).

Staff must monitor the beneficiary 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

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

PRTF programs 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 PRTF programs 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 resident's behavior in a way that reduces the safety risk to the resident or others;
- Has the temporary effect of restricting the resident's freedom of movement; and
- Is not a standard treatment for the resident'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 resident behavior that places the resident 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 resident'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 resident 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 resident's body. The term personal restraint does not include briefly holding, without undue force, a resident in order to calm or comfort him or her or holding a resident's hand to safely escort a resident 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 resident alone in a room or an area from which the resident is physically prevented from leaving.

A **serious injury** is defined as any significant impairment of the physical condition of the resident 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 resident’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 resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

Protection of Residents

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

- Each resident 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 resident and must be used only to ensure the safety of the resident or others during an emergency safety situation; and until the emergency safety situation has ceased and the resident’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 resident and, in the case of a minor, the resident’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 resident is in the program.
- Communicate its restraint and seclusion policy in a language that the resident, 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 resident, 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 resident's record.
- The requirement to provide a copy of the facility's restraint and seclusion policy to the resident and in the case of a minor, to the resident'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 resident'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 resident'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 residents ages 18 to 21, one hour for residents ages 9 to 17 or one-half hour for residents 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 resident must conduct a face-to-face assessment of the physical and psychological well-being of the resident including, but not limited to:
 - The resident's physical and psychological status;
 - The resident'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 resident'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 resident'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 resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must do both of the following:

- Consult with the resident's team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion.
- Document in the resident's record the date and time the team physician was consulted.

Monitoring of the Resident 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 resident 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 resident's well-being and trained in the use of emergency safety interventions must evaluate the resident's well-being immediately after the restraint is removed.

Monitoring of the Resident 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 resident 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 resident 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 resident in seclusion will not meet this requirement because such monitoring cannot determine if a resident 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 resident's well-being and trained in the use of emergency safety interventions must evaluate the resident's well-being immediately after the resident is removed from seclusion.

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

If the resident 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 resident 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 resident'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 resident 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 resident. Other staff and resident'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 resident's parent(s) or legal guardian(s). The facility must provide both the resident 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 resident 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 resident’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 resident’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 resident 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 resident 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 resident 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 resident 24 hours a day, 7 days a week.
- Staff must document in the resident’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 resident 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 behavioralhealth004@scdhhs.gov. 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 a resident's death, a serious injury to a resident, and a resident's suicide attempt. A **serious injury** is defined as any significant impairment of the physical condition of the resident 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 Protection and Advocacy system and should also report such occurrences to the referring state agency.

Staff must report any serious occurrence involving a resident to both SCDHHS and the State-designated Protection and Advocacy system no later than close of business the next business day after a serious occurrence. The report must include the name of the resident 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 resident'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 resident's record that the serious occurrence was reported to both SCDHHS and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident logs maintained by the facility.

For reporting purposes, the South Carolina designated Protection and Advocacy system contact information is:

Protection and Advocacy of People for Disabilities Inc.
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 Division of Behavioral Health
Attention: PRTF Serious Occurrences
Post Office Box 8206
Columbia, SC 29202-8206
Telephone: (803) 898-2565
Fax: (803) 255-8204

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' Division of Behavioral Health, and the CMS Regional Office no later than close of business the next business day after a death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.

Facilities must report deaths to parents/guardians no later than close of business the next business day after the beneficiary's death. Facilities should report deaths to referring 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

COST HISTORY

If a new facility enrolls in Medicaid and does not have a cost history, 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 beneficiary is under the age of 21.

9

PART II — ACUTE INPATIENT PSYCHIATRIC SERVICES

10

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 prior authorize admission(s) into 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

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 beneficiary's admission to an inpatient psychiatric facility 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, risk assessment.
- Mental health, substance use disorder and/or health care resources available in the community do not meet the treatment needs of the beneficiary.
- The proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- Services can reasonably be expected to improve the beneficiary'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 beneficiary's admission status dictates whether an independent review team or the facility-based interdisciplinary team is responsible for certifying the beneficiary's need for admission to acute inpatient services.

Independent Review Teams

An independent review team is a team that is not affiliated with the receiving inpatient psychiatric facility and no member has a financial, employment or consultant relationship with the admitting facility. For an individual who is a beneficiary when admitted to a facility or program, the CON must be completed by an independent team. The independent review team must consist of professionals in accordance to 42 CFR 441.153.

Interdisciplinary Teams

An interdisciplinary team is a team 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 independent review team must consist of professionals in accordance to 42 CFR 441.153.

Acute Inpatient Psychiatric Services Settings

Acute inpatient services are normally provided to Medicaid-eligible beneficiaries 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. Medicaid reimbursement is based on the DRG reimbursement system. 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. Medicaid reimbursement is based on the Prospective Payment System. 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 beneficiary's health, or harm to another person by the beneficiary.

An emergency admission must relate to the nature of the beneficiary'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 beneficiary's records, but it is not solely sufficient to substantiate the need for emergency admission. The psychiatric hospital's clinical records for each Medicaid beneficiary admitted under emergency procedures must support the claim that the admission was actually an emergency.

Urgent Admission

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

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

Post Admission Eligibility

The hospital completes the CON form for beneficiaries 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 beneficiary'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 beneficiary and family, as quickly as possible, for the beneficiary's return to home and community.

Programming must be individualized to the needs of each beneficiary 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 beneficiary. The provider is expected to appropriately treat a beneficiary, document the delivery of services and responses to treatment, and provide or obtain all services the beneficiary 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 beneficiary and his or her family.

Each provider must ensure that a structure exists that clearly supports stabilization, restoration, and preparation of the beneficiary 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 beneficiaries 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 beneficiary'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 beneficiary's successes. The beneficiary's underlying behavioral problems need not be fully resolved before the beneficiary can successfully transition back to a less restrictive setting. The most appropriate setting for long term therapeutic work is the environment in which the beneficiary 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 beneficiary and family have surmounted every problem or challenge. Transitions from acute inpatient facilities must adequately address the beneficiary'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 beneficiaries.

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 beneficiary that is 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.
- Medicaid beneficiary that is 65 and older.

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

MCOs may opt to cover acute inpatient services for members between 22-64 years of age. If the beneficiary 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://msp.scdhhs.gov/managed_care/site-page/mco-contract-pp for more information. The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at https://msp.scdhhs.gov/managed_care/ for additional information regarding MCO coverage.

Admission Criteria

Inpatient care rather than outpatient care is required only if the beneficiary'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 beneficiary 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 beneficiary;
- The medical predictability of something adverse happening to the beneficiary;
- The need for diagnostic studies; and
- The availability of diagnostic procedures at the time when and at the location where the beneficiary presents.

Severity of Illness

An admission occurs when the Severity of Illness/Intensity of Service criteria is met, and the physician expects the beneficiary will remain in the hospital longer than 24 hours. Only Medicaid-eligible beneficiaries who are admitted for psychiatric hospital care can receive Medicaid-reimbursable services. The facility must demonstrate that beneficiaries 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 beneficiary 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 beneficiary'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 beneficiary 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 beneficiary at increased risk;
- › Treatment in a less restricted environment not feasible due to the beneficiary'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 beneficiary 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 and meet the following requirements:

- Be licensed by DHEC;
- Services be provided under the direction of a SC licensed Physician; AND
- Participation in Medicare as a psychiatric hospital as specified in 482.60; OR
- Be 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 beneficiaries age 0-21); and
- Contract with SCDHHS.

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

- A written program description with their electronic provider enrollment application. Provider enrollment can be found at: <https://providerservices.scdhhs.gov/ProviderEnrollmentWeb/>;
- W-9 Form;
- A copy of your active accreditation documentation;
- DHEC 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.

Program Modifications

Existing Programs

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

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

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

Licensure and Certification

In-state facilities must be licensed by the DHEC and meet and maintain compliance with all requirements as set forth by SCDHEC 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.

Staffing Requirements

All acute inpatient psychiatric hospitals must be appropriately staffed to meet the needs of all beneficiaries in their care and ensure that the program 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 beneficiary.

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 program 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 beneficiaries, 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 beneficiaries, a copy of the individual's MVR will be kept in the individual's personnel

record; the program must also adhere to any other State or Federal regulations regarding transportation of beneficiaries 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 DHEC 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 beneficiary 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 beneficiaries 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 age 12 and above must be trained in the age-appropriate Mental Health First Aid training by July 1, 2018.

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 training programs 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

ACTIVE TREATMENT

Acute inpatient psychiatric services must involve “active treatment,” which means implementation of a professionally developed and supervised IPOC designed to achieve the beneficiary’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 beneficiary, identification and development and adaptive use of strengths, continuous assessment of needs, goal planning, execution of planned strategies and advocacy.

Beneficiaries must be engaged in active treatment.

Acute inpatient psychiatric programs must provide services and supports that change to continually meet the beneficiary’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 beneficiary 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 beneficiaries’ condition.
- Documentation of participation in programs of services as required in the Program Content 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 beneficiary’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 beneficiary’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 beneficiary's diagnostic needs is not provided or the beneficiary 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 beneficiary. The evaluation must identify factors related to or cause for admission to include diagnosis, summary of medical condition, and social status of the beneficiary. The physician/psychiatrist must document the type of services needed, make a recommendation concerning need for inpatient treatment, evaluate medications the beneficiary is on and make adjustments or changes as needed. Each beneficiary 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 beneficiary. 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 beneficiary'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 beneficiary is not stable enough to benefit and attend therapy sessions the reason must be documented and presented within the beneficiary's record. The document must be signed off by the servicing psychiatrist/physician.

Group Psychotherapy

Face-to-face, planned interventions with a group of beneficiaries, not to exceed one staff to eight beneficiaries. Group Psychotherapy must be individually documented for each beneficiary. A beneficiary 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 beneficiary'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 beneficiary 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 beneficiaries. 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 beneficiary'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 beneficiary's functioning and/or marked increase in personal distress.

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

Engagement Services and Activities

Services and activities include:

- Engaging the beneficiary in a purposeful, supportive, and helping relationship, addressing basic needs, that include determining the supports the beneficiary needs, the productive and leisure activities in which the beneficiary desires to participate that are informed by appropriate expectations in the post-discharge family, home, school and community settings.
- Understanding the beneficiary's personal history and the beneficiary'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 beneficiary's wants and needs, the beneficiary's aspirations for the future, resources that are or might be available to that beneficiary and their family, sources of motivation available to the beneficiary, and strengths and capabilities the beneficiary possesses. Services also include identifying and researching what educational, vocational and social resources are or might be available to the beneficiary to inform and facilitate the beneficiary's treatment, and identifying, researching, and understanding cultural factors that might have affected or that might affect the beneficiary'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 beneficiary's treatment.

Goal-Oriented Services and Activities

- Assisting and supporting the beneficiary in choosing and pursuing activities consistent with achieving his/her goals and objectives at a pace consistent with the beneficiary's capabilities and motivation.
- Instructing the beneficiary 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 beneficiary'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 beneficiary and family team may utilize.

Advocacy Services and Activities

Services and activities that involve coordinating the treatment and support efforts and advocating for the beneficiary, as appropriate, in developing goals and objectives within the beneficiary'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 beneficiary is considered discharged if the beneficiary:

- 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:

- Beneficiary has ability to function appropriately in a non-psychiatric hospital setting;
- Beneficiary 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 AUTHORIZATION

The admitting acute inpatient psychiatric service provider must submit the request for prior authorization along with the CON (for beneficiaries under 21) and the most recent diagnostic assessment to the SCDHHS KEPRO. KEPRO 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 KEPRO 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.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 KEPRO. Providers will have only one time to respond to KEPRO after additional information is requested.

The QIO or the SCDHHS designee may review the medical records of South Carolina Medicaid beneficiaries 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 program 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:

1. Pre-discharge Reviews
2. 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 Beneficiaries 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. The MCO will use established 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 within three calendar days.

In all cases, the provider is responsible for receiving and retaining proper prior authorization forms. Additionally, all acute inpatient authorizations for beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiary is admitted for Psychiatric Hospital Services.

If the beneficiary 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 beneficiary or legally responsible party decides to remain in the facility and the QIO determines that psychiatric hospital care is no longer medically necessary, the beneficiary will be responsible for payment.

The completed copy of the Non-Coverage Form should be forwarded to the Medicaid beneficiary, 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 beneficiary.

When a beneficiary 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.

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REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

Medicaid reimbursement is directly related to the delivery of services. Each beneficiary 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 beneficiary, his or her responsiveness to treatment, and the interaction and involvement of the staff should justify the services billed to Medicaid and the beneficiary'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 beneficiary and support the level of care.

Records shall contain at a minimum the following:

- The beneficiary'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 beneficiary'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 beneficiary'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 beneficiary per admission. If a beneficiary 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 beneficiary. Although the form is valid for 45 days, it must accurately reflect the beneficiary's state of health on the date of admission.
- The CON form must be submitted to the QIO and placed in the beneficiary's clinical case record.
- A new CON form is required when a beneficiary 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 beneficiary 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 beneficiary must have a written individual plan of care, which is goal-oriented and specific, describing the service to be provided. If the beneficiary 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 beneficiary's situation and reflects the need for acute inpatient level care;

- Be developed by the expanded beneficiary and family team – that is, the beneficiary, 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 beneficiary 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 beneficiary’s discharge from inpatient status at the earliest possible time;
- State treatment objectives primarily designed to prepare the beneficiary and family for the beneficiary’s return home; and prescribe an integrated program of 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 beneficiary’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 beneficiary’s admission;
 - A description of the functional level of the beneficiary;
 - Goals and objectives for the beneficiary that are primarily designed to prepare the beneficiary and family for the beneficiary’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 beneficiary;
 - Plans for continuing care, including review and modification to the beneficiary’s plan of care;

- Plans for the beneficiary’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:

- Beneficiary 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

- Beneficiary 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 beneficiary'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 beneficiaries).

Application of Time Out

A beneficiary 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 beneficiaries, such as in the beneficiary's room (exclusionary), or in the area of activity or other beneficiaries (inclusionary).

Staff must monitor the beneficiary 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 programs 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 programs 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 beneficiary’s behavior in a way that reduces the safety risk to the beneficiary or others;
- Has the temporary effect of restricting the beneficiary’s freedom of movement; and
- Is not a standard treatment for the beneficiary’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 beneficiary alone in a room or an area from which the beneficiary is physically prevented from leaving.

An **emergency safety situation** is defined as unanticipated beneficiary behavior that places the beneficiary 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 beneficiary’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 beneficiary’s body. The term personal restraint does not include briefly holding, without undue force, a beneficiary in order to calm or comfort him or her, or holding a beneficiary’s hand to safely escort a beneficiary from one area to another.

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

A **serious injury** is defined as any significant impairment of the physical condition of the beneficiary 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 beneficiary who has been declared legally incompetent by the applicable State court.

Staff is defined as those individuals with responsibility for managing a beneficiary'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 Beneficiaries

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

- Each beneficiary 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 beneficiary and must be used only to ensure the safety of the beneficiary or others during an emergency safety situation; and until the emergency safety situation has ceased and the beneficiary'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 beneficiary and, in the case of a minor, the beneficiary'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 resident is in the program.
- Communicate its restraint and seclusion policy in a language that the resident, 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 beneficiary, 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 beneficiary's record.
- The requirement to provide a copy of the facility's restraint and seclusion policy to the beneficiary and in the case of a minor, to the beneficiary'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 beneficiary alone in a room or an area from which the beneficiary 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 beneficiary’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 beneficiary’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 beneficiaries ages 18 or older, two hours for beneficiaries ages 9 to 17, or one hour for beneficiaries 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 beneficiary must conduct a face-to-face assessment of the physical and psychological well-being of the beneficiary including, but not limited to:
 - The beneficiary’s physical and psychological status;
 - The beneficiary’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 beneficiary’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 beneficiary'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 beneficiary's treatment team physician, unless the ordering physician is in fact the beneficiary's treatment team physician. The person ordering the use of restraint or seclusion must do both of the following:

- Consult with the beneficiary's team physician as soon as possible and inform the team physician of the emergency safety situation that required the beneficiary to be restrained or placed in seclusion.
- Document in the beneficiary's record the date and time the team physician was consulted.

Monitoring of the Beneficiary I 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 beneficiary 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 beneficiary's well-being and trained in the use of emergency safety interventions must evaluate the beneficiary's well-being immediately after the restraint is removed.

Monitoring of the Beneficiary in 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 beneficiary 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 beneficiary 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 beneficiary in seclusion will not meet this requirement because such monitoring

cannot determine if a beneficiary 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 beneficiary's well-being and trained in the use of emergency safety interventions must evaluate the beneficiary's well-being immediately after the beneficiary is removed from seclusion.

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

If the beneficiary 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 beneficiary 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 beneficiary'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 beneficiary 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 beneficiary. Other staff and beneficiary'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 beneficiary's parent(s) or legal guardian(s). The facility must provide both the beneficiary 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 beneficiary, 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 beneficiary’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 beneficiary’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 beneficiary 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 beneficiary 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 beneficiary 24 hours a day, 7 days a week.
- Staff must document in the beneficiary’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 beneficiary 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 resident’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

FEE-FOR-SERVICE

Medicaid reimbursement is available for services provided in acute inpatient facilities if the beneficiary is under the age of 21 or 65 and over. Medicaid reimbursement is not available for beneficiaries between 22 and 64 in IMDs. If the beneficiary 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.

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 beneficiary 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://msp.scdhhs.gov/managedcare//site-page/mco-contract-pp> for more information. The policy herein does not cover services under a MCO. Providers are encouraged to visit the SCDHHS website at <https://msp.scdhhs.gov/managedcare/> for additional information regarding MCO coverage.