

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



COMMUNITY MENTAL HEALTH (CMH) SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

CONTENTS

1. Program Overview	1
• Program Requirements	1
2. Covered Populations.....	2
• Eligibility/Special Populations	2
3. Eligible Providers	5
• Provider Qualifications.....	5
• Staff Qualifications	7
4. Covered Services and Definitions	10
5. Utilization Management.....	21
• Other Service/Product Limitations	21
6. Reporting/Documentation.....	23
• Documentation Requirements	23
• Service Documentation	31
7. Billing Guidance	36
• Non-Billable Medicaid Activities.....	36

1

PROGRAM OVERVIEW

PROGRAM REQUIREMENTS

Community mental health (MH) service providers must provide clinic services as defined in federal regulation 42 CFR 440.90. This manual describes these services, legal authorities and the characteristics of the providers of services. A Community Mental Health Center (CMHC) is a free-standing facility of the Department of Mental Health or Medical University of South Carolina, having as its primary function the diagnosis, treatment, counseling and/or rehabilitation involving mental, emotional and behavioral problems, disturbances or dysfunction (services are provided to beneficiaries on an outpatient basis)

South Carolina Department of Mental Health encourages the use of, and promotes access to, “evidence-based practices”, and “emerging best practices” in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis and treatment planning; and fosters improvement in the delivery system of MH services to children and adults in the most effective and cost-efficient manner.

Clinic Services

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

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

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

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

2

COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

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

Psychiatric Diagnostic Assessments (PDAs)

PDA with Medical Services - Physician, PDA with Medical Services - Advanced Practice Registered Nurse (APRN), PDA with Medical Services - Physician Assistant (PA) and PDA with Medical Services - Telepsychiatry

All Medicaid beneficiaries admitted to a MH facility are eligible to receive psychiatric diagnostic evaluation with medical services and must receive this service at least once within the first 90 days from the date of admission to the MH center or as the first service thereafter.

If a psychiatric diagnostic evaluation with medical services has not been rendered during a retroactively covered period, the psychiatric diagnostic evaluation must be rendered within 90 calendar days from the date a beneficiary is retroactively determined Medicaid eligible.

Beneficiaries receiving psychotropic medications are strongly encouraged to receive a psychiatric diagnostic evaluation with medical services every six months at a minimum.

Beneficiaries who have not had a face-to-face treatment service during a six-month period will require a new psychiatric diagnostic evaluation with medical services completed by a Physician, APRN or PA within 90 calendar days.

Injectable Medication Administration (MED. ADM.)

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

Nursing Services (NS)

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

Crisis Intervention (CI) Service

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

Individuals in crisis who require this service may commonly be using substances during the crisis.

Substance use should be recognized and addressed in an integrated fashion, as it may add to risk, increasing the need for engagement in care.

MH Assessment by Non-Physician (ASSMT)

All Medicaid beneficiaries requesting MH services, including those who present with co-occurring substance abuse symptomatology, are eligible.

Individual Psychotherapy (IND. TX.)

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

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

Beneficiaries experiencing an acute crisis or those with severe mental illness who need ongoing support are good candidates for supportive psychotherapy. These beneficiaries may also benefit from learning new skills that help them to manage the crisis and prevent recurrence.

Family Psychotherapy (FAM. TX.)

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

Group Psychotherapy (GP. TX.)

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

Multiple Family Group Psychotherapy (MFGP)

All beneficiaries and their families who Physicians, within the scope of their clinical practice, believe would benefit from this service, including those who may have co-occurring substance use disorders, are eligible. The eligibility of participants for group versus individual therapy is the same.

Behavioral Health Screening (BHS)

All Medicaid eligible beneficiaries are eligible for this service.

MH Service Plan Development (SPD) by Non-Physician

All beneficiaries are eligible for MH SPD by Non-Physician.

SPD - Interdisciplinary Team

All Medicaid eligible beneficiaries are eligible for this service.

Medical Evaluation and Management for Established Patient

All Medicaid eligible beneficiaries are eligible for this service.

3

ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

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

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

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

Each Community MH Service provider must also maintain a file that lists the clinical staff, their professional titles, and the services each staff member is privileged to render.

Physician Direction and Supervision for Clinic Services

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

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

Physician Responsibilities

To comply with the above requirements, the Physician/Psychiatrist must see all Medicaid beneficiaries within the first 90 days from the date of admission to a CMHC or earlier, based on the individual beneficiary's needs. Physicians should prescribe the type of care to be provided and periodically review the need for continued care.

Physicians must include a properly completed Physician Medical Order (PMO) form in the medical record to confirm the initial contact with the beneficiary. For the purposes of this manual, "contact" is defined as a face-to-face interaction between a staff member and a beneficiary or collateral.

"Collateral" is defined as persons who are significant others or members of the beneficiary, family or household, community setting who regularly interact with the beneficiary.

The Physician/Psychiatrist's signature is required on the beneficiary's Individualized Plan of Care (IPOC) to confirm diagnosis, medical necessity of the treatment, the appropriateness of care and authorization of all services that are required to be listed on the IPOC. Refer to the heading "Individualized Plan of Care (IPOC)" within this manual for more detail.

The Physician/Psychiatrist must evaluate all beneficiaries' needs for continued service at least once every 12 months. This evaluation will be confirmed by the Physician/Psychiatrist's signature and date on the IPOC.

Staff Requirements

The following information describes the credentialing requirements for staff delivering services in Community MH Service Programs. Prior to delivery of services, each staff member should be appropriately credentialed and privileged by the authorizing Community MH Service provider. Each CMHC must adhere to the standards of qualification of service provider credentials as defined below.

Community MH Services must be rendered by, or under the supervision of, a Mental Health Professional (MHP) as outlined in the individual service standard and in accordance with their respective scope of practice as allowed under South Carolina Law.

Mental Health Professional (MHP)

The following professionals are considered to be MHPs:

- A Psychiatrist must be a licensed Doctor of Medicine or Doctor of Osteopathy who has completed a residency in psychiatry and who is licensed to practice medicine in South Carolina.
- A Physician must be licensed to practice medicine in South Carolina.
- A Psychiatric Nurse or APRN must be a Registered Nurse (RN), licensed in South Carolina, with a minimum of a Master's degree in Nursing. APRN's with a Master's degree in Psychiatric Nursing or with a Master's degree in Nursing Science, prescribing authority and five years of experience with psychiatric patients can provide Initial Psychiatric Assessments at the discretion and under the supervision of the CMHC Medical Director or designated Physician at the CMHC.
- A Psychologist must possess a doctoral degree from an accredited university or college, and be licensed in South Carolina in the clinical, school or counseling areas.
- A Physician's Assistant (PA) must be licensed in South Carolina with the completion of an educational program for PAs approved by the Commission on Accredited Allied Health Education Programs.
- A Social Worker must possess a Master's degree in Social Work from an accredited university or college and be licensed by the State Board of Social Work Examiners.

- A Clinical Chaplain must possess a Master of Divinity from an accredited theological seminary and have two years of pastoral experience as a priest, minister or rabbi and one year of Clinical Pastoral Education that includes a provision for supervised clinical services.
- A Mental Health Counselor must possess a Master's or doctoral degree from a program that is primarily psychological in nature from an accredited university or college (e.g., counseling, guidance or social science equivalent).
- A MH Professional with a Master's equivalent must possess a Master's degree in a closely related field that is applicable to the bio-psycho-social treatment of the mentally ill. Included in this category are those appropriate Ph.D. candidates who have bypassed the Master's degree but have more than enough hours to satisfy a Master's requirement.

Other Qualified Professionals

The following qualified professionals may provide Community MH Services as outlined in the individual service standards and in accordance with State Law and their respective scope of practice:

- An RN must be licensed in South Carolina and at a minimum must possess an Associate's Degree in Nursing from a Board-approved Nursing education program and one year of experience working with the population to be served.
- A Licensed Practical Nurse (LPN) must be licensed in South Carolina with the completion of an accredited program of Nursing approved by the Board of Nursing and one year of experience working with the population to be served.
- A Non-MH Professional must possess a Bachelor's degree from an accredited university or college; or must have three years' experience in the direct care of persons with serious mental illness. They must also have completed an approved curriculum program as specified by the authorizing Community MH Service Provider.

STAFF QUALIFICATIONS

Psychiatric Diagnostic Assessments (PDAs)

PDA with Medical Services - Physician, PDA with Medical Services - APRN, PDA with Medical Services - PA, and PDA with Medical Services - Telepsychiatry

Any Physician, APRN or PA who is deemed suitable under the provider qualification's provisions may render PDA services.

APRN and Initial Psychiatric Assessments

A licensed APRN with a Master's degree in Psychiatric Nursing or with a Master's Degree in Nursing Science, prescribing authority and five years' experience with psychiatric patients may provide initial PDA at the discretion and under the supervision of the CMHC Medical Director or designated Physician at the CMHC.

- **PA and Initial Psychiatric Assessments**

A PA must be licensed in South Carolina with the completion of an educational program for PAs approved by the Commission on Accredited Allied Health Education Programs with prescribing authority and five years' experience with psychiatric patients may provide initial PDA at the discretion and under the supervision of the CMHC Medical Director or designated Physician at the CMHC.

- **Telepsychiatry**

When provided by a Physician, APRN or PA, the PDA can be rendered via interactive telecommunication' all other requirements must be met to render this service.

Injectable Medication Administration (MED. ADM.)

A Physician licensed to practice medicine in the State may render Medication Administration Services. An RN, LPN or licensed PA under the supervision of a Physician or APRN may also render this service. However, when an RN, LPN or PA renders this service, the supervising Physician must be accessible in case of an emergency.

Nursing Services (NS)

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

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

Crisis Intervention (CI) Services

CI services must be rendered by an MHP or an RN within their scope of practice.

MH Assessment by Non-Physician (ASSMT)

Assessment services must be rendered by an MHP. Other qualified professional staff time, if used while assisting the MHP, may be added to the MHP's bill time when the other qualified professional participates in the evaluation process; staff time includes only face-to-face service time.

Individual Psychotherapy (IND. TX.)

Psychotherapy must be rendered by an MHP.

Family Psychotherapy (FAM. TX.)

FP must be rendered by an MHP.

Group Psychotherapy (GP. TX.)

Group Psychotherapy must be rendered by an MHP.

Multiple Family Group Psychotherapy (MFGP)

MFGP must be rendered by an MHP.

Behavioral Health Screening (BHS)

BHS must be provided by qualified clinical professionals who have been specifically trained to review the screening tool and determine the level of referral.

MH SPD by Non-Physician

A Physician, MHP or a RN may render this service.

SPD - Interdisciplinary Team Conference with Beneficiary/Family

A Physician, a Licensed Practitioner of the Healing Arts (LPHA), Master's level staff or Licensed Baccalaureate Social Worker (LBSW) along with other entities or support teams and the beneficiary/collateral may participate in this service.

SPD - Interdisciplinary Team Conference without Beneficiary/Family

A Physician, LPHA, Master's level staff or LBSW along with other entities or support team may participate in this service.

Medical Evaluation and Management for Established Patients

A Physician/Psychiatrist, APRN/Psychiatric Nurse Practitioner or PA may render this service.

Staff-to-Beneficiary Ratio

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

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

4

COVERED SERVICES AND DEFINITIONS

Psychiatric Diagnostic Assessments (PDAs)

PDA with Medical Services - Physician, PDA with Medical Services - APRN, PDA with Medical Services - PA, and PDA with Medical Services - Telepsychiatry

PDA with medical services are face-to-face clinical interactions between a beneficiary and a Physician or APRN, or via Telepsychiatry to assess or monitor the beneficiary's psychiatric and/or physiological status for one or more of the following purposes:

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

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

Injectable Medication Administration (MED. ADM.)

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

Service Provision

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

Nursing Services (NS)

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

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

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

- Assess the need for beneficiaries to see the Physician.
- Determine the overt physiological effects related to the medication(s).
- Determine psychological effects of medications.
- Monitor beneficiaries' compliance to prescription directions.
- Educate beneficiaries as to the dosage, type, benefits, actions and potential adverse effects of the prescribed medications.
- Educate beneficiaries about psychiatric medications and substance abuse in accordance with nationally accepted practice guidelines.

Special Restrictions

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

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

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

Crisis Intervention (CI) Service

CI is a face-to-face or telephonic, time-limited, intensive therapeutic intervention with the beneficiary provided by an MHP or RN.

Face-to-face interventions are intended to:

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

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

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

Special Restrictions

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

MH Assessment by Non-Physician (ASSMT)

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

- The nature of the beneficiary's problems.
- Factors contributing to those problems.

- The beneficiary's strengths, abilities and resources to help solve the problems.
- One or more of the beneficiary's diagnoses.
- The basis upon which to develop a IPOC for a beneficiary.

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

The initial Clinical Assessment or comprehensive bio-psychosocial examination must be completed for all beneficiaries within the first three non-emergency visits. The initial Clinical Assessment or bio-psychosocial examination are provided to evaluate a beneficiary's mental condition, establish medical necessity, and, based on their diagnosis, determine the appropriate treatment.

Service Provision

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

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

Assessment Activities

The following activities are considered an assessment:

- Initial Clinical Assessment or Comprehensive Bio-psychosocial Evaluation that is conducted at the beginning of treatment when a beneficiary first request services:

- It serves as the basis for the IPOC and includes a clinical history, as well as any substance abuse history. The service establishes one or more diagnoses and the medical necessity of treatment.
- Psychological Testing conducted by a psychologist or MHP within the scope of their qualifications:
 - This test is used to assess the beneficiary's interests, ability, personality, or level of function as related to the medical and/or psychiatric diagnosis.
- Integrated Substance Use Disorder Assessment that provides the MHP with past patterns of substance use.
- Diagnostic Interview that is conducted at the beginning of treatment or at any other time during treatment as deemed necessary by members of the treatment team:
 - It is used to clarify a diagnosis or diagnoses and plan a course of treatment.

Individual Psychotherapy (IND. TX.)

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

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

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

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

Family Psychotherapy (FAM. TX.)

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

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

FP tends to be short-term treatment, with a focus on resolving specific problems such as eating disorders, difficulties with school, or adjustments such as bereavement or geographical relocation. Treatment should be strengths-based and focused on addressing family dynamics with the goal of reducing and managing conflict. FP promotes and encourages family support in order to enhance the beneficiary's individual and relational functioning. The goal of FP is to help family members recognize and address impairments in functioning, while maintaining a sense of family cohesion.

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

Group Psychotherapy (GP. TX.)

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

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

Group Psychotherapy is intended to help beneficiaries improve and manage their emotions and behaviors. Further, it helps beneficiaries change behavior and learn how to cope with problems in their lives, as well as encouraging personal development through the dynamics generated by the group.

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

Special Restrictions

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

Staff-to-Beneficiary Ratio

Group Psychotherapy requires one clinician and no more than eight beneficiaries in the group session. The ratio count applies to all beneficiaries receiving services by a provider regardless of whether or not the beneficiary is Medicaid eligible.

Multiple Family Group Psychotherapy (MFGP)

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

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

Staff-to-Beneficiary Ratio

MFGP requires one clinician and a minimum of two family units (a minimum of four individuals) and a maximum of up to eight individuals which includes the beneficiaries and their families.

Behavioral Health Screening (BHS)

The purpose of this service is to provide early identification of behavioral health issues and to facilitate appropriate referral for a focused assessment and/or treatment. BHS is a process designed to quickly assess the severity of behavioral health issues and/or substance use and to identify the appropriate level of treatment for individuals who have and/or are at risk of developing a behavioral health or substance use problem.

This service requires completion of a valid, brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized, South Carolina Department of Health and Human Services (SCDHHS) approved tool, through interviews or self-report. Some of the common tools used for screenings are GAIN, AUDIT, ASSIST, DAST, ECBI, SESBI, CIDI. Screenings should be scored utilizing the tool's standardized scoring methodology and referrals made based on the interpretation of the results.

Screenings should focus on patterns of behavior and associated factors such as legal problems, MH status, educational functioning and living situation. The beneficiary's awareness of the problem, feelings about his or her behavior, MH or substance use and motivation for changing behaviors may also be integral parts of the screen. Prior to the screening, attempts should be made to determine whether another screening had been conducted in the last 30 days. If a recent screening has been conducted, efforts should be made to access those records. A screening should be repeated, only if a significant change in behavior or functioning had been noted.

This screening creates a professional, helping atmosphere while gaining beneficiary information that will be used to make an appropriate referral, utilizing minimal beneficiary/staff time. The service is intended to encourage individuals to change their behavior and refers them for further assessment and/or treatment as appropriate.

A positive screen results in a brief intervention or a referral for behavioral health or substance use treatment.

MH SPD by Non-Physician

MH SPD by Non-Physician is a face-to-face or telephonic interaction between a Physician and a MHP or RN to jointly assess the beneficiary's mental and physical strengths, weaknesses, social history and support systems. The purpose of this service is to develop an individualized IPOC for the beneficiary, based on the beneficiary's needs, goals and objectives and identify appropriate treatment or services needed by the beneficiary to meet the goals.

Service Content

MH SPD by Non-Physician is the joint interaction between a Physician and MHP or a Physician and a RN, designed to:

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

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

The MHP and/or RN must provide multidisciplinary input and assure effective linkage and continuity of care.

SPD - Interdisciplinary Team

The purpose of this service is to allow the interdisciplinary team the opportunity to discuss and or review the beneficiary's needs in collaboration and develop an IPOC. The interdisciplinary team will establish the beneficiary's goals, objectives and identify appropriate treatment or services needed by the beneficiary to meet those goals. SPD assists beneficiaries and their families in planning, developing and choosing needed services.

SPD is interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop an IPOC based on the assessed needs, physical health, personal strengths, weaknesses, social history, support systems of the beneficiary and to establish treatment goals and treatment services to reach those goals.

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

An interdisciplinary team is typically composed of the beneficiary, his or her family and/or other individuals significant to the beneficiary, treatment providers and care coordinators.

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

When there are multiple agencies or providers involved in serving the beneficiary, SPD should be conducted as a team process with the beneficiary. This treatment planning process requires meeting with at least two other health and human service agencies or providers to develop an individualized, multi-agency service plan that describes corresponding needs of the beneficiary and identifies the primary or lead provider for accessing and/or coordinating needed service provision.

Multi-agency meetings may be face-to face or telephonic and only billable when the discussion focuses on planning and coordinating service provision for the identified beneficiary.

SPD - Interdisciplinary Team - Conference with Beneficiary/Family

The purpose of this service is to allow the Physician, LPHA, Master's level staff or LBSW to review with other entities or support teams. In addition, this service will provide the interdisciplinary team the opportunity to discuss issues that are relevant to the needs of the beneficiary with the beneficiary or family member being present. Effective service planning should include representation from all systems of support in which the beneficiary is engaged.

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

on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

The Physician, LPHA, Master's level or LBSW must sign the final document.

SPD Interdisciplinary Team - Conference without Beneficiary/Family

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

Medical Evaluation and Management for Established Patient

For more information regarding medical evaluation and management for established patients please refer to the Physicians Services Manual.

Medical Management Only (MMO)

MMO is a level of care provided to beneficiaries who, due to their level of functioning and psychiatric stability, do not require ongoing psychotherapeutic intervention. Beneficiaries who are eligible for MMO require only the prescription of appropriate medications and continued monitoring for side effects. Based on the judgment of the Physician or APRN, identified beneficiaries will be managed by medical staff. Exceptions to this requirement are crisis situations when the beneficiary may be seen by a qualified MHP and beneficiaries receiving Targeted Case Management. Services may be provided by Physicians, APRNs, RNs, PAs and LPNs. The Physician or APRN must determine that a beneficiary is appropriate for MMO level of care.

Beneficiaries meeting MMO criteria, as determined by the Physician or APRN, may only receive the following services:

- NS
- MH SPD by Non-Physician
- Injectable Medication Administration
- MH Assessment by a Non-Physician
- PDA with medical services
- PDA with medical services - APRN or PA

- CI services (up to two contacts per year)

The Physician, APRN or PA will perform the initial PDA with medical services to determine the appropriateness of the beneficiary for the program (please refer to the description of the service for additional information). The Physician, APRN or PA will assign the beneficiary to the program and prescribe the IPOC to be followed. The Physician, APRN or PA must include a properly completed PMO form in the record that clearly identifies the beneficiary to be appropriate for this level of care. The Physician, APRN or PA must sign and date the PMO. All eligible beneficiaries will be assessed at least annually to determine ongoing appropriateness of this level of care. When assessments are performed by an APRN or PA, the Physician must co-sign the note, thereby authorizing the IPOC and continued participation in this level of care. Thereafter, medical staff may see the beneficiary and must document the beneficiary's need to remain at this level of care. An assessment of each beneficiary in this level of care must be conducted at least annually by a Physician, APRN or PA.

Telepsychiatry

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

Please note the following requirements:

- Reimbursement requires the “real-time” presence of the beneficiary.
- Reimbursement is available for PDA with Medicaid and Medical Evaluation and Management Codes.
- GT modifier must be used when billing the services listed above. GT — Via interactive audio and video telecommunication systems.
- Telepsychiatry reimbursement is not available for the following MH services; injectable, NS, CI Individual Family, Group and Multiple FP and Psychological Testing which require “hands on” encounters, Mental Health Assessment by Non-Physician and SPD.
- All equipment must operate at a minimum communication transfer rate of 384 kbps.

5

UTILIZATION MANAGEMENT

OTHER SERVICE/PRODUCT LIMITATIONS

Service Limit Exception for Fee-for-Service Beneficiaries

Maximum billable units for all services are outlined on the provider portal. There may be clinical exceptions to the service limits when the number of units or encounters allowed may not be sufficient to meet the complex and intensive needs of a beneficiary. On these occasions, requests for frequencies beyond the service limits may be submitted directly to SCDHHS for approval. See below for required documentation for these requests:

- Most recent Diagnostic Assessment.
- Most recent IPOC.
- All CSNs for all services rendered to the beneficiary during the previous 90-days of the request.
- CMHC Fax Cover Sheet for Service Limit Exceptions (if applicable).
- CMHC Exception Request Form.

Requests must be complete and submitted in accordance with the defined sets of documentation requirements noted above. Requests that do not meet all of the requirements will not be processed. A copy of the fax cover sheet and exception request form can be found on the provider portal.

Requests can be submitted to SCDHHS via the following methods:

- Fax: "Attn: CMH Exceptions" to +1 803 255 8204
 - A fax cover sheet must be included with the fax.
- Encrypted email to: behavioralhealth002@scdhhs.gov

SCDHHS will either approve or deny or request additional information within 10 business days of receipt of the request. The provider will be notified in writing if additional information is required. Additionally, should the request be denied, the provider will be notified in writing. The denial letter will explain how the provider may appeal the decision.

Coordination of Care

Coordination of care must occur for beneficiaries who are being served by multiple agencies/providers. During the intake process, each provider is responsible for attempting to identify whether a beneficiary is already receiving treatment from another Medicaid provider and notifying any other involved Medicaid providers of the beneficiary's need for services. Needed services should never be denied to an individual because another provider has been identified as the service provider. Each provider should also notify other involved agencies or providers immediately if an individual in an overlapping situation discontinues his or her services.

6

REPORTING/DOCUMENTATION

DOCUMENTATION REQUIREMENTS

Medical Records

A medical record for each beneficiary must be present that includes sufficient documentation to justify medical necessity and permit a clinician not familiar with the beneficiary to evaluate the course of treatment.

The beneficiary's medical record should contain the following:

- A written comprehensive bio-psycho-social examination or initial clinical assessment conducted by a MHP.
- A PDA with medical services.
- All plans of care, reviews and addenda.
- Physician's orders, laboratory results, lists of medications, and prescriptions (when performed or ordered).
- CSNs.
- Copies of any testing performed on the beneficiary.
- Copies of all written reports.
- Consents and eligibility information, and any other documents relevant to the care and treatment of the beneficiary.

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

Medical records will be kept confidential in conformance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations and safeguarded as outlined in the Provider Administrative and Billing Manual.

Consent to Examinations and Treatment

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

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

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

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

Abbreviations and Symbols

Community MH Service abbreviations on the IPOC and/or CSNs must use only the approved abbreviation for services. Approved abbreviations for services can be found in the “Medicaid Billable Services” chart with the Community MH Services procedure code information on the provider portal. Service providers must maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation.

Legibility

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

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

Error Correction

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

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

Late Entries

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

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

Individualized Plan of Care (IPOC)

The IPOC is a comprehensive plan to improve the beneficiary’s condition developed in collaboration with a beneficiary and/or significant other(s). Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC.

IPOC Requirements

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

- The beneficiary’s name and Medicaid ID number.
- The primary diagnosis that is the basis for the treatment planned, as well as the code and description according to the current edition of the DSM.
- For individuals who have more than one diagnosis regarding MH, substance use, and/or medical conditions, all diagnoses should be recorded.
- Justification for treatment, frequency of services, and continuation of treatment statement based on the diagnosis and needs of the beneficiary.

For individuals who have concurrent substance abuse disorders, the other diagnoses should be integrated into the IPOC. A list of specific goals and objectives, and as appropriate, interventions coordinated with substance abuse service providers, should also be included.

- Authorized treatment process including the following:
 - Goals (stated by the beneficiary as possible) that are relevant to treatment.
 - Objectives that are outcome oriented and individualized.

- Interventions which include a list of specific services used to meet the stated goals and objectives must be included.
 - Services necessary to meet each objective.
 - The appropriate frequency of the services that are required in the IPOC.
 - The frequency of services must be listed on the IPOC. Each service should be listed by its name or approved abbreviation with either a planned frequency or, if allowable, PRN (as necessary for beneficiary needs). Services cannot be listed as both. Services which may be listed as PRN are PDA with medical services, MH Assessment by Non-Physician, Injectable Medication Administration, NS, CI Services and MH SPD by Non-Physician.
 - Expected dates to meet each objective, which should not exceed the duration of the IPOC.
 - The type of staff who will be rendering the service and professional title (MD, MHP, RN, etc.).
- Beneficiary signature (If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC.)
 - The signature(s) and title(s) of the MHP that developed the IPOC.
 - Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The signature of the MHP responsible for the IPOC is required.
 - The Physician/Psychiatrist's signature and date is required to confirm the diagnosis, medical necessity and appropriateness of care.
 - The initial IPOC must be signed by the reviewing Physician within 90 calendar days of a beneficiary's admission to a CMHC.
 - The Physician must sign a continued IPOC immediately after the MHP reviews it and prior to any delivery of services.

Services Required to be Listed on the IPOC

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

- IP
- FP
- GP

- MFGP

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

- Injectable Medication Administration
- MH Assessment by Non-Physician
- PDA
- CI
- MH SPD and SPD - Interdisciplinary Team
- NS

IPOC Due Date

The initial IPOC must be formulated, signed, and dated by the MHP and the reviewing Physician within 90 calendar days from the day a beneficiary enters services at the MH center.

The maximum duration of an IPOC is 12 months from the date of the Physician/Psychiatrist's signature on the IPOC. If the IPOC is reformulated prior to its expiration, the maximum duration is 12 months from the reviewing Physician's signature or the effective date identified by the Physician.

In situations where it appears necessary to continue treatment beyond the initially authorized duration, the current IPOC can be reviewed up to 30 days prior to its expiration date without altering the due date. The Physician must sign and date the IPOC, and then state an effective date, which is presumably consistent with the current IPOC expiration date. Failure to list an effective date will result in the IPOC expiring 12 months from the Physician's signature date and at that time, the MHP should meet with the beneficiary to discuss the continuation of treatment and make the necessary changes on the IPOC.

The initial IPOC must be developed, signed and dated by the MHP and reviewing Physician/ Psychiatrist within 45 calendar days from the day the beneficiary becomes retroactively eligible. A note indicating the date the beneficiary became retroactively eligible should be placed in the medical record.

IPOC Additions or Changes

Services added or frequencies of services changed in an existing IPOC must be signed or initialed and dated by the reviewing Physician. Beneficiaries are not required to have face-to-face contact with Physicians/Psychiatrists for the addition of services or changes in service frequency.

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

Addendum IPOC/Goal Sheet

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

IPOC Reformulation

Upon termination or expiration of the treatment period, the MHP must review the IPOC, preferably with the beneficiary, and evaluate the beneficiary’s progress in reference to each of the treatment objectives. Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. The signature of the MHP responsible for the review is required. The clinician should also assess the need for continued services and the specific services needed based on the progress of the beneficiary. The reformulated IPOC must include the newly recommended services. The Physician signature is required to confirm the diagnosis, medical necessity of the treatment, and the appropriateness of care for recommended services.

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

Progress Summaries

Progress summaries are periodic reviews to evaluate a progress toward the treatment objectives, appropriateness of the services being furnished and need for the continued participation in the Community MH Service Program. A review of the participation in all services must be conducted at least every 90 calendar days from the date begin receiving services, and must be summarized by the MHP and documented in the IPOC Progress Summary Report. The MHP will review the following areas:

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

Clinical Service Note (CSN)

All Community MH Services provided to Medicaid beneficiaries must be documented on a CSN. PDA with medical services rendered by a Physician/Psychiatrist may be documented on a PMO. Each service must be documented on a separate CSN or PMO. CSNs and PMOs must also be typed or handwritten using only black or blue ink, legible and filed in chronological order.

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

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

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

CSN Components

CSNs must document the following:

- Beneficiary name and Medicaid ID.
- The specific service that was rendered (as identified on the IPOC) or its approved abbreviation.
- A pertinent clinical description and delivery of the billable service.
- The date, start time, and bill time that the service was rendered (bill time is defined as time spent face-to-face with beneficiaries providing direct care).
- The duration of the service rendered.
- Services that correspond to billing in type, amount, duration and date.
- The signature, signature date, name, and title of the appropriate service provider and signature date:
 - When two or more staff members write on the same CSN, the individual responsible for that segment must sign each entry.
- The place of service as appropriate for the particular service provided.

The following list provides the codes most commonly used:

- 03 – School

- 11 – Doctor’s Office
 - 12 – Beneficiary’s Home
 - 19 – Off Campus Hospital
 - 21 – Inpatient Hospital
 - 22 – Outpatient Hospital
 - 23 – Emergency Room
 - 51 – Inpatient Psychiatric Facility
 - 53 – CMHC
 - 99 – Other Unlisted Facility
 - For billing purposes, services provided in the beneficiary’s natural/community environment, school, Community Residential Care Facility, Nursing Facility, other approved community MH facility, or other allowable places of service will use the place of service code 99 - Other Unlisted Facility.
- The focus or reason for the session/intervention (this should be related to a treatment objective or goal listed on the IPOC).
 - The intervention(s) provided by the clinician.
 - The response of the beneficiary to the clinician’s intervention(s).
 - The results of tests or measurements, if applicable.
 - The general progress and status of the beneficiary in reference to the treatment goals and objectives.
 - The plan for the next session.

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

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

The CSNs for the services identified below must include the components outlined above in addition to requirements detailed under “Service Documentation” (section below):

- PDA with medical services
- Injectable Medication Administration
- CI
- MH Assessment
- MH SPD by a non-Physician
- SPD - Interdisciplinary Team
- NS
- BHS

The content of the CSNs for these services is detailed under “Service Documentation” within this section.

Generic Notes

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

Referenced Information

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

When a Physician/Psychiatrist renders services to beneficiaries, the documentation on the CSN should reference the PMO.

SERVICE DOCUMENTATION

Psychiatric Diagnostic Assessments (PDAs)

PDA with Medical Services - Physician, PDA with Medical Services - APRN, PDA with Medical Services - PA, and PDA with Medical Services - Telepsychiatry

The Physician, APRN or PA who renders the service must include a properly completed PMO form in the record. The Physician, APRN or PA must sign and date the PMO. A CSN must be entered in the record that references the PMO.

A Community MH Services provider may obtain a copy of a PDA performed by another provider for the purpose of the initial PDA requirement, provided there are no clinical indications that necessitate another PDA. In these cases, under all circumstances, the receiving service provider is responsible for ensuring that beneficiaries receive PDAs as clinically necessary and for Medicaid billing purposes, in accordance with Medicaid requirements.

Injectable Medication Administration (MED. ADM.)

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

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

Nursing Services (NS)

NS are not required to be listed on the IPOC. A CSN will be used to document this service. NS must be entered on the CSN as the service to be rendered.

Medication Monitoring services require that the provider of the service also include the following items in addition to those required in the general CSN requirements:

- The medications the beneficiary is currently taking, or reference to the Physician's order or other document in the medical record that lists all the medications prescribed to the beneficiary.
- The side effects or adverse reactions experienced by the beneficiary.
- Whether the beneficiary is refusing or unable to take medications as ordered, or is compliant in taking medications as prescribed.
- How effective the medication(s) is in controlling symptoms.
- Any issues relating to concurrent substance use, documentation of education to the beneficiary, and support for the rationale for continuing the necessary medication.

Crisis Intervention (CI) Service

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

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

MH Assessment by Non-Physician (ASSMT)

MH Assessment is not required to be listed on the IPOC, but must be documented daily upon contact.

The initial assessment or comprehensive bio-psychosocial examination must be completed within the first three non-emergency visits and must include, at least, the following areas:

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

Integrated Substance Use Disorder Assessment that provide the MHP with past patterns of substance use includes the following:

- When the substance disorder occurred in relation to the MH symptoms.
- The specific abuse or dependence diagnoses.
- An identification of periods of abstinence or reduced use.
- A description of MH symptoms, functioning and treatment.

- Successful substance treatment during those periods.
- The beneficiary's current patterns of use, diagnoses, treatment participation, withdrawal risk, and the impact of substance use on the beneficiary's current MH symptoms.

MH SPD by Non-Physician

The CSN must document the Physician and/or MHP/RN's involvement in the following:

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

The MHP/RN and the Physician are required to sign and date the CSN corroborating the delivery of the service.

SPD - Interdisciplinary Team

The CSN must document the Physician and/or MHP/RN's involvement in the following:

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

The MHP/RN and the Physician are required to sign and date the CSN corroborating the delivery of the service.

Behavioral Health Screening (BHS)

BHSs should be documented upon contact with the beneficiary. The completed screening tool and its interpretation results must be filed in the beneficiary's record within three working days from the date of the service. Documentation must include the outcome of the screening and support the number of units billed.

Medical Management Only (MMO)

Participation in the MMO level of care must be clearly documented in the beneficiary's medical record. In addition to general documentation requirements and those specified in the individual service standard, the PMO or the CSN must contain the following:

- Intervening services since the last PDA with medical services.
- Assessment of whether the beneficiary is meeting his or her goal(s) and any desire to change the goal(s). Examples of goals may include: "take my medicine and stay out of the hospital," "continue to work," or "learn more about my medicine".
- An indication of any change in the beneficiary's goal(s) and that the beneficiary verbally agrees to continue this level of care.
- Justification of treatment.

The beneficiary's progress and any significant changes in the beneficiary's treatment must be documented in the beneficiary's record every 90 days. The summary may be documented in the PMO note or a CSN. If a beneficiary has not been seen by a Physician, an APRN or a RN during the preceding 90-day period, and does not have sufficient clinical information to evaluate the treatment prescription, a progress summary must be completed during the first contact thereafter. If the Physician or APRN determines that the beneficiary needs additional Community MH Services other than those allowed under this level of care, the beneficiary no longer meets the MMO criteria and all Medicaid standard Community MH Services requirements must apply.

All Medicaid billing requirements as set forth in the "Billing Guidance" section of this manual must be maintained.

7

BILLING GUIDANCE

Medicaid Community MH Services are billed in units of minutes or by encounter, depending on the service. Units billed must be substantiated by the clinical documentation. If a service is billed by encounter, only one encounter per day is billable (excluding Group Psychotherapy).

Each procedure code has a unit time and maximum frequency limit. Services billed in units must, not exceed the maximum number of units allowed per day. Service time is defined as the actual time the service provider spends “face-to-face” with beneficiaries and/or time spent working on behalf of beneficiaries while providing a Community MH Service. Service time does not include any “non-billable” activities, to include preparation time and travel time. The heading “Non-Billable Medicaid Activities” below outlines additional activities that fall under this category.

In all instances, service documentation must justify the number of units billed. See the documentation guidance set forth in this manual.

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

NON-BILLABLE MEDICAID ACTIVITIES

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

- Travel time.
- Attempted phone calls, home visits and face-to-face contacts.
- Record audits.
- Completion of any specially requested information regarding beneficiaries from the State office or from other agencies for administrative purposes.
- Recreation or socialization with a beneficiary.
- Documentation of service notes.
- Completion of Management Information System reports and monthly statistical reports.

- Unstructured beneficiary time (inactivity, free, and unstructured time may be necessary for a beneficiary, but is not part of a billable service).
- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (GED, Adult Development), or tutorial services in relation to a defined education course.
- Education interventions that do not include individual process interactions.
- Filing and mailing of reports.
- Medicaid eligibility determinations and redeterminations.
- Medicaid intake processing.
- Prior authorization for Medicaid services
- Required Medicaid utilization review.
- Early and Periodic Screening, Diagnostic, and Treatment administration.
- “Outreach” activities in which an agency or a provider attempts to contact potential Medicaid recipients.
- Participation in job interviews.
- The onsite instruction of specific employment tasks.
- Staff supervision of actual employment services.
- Assisting beneficiaries in obtaining job placements.
- Assisting beneficiaries in filling out applications (i.e., job, disability, etc.).
- Assisting beneficiaries in performing the job or performing jobs for beneficiaries.
- Drawing beneficiary’s blood and/or urine specimen, and/or taking the specimen(s) to the lab.
- Visiting beneficiaries while in another MH service program, unless for a special treatment activity.
- Retrieving medications for a beneficiary kept at the CMHC and handing out prescriptions or medications.
- Scheduling appointments with the Physician or any other clinician at the CMHC.

- Providing non-authorized services to children placed in high or moderate management group homes.
- Staffing between clinicians in the same clinical unit within the MH center for the purpose of supervision.
- Transporting beneficiaries to appointments or waiting for beneficiaries in waiting rooms.
- Respite care.