

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

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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).

The South Carolina Department of Health and Human Services (SCDHHS) 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 behavioral health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as interventions for which systematic empirical research has provided evidence of statistically significant effectiveness.

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

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/Psychiatrist.

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

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

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

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).

Medical Necessity

All Medicaid beneficiaries admitted to a MH facility are eligible to receive Psychiatric Diagnostic Assessments (PDAs) 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. The PDA and/ or IPOC can be used to determine medical necessity.

If a psychiatric diagnostic assessment 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/ Psychiatrist, APRN, or PA within 90 calendar days.

All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for ongoing treatment services. A Physician/ Psychiatrist, APRN, or PA must certify that the beneficiary meets the medical necessity criteria for each service. If the Medicaid recipient is in fee-for-service (FFS) Medicaid, the following guidelines must be used to confirm medical necessity. The determination of medically necessary treatment must be:

- Based on information provided by the beneficiary, the beneficiary's family, and/ or collaterals who are familiar with the beneficiary.
- Based on current clinical information.
- Made by the Physician/Psychiatrist, APRN, or PA as evident by the PDA or signature on the IPOC.

SERVICE SPECIFIC MEDICAL NECESSITY CRITERIA

Injectable Medication Administration (MED. ADM.)

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

Nursing Services (NS)

All Medicaid beneficiaries who Physicians/Psychiatrists 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.

Psychological Testing and Evaluation (PTE)

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

Individual Psychotherapy (IND. TX.)

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

Group Psychotherapy (GP. TX.)

All beneficiaries who Physicians/Psychiatrists, 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/Psychiatrists, 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.

Psychosocial Rehabilitation Services (PRS)

Admission Criteria for Adults (age 22 and older)

A–G must be met to satisfy criteria for admission into PRS services:

A. The beneficiary has received a DA, and has been diagnosed with a SPMI, which includes one of the following diagnoses: bipolar disorder, major depression, a diagnosis within the spectrum of psychotic disorders and/or SUD.

B. The beneficiary has a SPMI and/or SUD and the symptom-related problems interfere with the individual's functioning and living, working and/or learning environment.

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

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

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

i. Is not functioning at a level that would be expected of typically developing individuals their age.

- ii. Is at-risk of psychiatric hospitalization, homelessness, and/or isolation from social supports due to the beneficiary's SPMI and/or SUD.
 - iii. Exhibits behaviors that require repeated interventions by the mental health, social services and/or judicial system.
 - iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.
- F. Beneficiary is expected to benefit from the intervention and identified needs would not be better met by any other formal or informal system or support.
- G. The service is recommended on the IPOC and authorized by the psychiatrist/ APRN.

Continued Service Criteria for Adults (age 22 and older)

A–E must be met to satisfy criteria for continued PRS services:

- A. The beneficiary continues to meet the admission criteria.
- B. There is documentation from the Provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the service description.
- C. Beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from PRS, which remains appropriate to meet the beneficiary's needs.
- D. The beneficiary and others identified by the treatment plan process are active beneficiaries in the creation of the treatment plan and discharge plan and are actively participating in treatment. The beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.
- E. The desired outcome or level of functioning has not been restored and/or sustained over the time frame outlined in the beneficiary's IPOC.

Admission Criteria for Children (age 0–21)

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

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

functional impairment that interferes with three or more of the following areas: daily living, personal relationships, school/work settings and/or recreational setting.

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

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

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

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

G. The service is recommended on the IPOC and authorized by the psychiatrist/ APRN.

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

Continued Service Criteria for Children (ages 0–21)

A-E must be met to satisfy criteria for continued PRS services:

- A. The beneficiary continues to meet the admission criteria.
- B. There is documentation from the Provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the service description.
- C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from PRS, which remains appropriate to meet the beneficiary's needs.
- D. The family/caregiver/guardian, and others identified by the treatment plan process are actively participating in treatment. The beneficiary's designated others and treatment team agrees on treatment goals, objectives and interventions.

E. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's IPOC.

Behavior Modification (B-MOD)

Admission Criteria for Children and Adolescents (ages 0–21).

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

A. The beneficiary is under 22 years of age.

B. The beneficiary has received a DA, which includes a current DSM diagnosis that requires and will respond to therapeutic interventions and which documents the need for B-MOD.

C. The beneficiary has a SPMI, SED and/or SUD, and must be engaging in one or more of the following behaviors: physical aggression, verbal aggression, object aggression, and/or self-injurious behavior that presents risk of harm to self or others (children under the age of seven may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM).

D. The beneficiary's behaviors interfere with three or more of the following areas: daily living, personal relationships, school/work settings and/or recreational setting.

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

i. Is not functioning at a level that would be expected of typically developing individuals their age.

ii. Is deemed to be at-risk of psychiatric hospitalization or out-of-home placement.

iii. In the last 90 days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.

iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.

F. The beneficiary's behavioral needs require interventions to decrease identified behaviors and to facilitate the beneficiary's success in his or her home and community.

G. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the beneficiary's needs identified in the DA and IPOC, for the purpose of maintaining progress during and after treatment.

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

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

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

- i. For beneficiaries from birth until 1.5 years, has scored in the 81st percentile or above on the PSI.
- ii. For beneficiaries ages 1.5–5 years, has scored in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the CBCL.

Continued Service Criteria for Children and Adolescents (ages 0–21)

A–E must be met to satisfy criteria for continued B-MOD services:

- A. The beneficiary continues to meet the admission criteria.
- B. There is documentation from the Provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals stated in the beneficiary's IPOC. The progress summary must specifically capture progress on each goal listed on the IPOC.
- C. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's IPOC.
- D. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from B-MOD, which remains appropriate to meet the beneficiary's needs.
- E. The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Family Support (FS)

Admission Criteria

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

- A. The beneficiary is under the age of 22.
- B. The beneficiary has received a DA, which includes a current DSM diagnosis and specific clinical needs that will respond to therapeutic interventions and which documents the need for FS.
- C. The beneficiary has a SPMI, SED and/or SUD, and the symptom-related problems interfere with the individual's functioning, living, working, and/or learning environment. Children under the age of seven may qualify for these services if they are diagnosed with an applicable Z-code, per the current DSM.

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

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

i. Is not functioning at a level that would be expected of typically developing individuals their age.

ii. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement.

iii. In the last 90-days, exhibited behavior that resulted in at least one intervention by crisis response, social services or law enforcement.

iv. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior.

F. Family/caregiver agrees to be an active beneficiary in treatment; FS services should provide opportunities for the family/caregiver to acquire and improve skills needed to better understand and care for the needs of the beneficiary (e.g., managing crises, providing education about the beneficiary's diagnosis).

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

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

Continued Service Criteria

A–E must be met to satisfy criteria for continued FS services:

A. There is documentation from the Provider that the beneficiary is receiving the scope and intensity of services required to meet the program goals specific to the treatment needs stated in the beneficiary's IPOC.

B. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the beneficiary's IPOC.

C. The beneficiary has shown improvement in functioning in at least two of the following areas: daily living, personal relationships, school/work settings, and/or recreational setting, and is expected to continue to benefit from FS, which remains appropriate to meet the beneficiary's needs.

D. The beneficiary continues to meet the admission criteria.

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

goals, objectives and interventions.

Peer Support Services (PSS) *Available for DMH only*

Admission Criteria

- Beneficiary has been diagnosed with a SPMI, and/or a SUD.
- Beneficiary meets two or more of the following criteria as a result of the mental illness:
 - Has had significant difficulty independently and consistently accessing behavioral health services (e.g., relies on emergency department services, has had two or more inpatient admissions over the last year),
 - Is being released from incarceration, or being discharged from a hospital or facility-based program,
 - Has had severe functional impairment that interferes with activities of daily living, including hygiene, nutrition, finances, home maintenance, child care, or difficulties with other community service needs, such as housing, transportation or legal issues,
 - Has experienced significant challenges meeting educational or employment goals,
 - Lives in unsafe or temporary housing,
 - Does not have sufficient family or other social support, or the supports that are in place are insufficient to help ameliorate or manage his or her condition.
- Beneficiary is assessed to be at low risk of serious harm to self or others.
- Beneficiary has demonstrated a need for assistance with community living and the service is recommended by a LPHA acting within the scope of his/her professional licensure.
- The service, including frequency of the service, is recommended as a result of the DA,
- Beneficiary has an IPOC that addresses mental health concerns and any co-occurring general medical condition,
- The person is expected to benefit from the intervention and needs would not be better clinically met by any other formal or informal system or support.

Continued Service Criteria

- Beneficiary is eligible to continue this service if:
 - The beneficiary continues to meet admission guidelines for this level of care, or
 - The IPOC, current or revised, can be reasonably expected to improve the presenting mental illness, and objective behavioral indicator of improvement are documented in the beneficiary's progress notes, or

- Beneficiary is actively involved in the Peer Support process, and participating in interventions, or
- Beneficiary does not require a higher level of care, and no other intervention level would be appropriate, or
- Beneficiary is making some progress, but the interventions need to be modified so that greater gains can be achieved.

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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/Psychiatrist Direction and Supervision for Clinic Services

Clinic services require that services be provided to beneficiaries under the direction of a Physician/Psychiatrist, whether or not the clinic itself is administered by the Physician/Psychiatrist. That is, the Physician/Psychiatrist 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/Psychiatrist does not have to be on the premises when his or her beneficiary is receiving covered services, the Physician/Psychiatrist 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/Psychiatrist 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/Psychiatrists should prescribe the type of care to be provided and periodically review the need for continued care.

Physicians/Psychiatrists 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. An APRN or PA signature can be used in place of a Physician/Psychiatrist if the practice agreement between the APRN/PA and the Physician/Psychiatrist authorizes this practice.

The Physician/Psychiatrist/APRN/PA must evaluate all beneficiaries’ needs for continued service at least once every 12 months. This evaluation will be confirmed by the Physician/Psychiatrist/APRN/PA’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.
- The Peer Support Specialist (available for DMH only) must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a certification training program, and he or she must be 18 years of age or older.

Peer Support Specialist must meet the following qualifications:

- Have had a diagnosis of behavioral health or SUD, as defined by the American Psychiatric Association's DSM and received treatment for the disorder.
- Self-identify as having had a behavioral health and/or SUD.
- Be in a recovery program.

Peer support specialists must have the following experience:

- The ability to demonstrate recovery expertise including knowledge of approaches to support others in recovery and dual recovery, as well as the ability to demonstrate his or her own efforts at self-directed recovery.
- One year of active participation in a local or a national mental health and/or substance use consumer movement, which is evidenced by previous volunteer service or work experience.
- Peer support Providers must successfully complete a precertification program that consists of:
 - Forty hours of training including recovery goal setting, wellness recovery plans and problem-solving, person-centered services and advocacy.
 - A minimum of 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training. All trainings must be approved by SCDHHS or other authorized entity.

Supervision for PSS

Supervision must be provided by a master's level staff or higher or a bachelor's level staff with a CAC II certification. The supervisor must be available to supervise the peer support specialist and ensure that he or she provides services in a safe, efficient manner in accordance with accepted standards of clinical practice and certification and/or training standards as approved by SCDHHS. The supervisor is required to chair regularly scheduled staff meetings with the peer support specialists to discuss administrative and individual treatment issues. At a minimum, staff meetings shall occur monthly. Staff meetings are not separately billable under another clinical service, unless the staffing includes a Physician consultation. The supervisor shall review services that address specific program content and assess the beneficiary's needs. Issues relevant to the individual beneficiary will be documented in a staff note and noted in the beneficiary's medical record.

STAFF QUALIFICATIONS

Psychiatric Diagnostic Assessments (PDAs)

PDA with Medical Services – Physician/Psychiatrist, PDA with Medical Services - APRN, PDA with Medical Services - PA, and PDA with Medical Services - Telepsychiatry

Any Physician/Psychiatrist, 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/Psychiatrist 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/Psychiatrist at the CMHC.

- **Telepsychiatry**

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

Nursing Services (NS)

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

An RN or a Licensed Pharmacist, under the supervision of a Physician/Psychiatrist or an APRN, may render medication-monitoring activities. The Physician/Psychiatrist 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.

Psychological Testing and Evaluation (PTE)

PTE must be provided by qualified Clinical Psychologists operating within their scope of practice, as allowed by State Law and who have been specifically trained to provide and review the assessment tool and make a clinically appropriate referral. When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and the level of impairment, a psychologist must provide the diagnosis.

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/Psychiatrist, MHP or a RN may render this service.

SPD - Interdisciplinary Team Conference with Beneficiary/Family

A Physician/Psychiatrist, 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/Psychiatrist, 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.

Psychosocial Rehabilitation Services (PRS)

PRS must be rendered by a Physician/Psychiatrist, a Licensed Practitioner of the Healing Arts (LPHA), Master's level staff, Registered Nurse, Licensed Baccalaureate Social Worker (LBSW), or a Non-MH Professional.

A Bachelor's Degree or above is required to render PRS.

Behavioral Modification (B-MOD)

B-MOD must be rendered by a Physician/Psychiatrist, a Licensed Practitioner of the Healing Arts (LPHA), Master's level staff, Registered Nurse, Licensed Baccalaureate Social Worker (LBSW), or a Non-MH Professional.

A Bachelor's Degree or above is required to render B-MOD.

Family Support (FS)

FS must be rendered by a Physician/Psychiatrist, a Licensed Practitioner of the Healing Arts (LPHA), Master's level staff, Registered Nurse, Licensed Baccalaureate Social Worker (LBSW), or a Non-MH Professional.

A Bachelor's Degree or above is required to render FS.

Peer Support Services (PSS) Available for DMH only

PSS **must** be rendered by a Certified Peer Support Specialist.

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.

The following services have **only** a Staff-to-Beneficiary ratio of one-to-one:

- PDAs
- Injectable Medication Administration (MED ADM)
- Nursing Services (NS)
- Crisis Intervention (CI) Services
- MH Assessment by Non-Physician (ASSMT)
- Psychological Testing and Evaluation (PTE)
- Individual Psychotherapy (IND TX)
- Family Psychotherapy (FAM TX)
- Behavioral Health Screening (BHS)
- MH SPD by Non-Physician
- SPD-Interdisciplinary Team Conference w/ Beneficiary/ Family
- SPD-Interdisciplinary Team Conference w/out Beneficiary/ Family
- Medical Evaluation and Management for Established Patients
- Behavior Modification (B-MOD)
- Family Support (FS)

Two services, Psychosocial Rehabilitation Services (PRS) and Peer Support Services (PSS) can be provided one-on-one **OR** in group settings. When done in a group setting, the Staff-to-Beneficiary ratio is as follows:

PRS

PRS can be provided in small groups of no more than one staff to eight (1:8) adult beneficiaries and no more than one staff to eight (1:8) child and adolescent beneficiaries regardless of the payer source of the beneficiaries in the group. Only staff who meet the staff qualification requirements for

PRS are considered for the 1:8 ratio. For example: If a group consists of nine children, two staff must be present and actively rendering the service. If two staff are not present and actively rendering the service, the Provider cannot be reimbursed for the service as the ratio exceeds 1:8.

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

PSS

When rendered in groups, PSS shall not exceed one professional per eight beneficiaries.

The following two services are **only** provided in group settings with the Staff-to-Beneficiary ratio as follows:

Group Therapy (GR TX)

Group Psychotherapy requires one clinician and no more than ten beneficiaries in the group session. However, when provided in a school setting, the ratio should be 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 Therapy (MFGT)

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

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COVERED SERVICES AND DEFINITIONS

Psychiatric Diagnostic Assessments (PDAs)

PDA with Medical Services – Physician/Psychiatrist, 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/Psychiatrist 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/Psychiatrist. 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/Psychiatrist or APRN order documented on a PMO. The Physician/Psychiatrist 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.

Neuropharmagen® Genomic Testing (PGx)

Neuropharmagen® is a pharmacogenomic test (PGx) that allows providers to see how patients would interact with different medications for mental health diagnoses without going through a trial-and-error process to determine optimal medication and dosage. Adult beneficiaries with full benefit are eligible to receive this test.

Service Provision

Prior authorization must be obtained for this genomic test and must meet the following criteria:

- Test must be ordered by a board-certified psychiatrist or by a psychiatrist extender (psychiatric physician assistant, psychiatric nurse practitioner) under the supervision of a board-certified psychiatrist; AND
- Patient must have one of the following mental health conditions: generalized anxiety disorder, major depressive disorder, obsessive compulsive disorder, bipolar disorder, or schizophrenia; AND
- The Medicaid member must meet at least one of the following:
 1. Has experienced a trial and failure of two previous psychoactive drugs for the mental health condition being treated. OR
 2. Is currently taking more than two medications to treat the mental health condition.

The prior authorization form for this test can be found in the Forms section of this manual.

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/Psychiatrist.
- 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. When provided in a school setting, two CI services are allowed prior to medical necessity being determined. After the second CI, medical necessity needs to be determined before rendering any other service.

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 requests 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.

Psychological Testing and Evaluation (PTE)

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

for professional practice, and may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, motivations, and/or personality characteristics, as well as use of other non-experimental methods of evaluation.

PTE may be used for the purpose of diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning.

Prior to administering a battery of tests, it is important for the evaluating psychologist to review relevant clinical information from the most recent DA and/or medical, psychiatric and educational evaluations. The psychologist must consider historical clinical information, identify specific referral questions to be addressed by the evaluation, and determine that the clinical questions cannot be addressed through a diagnostic interview with a skilled clinician.

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

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.

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.

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, and 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/Psychiatrist and a MHP or RN to jointly assess the beneficiary's mental and physical strengths, weaknesses, social history and support systems. This service can also be done between an APRN/PA and a MHP or RN if the APRN/PA practice agreement allows for it. 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/Psychiatrist/APRN/PA and MHP or a Physician/Psychiatrist/APRN/PA 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/Psychiatrist/APRN/PA 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/Psychiatrist, 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/Psychiatrist, LPHA, master's level qualified clinical professional, or LBSW must sign the final document.

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

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 or are receiving the psychotherapeutic interventions from outside providers, such as in a school or clubhouse setting. 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/Psychiatrist/APRN or PA, 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/Psychiatrists, APRNs, RNs, PAs and LPNs. The Physician/Psychiatrist/APRN or PA must determine that a beneficiary is appropriate for MMO level of care.

Beneficiaries meeting MMO criteria, as determined by the Physician/Psychiatrist/APRN or PA, 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/Psychiatrist, 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/Psychiatrist, APRN or PA will assign the beneficiary to the program and prescribe the IPOC to be followed. The Physician/Psychiatrist, 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/Psychiatrist, 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. 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/Psychiatrist, APRN or PA.

Telepsychiatry

Telehealth Overview

The Centers for Medicare and Medicaid Services (CMS) defines telehealth as the use of electronic information and telecommunications technologies to extend care when a provider and a patient are not in the same place at the same time.

Services rendered via telehealth may be rendered synchronously or asynchronously using a telecommunication system (audio/video) that permits interactive communications between a provider and a patient. The telecommunication system must be Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant. SCDHHS only reimburses for services conducted synchronously, using both audio and video components unless otherwise specified.

Services rendered via telehealth are not an addition to Medicaid-covered services but a mode of delivery of certain covered services. Quality of health care must be maintained regardless of the mode of delivery.

Telehealth Definitions:

Synchronous Telehealth

Synchronous telehealth is real-time, audio-video communication that connects physicians and patients in different locations (referring site and consulting site).

Referring Provider

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment.

Consulting provider

The consulting provider is the provider who evaluates the beneficiary via telehealth upon the recommendation of the referring provider.

Eligible Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for covered Medicaid services via telehealth in accordance with SCDHHS coverage policies and the provider's scope of practice. Both the referring and the consulting providers must be enrolled in the South Carolina Medicaid program.

Referring Sites

A referring site (also called the patient site) is the location of an eligible Medicaid beneficiary at the time of the telehealth session. Medicaid beneficiaries are eligible for services via telehealth only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters must be a knowledgeable person on how the equipment works and able to provide clinical support if needed during a session.

Covered referring sites are:

- The office of a qualified practitioner defined as a physician, NP, CNM, PA, or LIP
- Hospital (inpatient and OP)
- RHCs
- FQHCs
- Public Schools
- Patient home

Consulting Sites

A consultant site (also called the distant site) is the site at which the provider is located at the time of the telehealth session. The provider performing the medical care must be enrolled in the South Carolina Medicaid program and provide services in accordance with the licensing board and their scope of practice.

Practitioners at the distant site qualified to furnish services via telehealth are:

- Physicians
- NPs
- PAs

Covered Services

Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations and testing, delivered via a telecommunication system. A licensed physician, NP, PA, licensed psychologist, licensed professional counselor, licensed independent social worker, and licensed marriage and family counselor may provide telepsychiatry services.

Office and OP visits that are conducted via telehealth are counted towards the applicable benefit limits for these services.

Healthy Connections Medicaid allows the service to be delivered via telehealth when the service meets the following criteria:

- The beneficiary must be present and participating in the telehealth visit, unless otherwise specified in the procedure code description.
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used, permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted.
- The telehealth equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Any staff involved in the telehealth visit must be trained in the use of the telehealth equipment and competent in its operation.

- A trained healthcare professional at the referring site (patient site presenter) is required to present the beneficiary to the provider at the consulting site and remain available as clinically appropriate (this condition is waived when the referring site is the patient home).
- If the beneficiary is a minor (under 18 years old), a parent and/or guardian must present the minor for telehealth service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telehealth session unless attendance is therapeutically appropriate.
- The beneficiary retains the right to withdraw from the telehealth visit at any time.
- All telehealth activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.
- The beneficiary has access to all transmitted medical information, except for live interactive video, as there is often no stored data in such encounters.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.
- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need.
- The medical care can be safely furnished.
- No equally effective, more conservative or less costly treatment is available statewide.

Psychosocial Rehabilitation Services (PRS)

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

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

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

- Interpersonal ST that enhances the beneficiary's communication skills, ability to develop and maintain environmental supports, and ability to develop and maintain interpersonal relationships.

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

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

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

Behavior Modification (B-MOD)

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

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

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

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

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

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

Family Support (FS)

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

FS is intended to:

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

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

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

Peer Support Services (PSS)

The purpose of this face-to-face service is to assist beneficiaries' recovery from mental health and/or substance abuse disorders by sharing similar lived experience and recovery.

This service is person-centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

The qualified peer support specialist gives advice and guidance, provides insight, shares information on services and empowers the beneficiary to make healthy decisions. The unique relationship between the peer support specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of PSS.

The peer support specialist will utilize their own experience and training to assist the beneficiary in understanding how to manage their illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers and work towards their goals. The peer support specialist will also provide ongoing support to keep beneficiaries engaged in proactive and continual follow up treatment.

The peer support specialist actively engages the beneficiary to lead and direct the design of the plan of care and empowers the beneficiary to achieve their specific individualized goals. Beneficiaries are empowered to make changes to enhance their lives and make decisions about the activities and services they receive.

Services are multi-faceted and should emphasize the following:

- Personal safety
- Self-worth
- Introspection
- Choice
- Confidence
- Growth
- Connection
- Boundary setting
- Planning
- Self-advocacy
- Personal fulfillment
- The Helper Therapy Principle
- CM
- Education
- Meaningful activity and work
- Effective communications skills

Due to the high prevalence of beneficiaries with mental health and/or SUDs and the value of peer support in promoting dual recovery, identifying individuals co-occurring disorders who require a dual treatment is a priority.

PSS reinforces and enhances the beneficiary's ability to cope and function in the community and develop natural supports. The beneficiary must be willing to participate in the service delivery. Services are structured and planned one-to-one or group activities that promote socialization, recovery, self-advocacy and preservation.

PSS must be coordinated within the context of a comprehensive, individualized POC that includes specific individualized goals. Providers should use a person-centered planning process to help promote beneficiary ownership of the POC.

Such methods actively engage and empower the beneficiary and individuals selected by the beneficiary, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the beneficiary in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

Service interventions include the following:

- Self-help activities that cultivate the beneficiary's ability to make informed and independent choices. Activities help the beneficiary develop a network for information and support from others who have been through similar experiences.
- Self-improvement planning and facilitating specific, realistic activities leading to increased self-worth and improved self-concepts.
- Assistance with substance use reduction or elimination provides support for self-help, self-improvement, skill development, and social networking to promote healthy choices, decisions, and skills regarding SUDs or mental illness and recovery.
- System advocacy assists beneficiaries in making telephone calls and composing letters about issues related to SUDs, or mental illness or recovery.
- Individual advocacy discusses concerns about medications or diagnoses with a Physician or nurse at the beneficiary's requests. Further, it helps beneficiaries arrange the necessary treatment when requested, guiding them toward a proactive role in their own treatment.
- Crisis support assists beneficiaries with the development of a crisis plan. It teaches beneficiaries:
 - How to recognize the early signs of a relapse.
 - How to request help to prevent a crisis.
 - How to use a crisis plan.
 - How to use less restrictive, hospital alternatives.

- How to divert from using the emergency room.
- How to make choices about alternative crisis support.
- Housing interventions instruct beneficiaries in learning how to maintain stable housing or learning how to change an inadequate housing situation
- Social network interventions assist beneficiaries with learning about the need to end unhealthy personal relationships, how to start a new relationship, and how to improve communication with family members.
- Education and/or employment interventions assist beneficiaries in obtaining information about going back to school or getting job training. Interventions give beneficiaries an opportunity to acquire knowledge about mainstreaming back into full-time or part-time work. Additionally, they are taught how to obtain reasonable accommodations under the Americans with Disabilities Acts (ADA).

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: behavioralhealth004@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 an MHP.
- A PDA with medical services.
- All plans of care, reviews and addenda.
- Physician/Psychiatrist'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/Psychiatrist 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. If the interventions include evidence-based practices, include those as well.
- 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/Psychiatrist within 90 calendar days of a beneficiary's admission to a CMHC. *
- The Physician/Psychiatrist must sign a continued IPOC immediately after the MHP reviews it and prior to any delivery of services.*

* An APRN or PA can sign the IPOC if the practice agreement with the Physician/ Psychiatrist authorizes this practice.

Services Required to be Listed on the IPOC

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

- IP
- FP
- GP
- MFGP
- PRS
- B-MOD
- FS
- PSS

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
- Psychological Testing and Evaluation
- 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/Psychiatrist/APRN or PA 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/APRN or PA's signature on the IPOC. If the IPOC is reformulated prior to its expiration, the maximum duration is

12 months from the reviewing Physician/Psychiatrist/APRN or PA's signature or the effective date identified by the Physician/Psychiatrist/APRN or PA.

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/Psychiatrist/APRN or PA 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/Psychiatrist/APRN or PA'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/APRN or PA 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/Psychiatrist/APRN or PA. Beneficiaries are not required to have face-to-face contact with Physicians/Psychiatrists/APRNs or PAs for the addition of services or changes in service frequency.

When additions or changes are authorized without face-to-face contact with the Physician/Psychiatrist/APRN or PA, the contact should be documented in the record and should be signed and/or initialed by the Physician/Psychiatrist/APRN or PA immediately upon availability. Should the frequency be changed, or service be provided before the Physician/Psychiatrist/APRN or PA signature is obtained, the record must contain a CSN justifying the change. Documentation should reflect why the additions or changes are necessary for continued growth and development of the beneficiary.

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/Psychiatrist/APRN or PA. 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/Psychiatrist/APRN or PA 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. Any barriers to progress should also be identified.
- The appropriateness of the services provided and their frequency. Failure to provide the recommended services and their frequency should also be explained.
- 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
- Psychological Testing and Evaluation
- 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/Psychiatrist, PDA with Medical Services - APRN, PDA with Medical Services - PA, and PDA with Medical Services - Telepsychiatry

The Physician/Psychiatrist, APRN or PA who renders the service must include a properly completed PMO form in the record. The Physician/Psychiatrist, 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/Psychiatrist'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 provides 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.

Psychological Testing and Evaluation (PTE)

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

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

Documentation must include:

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

MH SPD by Non-Physician

The CSN must document the Physician/Psychiatrist/APRN or PA 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/Psychiatrist/APRN or PA are required to sign and date the CSN corroborating the delivery of the service.

SPD - Interdisciplinary Team

The CSN must document the Physician/Psychiatrist/APRN or PA 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/Psychiatrist/APRN or PA 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.

Psychosocial Rehabilitation Services (PRS)

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

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

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

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

Behavior Modification (B-MOD)

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

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

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

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

For beneficiaries aged 0 through 15, the Parent/Caregiver/Guardian Agreement to Participate in CSS form must be completed and maintained in the beneficiary's record.

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

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

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

BEHAVIOR MODIFICATION PLAN (BMP)

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

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

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

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

- Name
- Medicaid Number
- Date of BMP and/or date of revision
- Target Behavior(s):
 - An operational definition of each problem behavior to be decreased.
 - An operational definition of each replacement behavior to be increased.
 - A measurable objective for each problem behavior and replacement behavior.
- Identify the desired behavioral change.
- Intervention Strategies: includes specific interventions and strategies to be implemented in addressing the target behavior(s)/goal(s).

- Environmental Changes: includes any changes to the setting or environment necessary to effectively implement the strategies and interventions.
- Timelines/Review Dates: includes segments of time during which specific portions of the BMP are to be addressed, as well as specific dates by which specific portions of the BMP are to be reviewed, with regard to progress.
- Behavioral Crisis Plan: How will a behavioral crisis be handled?
- Monitoring Progress/Evaluation Methods: includes a description of how progress toward achieving desired outcomes will be monitored and evaluated, including timeframes and data collection.
- Progress Review Date: the date the plan will be reviewed for effectiveness.
- Names of beneficiaries in the creation of the BMP.
- Signatures of persons who participated in the development of the plan (beneficiary, family/caregiver and B-MOD staff).

Family Support (FS)

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

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

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

For children who are in foster care, the Parent/Caregiver/Guardian Agreement must be signed by the foster parent. In the event the foster parent changes during the 90-day authorization period, the new foster parent must sign the Parent/Caregiver/Guardian Agreement for the next 90-day authorization cycle. In the event that there is a refusal or an inability to sign the agreement FS services must not be provided. The beneficiary's IPOC and treatment process should be youth guided and family driven. The beneficiary, the beneficiary's designated others, and treatment team agree on treatment goals, objectives and interventions.

Peer Support Services (PSS)

PSS must be documented in the IPOC with a planned frequency and should be documented upon contact with the beneficiary. The staff providing the service is responsible for completing and signing the documentation. Documentation should clearly identify the specific goals from the IPOC for which the delivery of this service addresses.

Billable services must be documented in units on the beneficiary's CSN. Additionally, the documentation must meet all SCDHHS requirements for CSNs. A CSN is required for each beneficiary in a group setting.

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/Psychiatrist, 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/Psychiatrist 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.

DISCHARGE/TRANSITION CRITERIA

Documentation should be present when a discharge or transition occurs. Beneficiaries should be considered for discharge or transfer to another level of care when any of the following criteria are met:

- The beneficiary's level of functioning has significantly improved.
- The beneficiary has made limited or no progress with respect to the goals outlined in the IPOC.
- The beneficiary has achieved the goals as outlined in the IPOC or reached maximum benefit.

- The beneficiary has developed the skills and resources needed to transition to a lower level of care.
- The beneficiary requested to be discharged from treatment and is not imminently dangerous to self or others.
- The beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals. The reason for discharge and the plan for the beneficiary moving forward should be well documented in a clinical service note.

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BILLING GUIDANCE

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.