SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

REHABILITATIVE BEHAVIORAL HEALTH SERVICES (RBHS) PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

PROGRAM DESCRIPTION

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of behavioral health services delivered to Healthy Connections Medicaid members via the following programs:

- Fee-for-service (FFS)
- Managed care organizations (MCO)

The Rehabilitative Behavioral Health Services (RBHS) Manual supplements SCDHHS' general policies and procedures detailed in the Provider Administrative and Billing Manual. It provides policies and requirements specific for rehabilitative behavioral health therapy and service providers for the FFS program. For services delivered to MCO members, providers must follow the member's MCO policies and requirements.

For the purpose of this manual, RBHS are defined as medical or therapeutic services recommended by a physician or other licensed practitioner of the healing arts (LPHA) aimed at promoting and maintaining mental, emotional and psychosocial wellbeing.

RBHS services are delivered in outpatient community settings (with the exception of residential substance use services). In accordance with 42 CFR 435.1009-1011, RBHS are not available for members residing in an Institution of Mental Disease (IMD).

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

RBHS providers must review, reference and comply with both the RBHS provider manual and the Provider Administrative and Billing Manual.

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

APPENDICES TO THE RBHS PROVIDER MANUAL

Evidence-based Practices

Providers authorized, certified and/or licensed to provide one of the identified Medicaid-reimbursable evidence-based practices below may find necessary service and billing information specific to the model in the appendices linked on the RBHS Manual webpage:

- Appendix 3: Assertive Community Treatment (ACT)
- Appendix 4: Multisystemic Therapy (MST)
- Appendix 5: Homebuilders®

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

RBHS are provided to or directed exclusively toward the treatment of the member for prevention or treatment of behavioral health disorders. Such diagnostic and rehabilitative services aim to restore maximum functioning and the independence necessary to improve the member's quality of life and to assist them in achieving long-term stability.

The following members may receive medically necessary diagnostic and rehabilitative behavioral health services:

- Children: Members age zero through 20 years old (through the last day of the month of the 21st birthday).
- Adults: Members age 21 years and older.

Eligibility for Services

The determination of eligibility for services must include a comprehensive diagnostic assessment of the member.

Unless otherwise specified in the service description, Medicaid-eligible members may receive services when there is a primary psychiatric diagnosis as defined by the current edition of the Diagnostic and Statistical Manual (DSM) and/or International Classification of Diseases (ICD). Those with certain conditions (i.e., irreversible dementias, intellectual or related disabilities, developmental disorders) may be precluded from RBHS if they are not likely to benefit from the majority of such services; however, if there is a co-occurring serious behavioral health disorder as defined, it is possible services may be deemed medically necessary.

Members with potentially exclusionary conditions must be carefully assessed to determine if a co-occurring behavioral health disorder exists and if it could be effectively addressed with RBHS. A determination is made based on whether the member is reasonably expected to improve in adaptive, social and/or behavioral functioning from the delivery of RBHS.

Verifying Member Eligibility

Participating Healthy Connections Medicaid-enrolled providers must verify the member's eligibility on the date of service. Members must be eligible on the date of service for payment to be made. Providers may access member eligibility information through the SCDHHS' Web Portal or the Provider Service Center (PSC).

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

An eligible provider is a firm, corporation, association, or an institution practicing as one business entity with a written participation agreement in effect with SCDHHS to provide behavioral health services to members enrolled in the Healthy Connections Medicaid program pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the Social Security Act, as amended.

As it relates to the delivery of rehabilitative behavioral health services specified in this manual, a Medicaid-enrolled provider will be referred to as an "RBHS provider." This manual pertains to policy and requirements for RBHS organizations.

Except as required by 42 CFR 431.52, providers of RBHS services must be located within the South Carolina Medicaid Service Area (SCMSA) to ensure (i) quality care is delivered based on prevailing clinical standards, (ii) the full array of covered services is available to any eligible member under the behavioral health benefit, and (iii) each member has access to in-person care.

RBHS organizations and their providers must follow state and federal laws, rules and regulations and must meet all applicable Medicaid provider qualifications; LPHAs must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination and disciplinary action regarding the laws and standards of their profession, as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor, Licensing and Regulation (SCLLR):

- LPHAs must maintain a current, valid, unrestricted license from the appropriate authority to practice in South Carolina or the SCMSA and must operate within their scope of practice and follow their discipline's established ethical guidelines.
- LPHAs delivering or supervising RBHS services must conform to the scope of practice as indicated by their respective licensing and/or certification boards or as stipulated in this manual.

Enrolled providers are prohibited from using their National Provider Identifier (NPI) to bill Medicaid for services rendered by a non-enrolled, terminated or excluded provider. This stipulation does not include providers able to render services under direct supervision of a licensed, enrolled provider.

For general information regarding provider qualifications and enrollment in the South Carolina Healthy Connections Medicaid program please refer to the Provider Administrative and Billing Manual and to SCDHHS's website.

During completion of the online Medicaid provider enrollment application, providers must select "New Enrollment" and the following options:

Field	Option
Enrollment Type	Organization
Provider Type	Behavioral Health Services
Primary Specialty	Private Rehabilitative Behavioral Health Services

Enrollment in the Medicaid program does not provide a guarantee of referrals or a certain funding level. Failure to comply with all Medicaid policy requirements may result in termination of Medicaid enrollment.

Additional RBHS Organization Provider Enrollment Requirements

The Centers for Medicare and Medicaid Services (CMS) strengthened requirements for Medicaid provider screenings to prevent fraud, waste and abuse. CMS requires state Medicaid agencies to screen all provider applications based on a categorical risk level of "limited," "moderate," or "high." This categorization helps the agency align with federal requirements and ensures taxpayer funds are appropriately safeguarded.

When a state Medicaid agency designates a provider type as a "high" categorical risk, the agency must require fingerprint-based criminal background checks (FCBC) for providers and any entity with 5% or more direct or indirect ownership interest in the provider. RBHS organizations are included in the "high risk" category and as such are required to comply with the CMS regulations (42 CFR Part 455 subpart E) associated with this category. The FCBC must be completed during the enrollment process. Additionally, it is vital that provider owners and managing employees understand that they can be held criminally liable for the actions of the provider organization's- employees, agents and representatives.

Requirements for enrollment as a "high-risk" provider include the following steps:

- Newly enrolling RBHS organizations must complete level one and level two FCBC with South Carolina Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI).
- Newly enrolling RBHS organizations must undergo a pre-enrollment site visit.
- RBHS organizations may undergo a post-enrollment site visit to verify that the information submitted to SCDHHS is accurate and to determine compliance with federal and state enrollment requirements. (§ 455.432[(a)]).
- RBHS organizations must provide 100% disclosure of ownership to the grandparent level and attest to the disclosure of ownership during the provider enrollment process in accordance with CFR 42 §455.102.

Note: In accordance with S.C. Code Ann. §40-75-290 (Supp. 2023, as amended), the above requirements do not apply to state agency providers, mental health counselors who are school district employees, or entities acting on behalf of a state agency, including child-placing agencies (CPAs), county substance use authorities, and Developmental Evaluation Centers (DECs).

Newly enrolled RBHS organizations may learn more about fingerprinting requirements, high-risk provider types and disqualifying criteria by visiting the list of frequently asked questions (FAQ) on the SCDHHS' provider enrollment webpage.

Required Qualifications for RBHS Organizations

A. Accreditation

RBHS organizations must be accredited by one of the following accreditation authorities:

- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Council on Accreditation (COA, a Service of Social Current)
- The Joint Commission (TJC)

Accreditation status must be maintained during the entire period of enrollment with SCDHHS. This includes, but is not limited to, periods of transition from one accreditation organization to another. Failure to maintain accreditation will result in termination of enrollment.

Each discrete service rendered by RBHS organizations must be accredited before billing for the service. Any claims submitted for services that are not accredited are not reimbursable and may result in provider termination from the Healthy Connections Medicaid program.

Please refer to the accreditation crosswalk located on the RBHS webpage for further information concerning services and the above accreditation organizations.

Note: The service accreditation requirements apply to private or state-affiliated RBHS organizations; private organizations enrolled for the specific and sole purpose of providing an evidence-based practice (EBP) as identified in the Appendices (i.e., Assertive Community Treatment, Multisystemic Therapy, or Homebuilders) are exempt from the accreditation requirement; however, if such providers deliver other RBHS services in addition to the designated EBPs, accreditation is required as indicated above.

RBHS organizations must maintain, and be able to provide upon request, evidence of the accreditation certificate, the accreditation letter identifying the specific services that have been accredited, and the most recent accreditation survey report. Providers must submit evidence of meeting service accreditation requirements when requested by completing the Accreditation for RBHS form, located in the forms section of the manual and submitting it to the Office of Behavioral Health via email at MedicaidStatePlan@scdhhs.gov.

Any denial, loss of, or change in accreditation status must be reported via email to the Office of Behavioral Health at MedicaidStatePlan@scdhhs.gov using the program changes for RBHS form located in the forms section **within five business days** of receiving the notice from the accrediting organization.

Failure to notify SCDHHS of denial or any change in accreditation status may result in termination of enrollment. If at any time, a provider loses accreditation, termination of enrollment will occur. The applicant may not reapply for enrollment for one year from the effective date of the termination.

Additionally, the applicant must be fully accredited at the time of application after the one-year period post-loss of accreditation.

B. Location/Zoning Requirements

RBHS organizations must be housed in an office located in a commercially zoned area. A permanent sign must be affixed externally to the provider's office to identify the location. Providers must post office hours/hours of operation and emergency contact information for after-hours emergencies and support.

C. RBHS Organizations Providing Residential Treatment

Residential settings must follow the guidelines set forth in the SCDHHS Provider Enrollment and Screening Requirements and be in compliance with all applicable federal and state requirements. Residential facilities must be licensed by and in good standing with the South Carolina Department of Social Services (DSS) and/or the South Carolina Department of Public Health (DPH), as applicable. Facilities located outside of South Carolina but within the SCMSA must be licensed according to applicable law in the states of Georgia and/or North Carolina and in good standing.

Residential facilities must be limited to 16 or fewer beds in order to receive Medicaid reimbursement as federal law prohibits Medicaid payment to IMDs as described in 42 CFR 435.1009-1011.

D. Business Requirements

RBHS organizations must meet the following requirements at all times:

- SCDHHS and the U.S. Department of Health and Human Services (DHHS) assume no responsibility with respect to accidents, illness, or claims arising out of any activity performed by any state or private organization. The organization shall take necessary steps itself to insure or protect members and its personnel. The provider agrees to comply with all applicable local, state and federal occupational and safety acts, rules and regulations.
- Have cost information available for review by SCDHHS, upon request.
- Have a current business license and certificate of occupancy for each site located in South Carolina or the SCMSA. Business licenses and certificates of occupancy must be maintained throughout the entire period of enrollment with SCDHHS.
- If a county or a municipality within a state does not issue business licenses or certificates of occupancy, the provider must demonstrate evidence of the following documentation:
  - Articles of Incorporation and signature pages
  - Registration with the Secretary of State

- A new business license and certificate of occupancy must be obtained any time a provider moves locations within South Carolina or the SCMSA.
- Office location(s) and the rendering of any service(s) must be located in South Carolina or within the SCMSA.
- Certificate of insurance indicating the provider maintains Commercial General Liability or Comprehensive Liability Insurance of at least $1million/per occurrence, $3 million/general aggregate.
- Proof of Worker's Compensation insurance if provider employs five or more full-time staff.

- Accept the reimbursement rates established by Healthy Connections Medicaid.
- Have a computer, internet access, dedicated landline business phone number and an email address to conduct business with SCDHHS.

To request enrollment information, providers may contact the PSC at (888) 289-0709, submit an online inquiry at https://www.scdhhs.gov/providers/contact-provider-representative or access the online Medicaid enrollment application on the SCDHHS website. Once enrolled, providers are required to revalidate enrollment every year.

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

- Confidentiality and protection of health information
- Consent for treatment
- Record security and maintenance
- Record retention
- Use of secure electronic signatures if provider uses an electronic health record or electronic medical record program
- Release of information
- Member's rights and responsibilities
- Prohibition of abuse, neglect and exploitation of members
- Code of ethics
- Freedom of choice
- Limited English proficiency
- Compliance program (including fraud, waste, and abuse)
- Admission and discharge of members
- Conditions for termination of members from services, including:
  - A list of reasons for termination,
  - Methods of averting the termination,
  - Education/consultation with members and/or family about termination (i.e., resources and options), and
  - Evidence member/family informed of termination.
- Personnel practices (including recruiting, hiring and retention of staff as well as maintenance of personnel records)
- Use of volunteers and students/interns

E. Reporting Program Changes

SCDHHS requires that a provider report programmatic change(s) to the Office of Behavioral Health. This updated information must be submitted on the Program Changes for RBHS Form within 10 days of the change. The provider will not be able to report any changes by phone. The form must be submitted via MedicaidStatePlan@scdhhs.gov and faxed to the PSC at (803) 870-9022.

The following program changes must be reported by the provider:

- Change in administrator (chief executive officer (CEO)/director)
- Change in clinical director
- Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time.
- Adverse events concerning staff licensure (such as suspended/terminated license).
- Any change in accreditation status as identified in the Accreditation section of this manual including, but not limited to, all re-accreditation survey results.
- Any change in facility license.
- Other changes which affect compliance with Medicaid requirements.

Note: RBHS organizations opening new practice locations must complete a new provider enrollment application and obtain a separate Medicaid provider ID to differentiate the entities. For RBHS organizations enrolled for the sole purpose of delivering an EBP (ACT, MST, or Homebuilders), opening a new team location under the overarching enrolled entity do not require a separate enrollment/Medicaid provider ID.

If the provider's and/or the administrator's name(s) change(s), the provider must submit a new Disclosure of Ownership and Control Interest Statement form and an updated W-9 form to the PSC. Please refer to the SCDHHS website for the disclosure form. Questions concerning the W-9 Form should be directed to the PSC.

Providers planning to or currently operating a child/family care facility for Medicaid members must ensure compliance with all state and federal mandates. Providers are encouraged to contact DSS for information regarding registry and/or licensing requirements. Providers out of compliance are subject to termination.

Providers must refer to the South Carolina Children's Code of Laws Title 63 to ensure compliance with state licensing and child welfare regulations. Information can be located on the South Carolina Child Care website.

F. Quality Assurance Reviews

Periodic quality assurance reviews will be conducted by SCDHHS' quality assurance team or their designee. If the review identifies noncompliance with certain Medicaid policies and regulations, a Corrective Action Plan (CAP) may be issued for these deficiencies. If a CAP is required, the provider must submit it within 15 business days of receiving the Summary of Findings. No extensions will be granted unless expressly stated in writing from a member of SCDHHS' quality assurance team or their designee.

A template of the CAP can be found in the forms section of this manual. If, after review of the CAP, SCDHHS determines that a modification is necessary, the provider must respond with an amended CAP within five business days from the date of notice. Once the CAP is accepted by SCDHHS, the provider must sign, date and return the CAP, along with any requested documentation, within five business days of receipt. Failure to comply with the terms of this section could result in sanctions that could include, but not be limited to, completion of mandatory provider education or the

suspension or termination of a provider's enrollment in the South Carolina Healthy Connections Medicaid program.

G. Staffing Requirements

The RBHS organization must include, at a minimum, four separate and distinct staff members, including a CEO or administrator, a clinical director and two other professional or paraprofessional staff to provide direct services. These positions cannot have overlapping job duties.

The RBHS organization must have a designated full-time administrator (CEO/Agency Director) with clear authority over general administration and implementation of requirements established by the RBHS Medicaid policy. This includes responsibility to oversee the budget and accounting systems implemented by the provider, authority to direct and prioritize work regardless of where it is performed and responsibility for the business operation of the entity. During times of absence (i.e., medical leave, vacation, etc.), the provider must appoint, in writing, a qualified designee with administrative program experience.

The RBHS organization must have a designated full-time clinical director responsible for clinical supervision and implementation of clinical programming rendered by the organization. The clinical director must be available to staff by phone during all hours the provider is in operation for clinical consultation and emergency support. During times of absence (i.e., medical leave, vacation, etc.), the provider must appoint, in writing, a qualified designee. The clinical director cannot be counted as one of the two required professional or paraprofessional staff.

For private RBHS organizations, clinical directors must be LPHAs. If the provider is located in the SCMSA, they must be licensed at the independent level in the practicing state.

Note: The LPHA requirement for clinical directors may be waived, as determined by SCDHHS, for entities providing evidence-based practices only (MST, ACT, or Homebuilders) if that service description allows other trained and qualified professionals to provide clinical oversight of the program. If other RBHS services are provided, the LPHA criteria is a requirement. See the Appendices section in the manual for additional information on EBP model-specific staffing criteria.

H. Staff Qualifications

All providers within RBHS organizations must fulfill the requirements for South Carolina licensure/certification and appropriate standards of conduct by means of evaluation, education, examination and disciplinary action regarding the laws and standards of their profession, as promulgated by the South Carolina Code of Laws and established and enforced by the SCLLR. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in South Carolina or the SCMSA and must operate within their scope of practice.

Professional Title	Degree and License or Certification Required	Allowable Services
Psychiatrist	• Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) and completed residency in psychiatry • Licensed by the South Carolina Board of Medicine	All services, except PSS, TFC
Physician	• MD or DO • Licensed by the South Carolina Board of Medicine	All services, except PSS, PTE, TFC
Physician Assistant (PA)	• Graduate degree in PA Studies • Licensed by South Carolina Board of Medical Examiners	All services, except PSS, PTE, TFC
Advanced Practice Registered Nurse (APRN)	• Graduate degree in nursing • Licensed by South Carolina Board of Nursing	All services, except PSS, PTE, TFC
Pharmacist	• Doctor of Pharmacy degree • Licensed by South Carolina Board of Pharmacy	Medication management
Licensed Registered Nurse (RN)	• Associate or bachelor's degree in nursing and one year of experience working with the population to be served. • Licensed by South Carolina Board of Nursing	B-MOD, FS, MM, PRS, MA, ST, SUDA, SUS, VI, CIS, TCC, ACT
Licensed Practical Nurse (LPN)	• High school diploma or GED; completion of a nursing program approved by the South Carolina Board of Nursing and one year of experience working with the population to be served, • Licensed by South Carolina Board of Nursing	MM, MA, SUN, SUDA, VI
Psychologist	• Doctoral degree in psychology (PhD or PsyD) • Licensed by South Carolina Board of Psychology Examiners	All services except E&M, VI, MM, MA, SUN, PSS, TFC
Licensed Psychoeducational Specialist (LPES)	• Master’s degree plus 30 course hours of psychopathology, successful completion of Educational Testing Service School Psychology Exam (PRAXIS)	B-MOD, BHS, CI, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SUC, ST, PTE, PTA, SUDA, SUS, CIS, TCC, ACT, MST

Professional Title	Degree and License or Certification Required	Allowable Services
	• Licensed by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psychoeducational Specialists	
Licensed Independent Social Worker-Clinical Practice (LISW-CP)	• Master of Social Work (MSW) • Licensed by South Carolina Board of Social Work Examiners	B-MOD, BHS, CI, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB
Licensed Master Social Worker (LMSW)	• MSW • Licensed by South Carolina Board of Social Work Examiners	B-MOD, BHS, CI, DA*, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB *(*see note)*
Licensed Professional Counselor (LPC)	• Graduate degree in counseling or related field • Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psychoeducational Specialists	B-MOD, BHS, CI, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB
Licensed Marriage and Family Therapist (LMFT)	• Graduate degree in marriage and family studies or related field • Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psychoeducational Specialists	B-MOD, BHS, CI, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB
Licensed Addiction Counselor (LAC)	• Graduate degree in counseling or another related field • Licensed by South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psychoeducational Specialists	B-MOD, BHS, CI, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB

Professional Title	Degree and License or Certification Required	Allowable Services
Certified Substance Abuse Professional (CSAP)	• Master's degree in counseling or related field and certification as an addictions counselor. • Certified by Addiction Professionals of South Carolina (APSC) and/or NAADAC, the Association for Addiction Professionals.	B-MOD, BHS, CI, DA*, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SUC, ST, SUDA, SUS, CIS, ACT, TCC, MST, IIHS-HB *(*see note)*
Substance Abuse Professional (SAP)	• Minimum of a bachelor's degree in a health or human services related field and certified as an alcohol and drug counselor. • APSC or NAADAC, the Association of Addiction Professionals, certified, or in the process of becoming certified.	B-MOD, BHS, CI, FS, PRS, SUC, ST, SUDA, SUS, (Assist with developing) SPD, CIS, TCC, MST, IIHS-HB
Clinical Chaplain	• 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 and one year of experience working with the population to be served. • Documentation of training and experience	B-MOD, BHS, CI, DA*, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB *(*see note)*
Qualified Clinical Professional (QCP)	• For employees of service-providing state agencies: Master's or doctoral degree in counseling or related field from an accredited university or college and one year of experience working with the population to be served.	B-MOD, BHS, CI, DA, FS, FP, GP, IP, MFGP, PRS, SPD, SUC, ST, SUDA, SUS, CIS, ACT, TCC, MST, IIHS-HB
Mental Health Professional (MHP)	• Master's or doctoral degree in counseling or related field from an accredited university or college and one year of experience working with the population to be served.	B-MOD, BHS, CI, DA*, FS, FP*, GP*, IP*, MFGP*, PRS, SPD, SUC, ST, SUDA, SUS, CIS, TCC, ACT, MST, IIHS-HB *(*see note)*
Homebuilders Specialist	• Bachelor's or master's degree in counseling or a related field plus two years of experience working with families.	IIHS-HB

Professional Title	Degree and License or Certification Required	Allowable Services
	• Completed training as required by Institute for Family Development and providing services within a certified Homebuilders program.	
Licensed Bachelor of Social Work (LBSW)	• Bachelor's degree in social work. • Licensed by South Carolina Board of Social Work Examiners	B-MOD, BHS, CI, FS, PRS, SUC, ST, SUDA, SUS, SPD, CIS, TCC, ACT, MST, IIHS-HB
Human Services Professional (HSP)	• Bachelor's degree in counseling or related field or bachelor's degree in unrelated field and a minimum of 45 documented training hours related to behavioral health issues and treatment. Must have two years' experience with population served to be eligible to provide MST.	B-MOD, BHS, CI, FS, PRS, SUC, ST, SUDA, SUS, (Assist with developing) SPD, TCC, CIS, ACT, MST, IIHS-HB, IIHS-IC
Mental Health Services Provider	• Bachelor's degree in counseling or related field and three years of experience working with the population served (i.e., adults with serious mental illness)	ACT
Child Services Professional	• Bachelor's degree in human services field or early childhood education, child development, or related field or bachelor's degree in unrelated field and a minimum of 45 documented training hours related to child development and children's mental health issues and treatment.	B-MOD, BHS, CI, FS, PRS, SUC, ST, SUDA, SUS, (Assist with developing) SPD, TCC, CIS
Certified Peer Support Specialist (CPSS) or Certified Peer Supervisor	• High school diploma or GED equivalent • Precertification program: 40 hours of training; minimum 20 hours of continuing education training annually, of which at least 12 hours must be face-to-face training. • South Carolina Certification as a peer support specialist or certified peer supervisor.	ACT, CIS, PSS
South Carolina Office of Substance Use Services (OSUS) Only:		

Professional Title	Degree and License or Certification Required	Allowable Services
Substance Abuse Specialist (SAS)	• High school diploma or GED equivalent and three years of documented direct care experience working with the identified target population or completion of a South Carolina Office of Substance Use Services-approved training and certification program.	PRS, B-MOD, FS, ST

Note: Service providers in private RBHS organizations must be licensed at the independent level or under the direct supervision of the clinical director to deliver psychotherapy (individual, family, group, and MFGP). DAs require completion by an LPHA; however, DAs facilitated by a non-independently licensed professional is allowable in a private organization when supervised and co-signed by an LPHA.

Evaluation of Medical Necessity in RBHS Organizations

LPHAs must validate that the member meets the medical necessity criteria for each service. RBHS organizations must be enrolled in Healthy Connections Medicaid and LPHAs must be licensed at the independent level in their practicing state (South Carolina, North Carolina, or Georgia, respectively).

The following South Carolina professionals are qualified to evaluate medical necessity:

- Licensed physician (MD, DO)
- Licensed PA, Licensed APRN
- Licensed Psychologist
- Licensed Psycho-educational Specialist
- LISW-CP
- LMSW (see note)
- LPC
- LMFT
- LAC (master's degree and above)

Note: Based on South Carolina state statute (SC Code § 40-63-10 et seq.), a LMSW may engage in the practice of clinical social work within a recognized, organized setting such as a social, medical or governmental agency (i.e., hospital, school). In these settings, LMSWs may operate under general supervision of a physician, psychologist, or other LPHA who is also employed or contracted with the same facility. Supervision must occur within the same agency setting where the LMSW provides services. LMSWs may not practice privately or independently outside of the organized setting.

Ordering/Referring/Prescribing (ORP) Providers

Providers who order, refer or prescribe for services delivered under the South Carolina State Plan for Medical Assistance or under a waiver of the plan, must be enrolled as participating

providers. ORP providers may choose to be fully enrolled or enrolled using the ORP-only pathway by selecting the "Ordering/Referring" enrollment type via the SCDHHS enrollment website. **This includes psychiatrists and other physicians practicing within an RBHS organization who are HIPAA-covered individuals and qualified to order, refer or prescribe in accordance with their scope of practice.**

Qualified individuals must be enrolled in South Carolina Healthy Connections Medicaid to order, refer or prescribe services for Medicaid members and/or to bill Medicaid for said services. For information on how to become a Medicaid provider refer to SCDHHS website at: https://www.scdhhs.gov/providers/become-provider.

South Carolina Healthy Connections Medicaid will reimburse for medically necessary items or services for Medicaid members that have been ordered, referred, or prescribed by a South Carolina Healthy Connections Medicaid enrolled or ORP enrolled physician or other qualified professional.

Orders must be provided by an individual psychiatrist or other physician (identified by an NPI number with an entity type code of "1"). Organizations cannot order, refer, or prescribe.

To prevent a member's inability to obtain covered, prescribed psychotropic or MAT medications from their preferred pharmacy, all physicians and other qualified providers rendering services described in this provider manual must enroll as an ORP provider unless they are already individually enrolled in Medicaid. ORP enrollment is an abbreviated enrollment pathway for the sole purpose of ORP compliance.

Staff Monitoring/Supervision

RBHS provided by licensed or certified professionals must follow supervision requirements as mandated by South Carolina State Law or the law of the state where the individual is practicing, for each respective profession, if practice is located in the SCMSA.

Except where otherwise stipulated in this manual, services provided by any unlicensed/uncertified professionals must be clinically supervised by an LPHA or appropriately credentialed supervisor. Licensed and/or master's level clinical professionals have the responsibility of planning and guiding the delivery of services provided by unlicensed or uncertified professionals. Licensed and/or master's level clinical professionals will evaluate and assess the member, as needed.

When services are provided by an unlicensed or uncertified professional or a paraprofessional, the state agency or private organization must ensure the following:

- The qualified licensed or master's level clinical professional who monitors the performance of the unlicensed professional or paraprofessional must provide documented consultation, guidance, and education with respect to the clinical skills, competencies and treatment provided, at least every 30 days.
- The supervising licensed or master's level clinical professional must maintain a log documenting supervision of the services provided to each member by the unlicensed or uncertified professional or paraprofessional.

- Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care and the individual member's progress. Issues discussed and clinical guidance relevant to an individual member will be documented in a service note in the clinical record.

OSUS-affiliated organizations only:
SAPs who are in the process of becoming credentialed must be supervised by an appropriate clinical supervisor, as identified by APSC.

RBHS Provider Training Requirements

RBHS organizations are responsible for ensuring that all staff are appropriately trained, including subcontractors, volunteers, students/interns and other individuals under the authority of the billing provider. RBHS organizations are responsible for the development and provision of training for their staff when professionally developed training is not available. Individuals who are qualified based on documented professional behavioral health experience, prior training, and certification and/or licensure to conduct such training shall carry out the instruction.

Case supervision and consultation do not supplant training requirements. The frequency of supervision is evaluated on a case-by-case basis, however, training is required and periodically renewed for all RBHS providers.

Note: The specified training below is not required for providers delivering only an evidence-based practice (EBP) (i.e., Assertive Community Treatment, Multisystemic Therapy, or Homebuilders) unless they are providing other RBHS. If at any time the EBP provider entity expands to include provision of additional services, they are required to facilitate and document training as per the schedule below.

The following table outlines the training requirements for staff of RBHS organizations:

Training	Orientation	Core Services	Community Support Services
Timeframe to complete	Prior to rendering any services	Within first 60 days of hire	Within first 60 days of hire
Minimum number of hours	20 total hours	Eight total hours	Eight hours minimum plus an additional three hours of "Service Specific Training" for each specific service rendered by individual staff for the following: CSS, PRS, B-MOD, FS, PSS, TCC, CIS, TFC and ST

Required materials to be covered	• Confidentiality • Protected Health Information/Consent to Medical Treatment • Member Rights • Prohibition of Abuse, Neglect, & Exploitation/Mandated Reporting Procedures • Overview of Provider's Policy and Procedures • Ethics & Professional Conduct • Overview of Behavioral Health Services • Trauma-informed Care • Health & Safety/ Emergency Preparedness • Workplace Violence • Cultural & Linguistic Competency/Diversity • Fraud, Waste, & Abuse • Overview of Service Documentation • Expectations & Submission of Medicaid Claims (for Admin. Staff)	• Person-Centered Values, Principles, and Approaches • Suicide Prevention, Screening, and Intervention • Diagnostic Assessment and Case Conceptualization • IPOC Development	Eight hours minimum, covering the following topics: • Person-centered Values, Principles and Approaches • Suicide Prevention, Screening and Intervention • IPOC Development • Childhood/Adolescent Development (if serving population) 3 hours minimum for each CSS Service-Specific Training, covering the following topics: • Purpose and Service Description • Medical Necessity Criteria for all Populations Served • Staff Qualifications • Staff-to-Member Ratio • Billing Frequency • Billable Places of Service • Non-Billable Medicaid Activities • Documentation Requirements • Service Modalities • Interventions Staff training plan example: Staff A renders both FS and BMOD to members. Staff A must have three hours of FS training and three hours of BMOD interventions training.

Resources	
	Providers are encouraged to use these resources in developing identified training topics. Where resources are not listed specific to a training topic, the RBHS organization may develop an appropriate training for all provider levels under the direction of the organization's quality improvement staff and/or clinical leadership. **Confidentiality/Protected Health Information/Consent to Medical Treatment** • Overview of CFR Title 45, Section 164.502 (45 CFR 164.502 - Uses and disclosures of protected health information: General rules) and the Health Insurance Portability and Accountability Act (HIPPA) of 1996. • 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records; Final Rule effective April 16, 2024 • South Carolina Code of Laws, Section 63-5-340. Minor's consent to health services. • Legal Aspects of Clinical Care: Minor's Rights to Consent in SC • Code of Laws - Title 44 - Chapter 22 - Rights Of Mental Health Patients **Member Rights** Overview of the following (but not limited to): • Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80) • Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84) • The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36) • The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91) • Appeal • Freedom of Choice **Prohibition of Abuse, Neglect and Exploitation** Focuses on mandated reporting, the provider's mandatory reporting policy, requirements for reporting abuse, neglect, exploitation, and disciplinary actions (internally and lawfully) which may be taken as a result of failure to report or follow policy and procedures. • South Carolina Mandatory Reporter Law: South Carolina Code of Laws, Section 63-7-310. Persons required to report. **Health and Safety; Emergency Preparedness** Focuses on procedures detailing actions to be taken in the event or occurrence of a natural disaster (i.e., tornado, hurricane, flood, earthquake, ice storm, snowstorm, etc.) and/or violent or other threatening situation (i.e., explosion, gas leak, biochemical threats, acts of terrorism, workplace violence and use of weapons, etc.). **Trauma-Informed Care** • NAMI TraumaInSight • SAMHSA TIP 57: Trauma-Informed Care in Behavioral Health Services • SAMHSA's Practical Guide for Implementing a Trauma-Informed Approach **Suicide Screening/Prevention**

	• C-SSRS Screen Version • Columbia Suicide Severity Rating Scale (C-SSRS) | SAMHSA The Lighthouse Project - The Columbia Lighthouse Project • CALM: Counseling on Access to Lethal Means: Suicide Prevention Resource Center

Providers are expected to operate within current best practices to ensure competence of and quality of care provided by staff. Training is essential to the development of a competent workforce capable of providing quality RBHS.

Training records must be maintained on each staff member that clearly indicates the name of training attended and the instructor or entity providing it, date of staff completion and hours of training delivered, a course outline reflecting course content (***or*** documented course description and/or course objectives) and a certificate of completion, as applicable.

Emergency Safety Intervention

The emergency safety intervention policy applies to any community-based provider that has policies prohibiting the use of seclusion or restraints, but who may have an emergency situation requiring staff intervention. Providers must have a written policy and procedure for emergency situations and must ensure that direct care staff are prepared and trained in the event of an emergency.

If the provider intends to use a restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a member successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring the member's safety. For more information on selecting training models, review the Project Rest Manual of Recommended Practice, available on the Family Resource Center for Disabilities and Special Needs website.
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion or restraints are being used that adhere to all state licensing laws and regulations (including all reporting requirements).

Failure to have these policies and staff training in place at the time service will result in termination from the Healthy Connections Medicaid program and possible recovery of payments.

Maintenance of Staff Credentials

Providers shall ensure that all staff, including subcontractors, volunteers, students/interns and other individuals under the authority of the provider who come into contact with members, are properly qualified, trained and supervised. Providers must comply with all other applicable state and federal requirements.

Providers must maintain documentation which verifies that all staff are properly qualified, screened, trained and supervised, including subcontractors, volunteers, students and/or interns and other individuals under the authority of the provider. Providers must maintain and make available upon request appropriate records and documentation of such qualifications, training and investigations. Failure of the provider to comply with this provision may result in the immediate termination of enrollment. SCDHHS may, upon good cause shown by the provider, and within the discretion of SCDHHS, allow the provider a reasonable amount of time to provide the documents requested.

Providers must maintain signature sheet(s) or electronic signature database(s) that identify all individuals rendering services by name, signature, credentials and initials.

The following required documents must be present in each personnel file, as applicable, prior to the start of employment and rendering of services to members:

- A completed and signed employment application form (including criminal history disclosure).
- A completed and signed job description that reflects the service(s) the person is responsible for rendering.
- Official college transcripts or copy of the high school diploma or GED from the education institution.
- Copies and primary source verification of all applicable professional licenses and certifications upon the start of employment and annually thereafter.
- Evidence of a fingerprint criminal background check (SLED and FBI) completed prior to the start of employment and annual criminal records checks thereafter.
  - All criminal records checks must include statewide (SC) data and any other state(s) where the worker has resided within the prior 10 years; this must include no less than a 10-year search.
- In order for providers to make an offer of employment or retain current employees, the criminal background results must not indicate any findings or criminal charges against the potential or current employee in the following categories:
  - Conviction for abuse, neglect, or exploitation of adults (as defined in the Omnibus Adult Protection Act, S.C. Code Ann. Title 43, Chapter 35); ***or*** conviction for abuse, neglect, or exploitation of children (as defined in the Children's Code, S.C. Code Ann. Title 63, Chapter 7).
  - Felony conviction for any of the following, including guilty pleas and adjudicated pretrial diversions:
    - Crimes against persons, such as murder, manslaughter, criminal sexual conduct, and/or aggravated assault and/or other similar crimes.
    - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and/or other similar crimes.
  - Any felony that placed the Medicaid program or its members at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct).
  - Any felonies outlined in section 1128 of the Social Security Act (SCDHHS reserves the right to consider certain misdemeanors for exclusion, such as health care license revocation or failure to provide medically necessary services).

  - Conviction of any kind concerning the misuse or abuse of any public assistance program (including, but not limited to, fraudulently obtaining benefits, engaging in fraudulent billing practices and embezzling or otherwise misusing public assistance funds in any manner).
- Evidence of exclusion checks from Medicare or Medicaid programs completed prior to the start of employment and annually thereafter. The following sources shall be checked for all individuals and verify no provider exclusion:
  - South Carolina excluded providers list: https://www.scdhhs.gov/fraud-waste-and-abuse
  - Office of the Inspector General Provider exclusion database: Search the Exclusions Database | Office of Inspector General
  - Federal System for Award Management: Home | SAM.gov
- Evidence of state and national sex offender registry checks completed prior to the start of employment and annually thereafter.
- Evidence of child abuse registry checks completed prior to the start of employment and annually thereafter.
  - Results of both child abuse and state/national sex offender registry checks must not indicate any findings and/or criminal charges against an individual.
- Evidence of professional sanctions checks completed for licensed, certified, and unlicensed staff prior to the start of employment and annually thereafter.
  - Results of the professional sanctions checks must not indicate any substantiated findings of abuse or neglect against the individual. This includes all applicable state licensing/certification boards and registries.

PROVIDER REQUIREMENTS FOR RBHS COMMUNITY SUPPORT SERVICES

Provider Credentialing for Therapeutic Child Care (TCC)

Enrolled RBHS providers must apply to become credentialed in TCC and must meet the following requirements:

- Hold a DSS license or approval as a daycare facility.
- At least one staff member must be credentialed in Trauma-focused Cognitive Behavior Therapy (TF-CBT), Parent-child Interaction Therapy (PCIT), or Child-parent Psychotherapy (CPP).
- Accredited by one of the following entities in at least one of the applicable standards:
  1. CARF:
     - CYS manual: Counseling/outpatient, early childhood development, intensive family-based services, intensive outpatient treatment and/or community transition
     - Behavioral Health manual: Intensive family-based services, and/or outpatient programs
  2. COA:
     - Child and family development and support services, day treatment services (DTX), family preservation and stabilization services, outpatient mental health services (MH), or
     - Services for MH and/or substance use disorders (SUD)
  3. TJC:
     - Behavioral Health Care Day Treatment: Child/youth category and/or MH - Child/youth category

Community Integration Services (CIS)

In order to render CIS, providers must meet the following requirements:

- Providers (RBHS organization as well as the clinical director) must have three years of experience serving adults with serious mental illness (SMI) or co-occurring SUDs in a structured setting.
- CIS must be facility-based.
- CIS program facility must be open for a minimum of five hours per day, at least five days a week.
- Accredited by one of the following entities in at least one of the applicable standards:
  1. CARF:
     - Behavioral Health manual: Community integration
  2. COA:
     - Vocational rehabilitation services, supported community living services, services for substance use conditions, MH/SUD, psychiatric rehabilitation services, MH, adult day services, counseling, support and education services and/or DTX
  3. TJC:
     - Behavioral Health Care Day Treatment: Adult and/or MH — adult, community integration

RBHS SERVICE-SPECIFIC STAFF QUALIFICATIONS

Staff-to-member Ratio

Unless otherwise specified below, staff to member ratio is one qualified professional to one member (1:1). Services are provided by the appropriate qualified practitioner as defined in the Staff Qualifications section of this manual and in accordance with South Carolina state law. Other members or patients of the provider in excess of the allowed ratio cannot be present during the delivery of the service.

Screening and Assessment Services

Diagnostic Assessment (DA)

The rendering professionals, regardless of licensure, credentials and supervision requirements, must be specifically trained to complete the organization's assessment tool capturing the Medicaid required clinical elements and to make clinically appropriate referrals and recommendations.

Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) Assessment

The CALOCUS-CASII must be administered by an LPHA or a master's level clinician with three years of experience (or be previously approved by SCDHHS to administer the CALOCUS). All new practitioners must have successfully completed training on the CALOCUS-CASII and passed a competency test.

The training can be obtained through any authorized provider; however, recommended training is through the American Academy of Child and Adolescent Psychiatry (AACAP). Additional information may be found on the AACP website. All certifications must be submitted to SCDHHS Office of Behavioral Health Services (MedicaidStatePlan@scdhhs.gov) for final approval prior to administering the instrument to members.

Psychological Testing and Evaluation (PTE) and Psychological or Neuropsychological Test Administration and Scoring (PTA)

PTE and PTA must be provided by a qualified licensed psychologist. 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.

Service Plan Development (SPD) of the Individual Plan of Care (IPOC)

SPD-Interdisciplinary Team Conference

Team conferences require participation from at least one other health or human services agency or provider involved with the member.

Members may attend SPD staffings and are actively involved in the development, revision, coordination and implementation of the resultant IPOC.

Core Treatment Services

Group Psychotherapy (GP)

GP requires at least one qualified clinical professional and no more than eight members (1:8). Patients in excess of the allowed ratio shall not be present during the delivery of the service.

Multiple Family Group Psychotherapy (MFGP)

MFGP requires at least one qualified clinical professional for a minimum of two-family units served (minimum of four individuals; 1:4) and a maximum of up to eight individuals (1:8) which includes the members and their families. Patients in excess of the allowed ratio shall not be present during the delivery of the service.

While it is preferrable and good clinical practice to have a co-leader in GP or MFGP, especially those at maximum capacity, it is not required for Medicaid reimbursement.

Community Support Services

Providers rendering direct services to children in a Therapeutic Foster Care placement must have, at a minimum, a high school diploma or GED.

Psychosocial Rehabilitation Services (PRS)

PRS rendered by paraprofessionals must be under the supervision of a qualified clinical professional. A bachelor's degree or above (or SAS certification if affiliated with OSUS) is required to render PRS.

PRS can be provided individually and in-person with one member at a time. PRS can also be provided in small groups of no more than one staff to eight (1:8) adult members and no more than one staff to eight (1:8) child or adolescent members, regardless of the payor source of the members in the group.

Only staff who meet the requirements specified in the Staff Qualifications section of this manual for PRS are considered in 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. If the second staff member is not appropriately qualified, reimbursement of the service is not allowable. Members in excess of the allowed ratio shall not be present during the delivery of the service.

Behavior Modification (BMOD)
BMOD services rendered by paraprofessionals must be under the supervision of qualified clinical staff. A bachelor's degree and above or SAS certification is required to render the service. BMOD incorporates a behavior modification plan, as outlined in the Reporting/Documentation section of this manual (Section 8).

BMOD is not allowable in group settings.

Family Support (FS) (Ages 0-21)
Staff providing FS must have a bachelor's degree or above or be a certified SAS.

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

Therapeutic Childcare (TCC)
TCC providers must be under the supervision of licensed clinical staff. In addition, at least one clinical staff member must be rostered to provide TF-CBT, PCIT, or CPP.

For the initial year of an organization providing TCC, the rostering requirement may be satisfied by a clinician actively engaged in training and supervision for TF-CBT, PCIT, or CPP as part of the rostering process. It is also understood that other evidence-based therapeutic models may be included in treatment, as appropriate, based on the individual needs of members and their families.

TCC can be provided individually and in-person with one member at a time or provided in-person with two to six members (1:2 – 1:6) in a small group (unless state daycare license requirements mandate a smaller ratio), regardless of the payer source of the members in the group.

Only staff who meet the staff qualifications for TCC are considered in the 1:6 ratio.

For example: If a group consists of seven 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 1:6.

Community Integration Services (CIS)
CIS must be provided by qualified clinical professionals and/or paraprofessionals as defined in the Staff Qualifications section of this manual. CIS rendered by paraprofessionals must be under the supervision of qualified clinical professionals and/or LPHAs.

Staff to member ratio of 1:8 or less must be maintained at all times in order to claim reimbursement for the service.

Therapeutic Foster Care (TFC)

TFC services must be rendered in an SCDSS licensed therapeutic foster home provided by child placing agencies contracted with and certified by SCDSS. TFC providers are qualified staff under the supervision of qualified clinical professionals as specified in the Staff Qualifications section of this manual.

TFC is provided individually and in-person with one member at a time and must be provided by custodial foster parents. The number of members in a therapeutic foster home along with the number of caregivers in that home is determined by SCDSS and is expressed in licensure and contract language promulgated by SCDSS.

Peer Support Services (PSS)

The certified peer support specialist (CPSS) must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a South Carolina certification training program and receive required ongoing continuing education. The provider must be 18 years of age or older. Those certified as CPSS Supervisors also meet criteria for delivery of PSS.

CPSS' must meet the following qualifications:

- Must have "lived experience" (i.e., a diagnosis of a behavioral health disorder and/or SUD, as defined by the American Psychiatric Association's Diagnostic and Statistical Manual, and received treatment for the disorder(s).
- Self-identify as having experienced a behavioral health disorder and/or SUD.
- Be in active recovery.
- CPSS' 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 certification program that consists of:
  - 40 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 annually, of which at least 12 hours must be face-to-face. All trainings must be approved by the certification entity.

Crisis Management Services

Crisis Intervention (CI)

Bachelor's level staff providing this service must have documented training in crisis management.

SUBSTANCE USE SERVICES-SPECIFIC STAFF QUALIFICATIONS

Providers of substance use services must follow guidelines as specified for the RBHS services identified above; staff qualifications that differ for substance use-specific services are identified below.

Note: For all group services, the specified staff-to-client ratio applies regardless of whether all group members are Medicaid-eligible.

Substance Use Screening and Assessment, Counseling Services

Substance Use Screening and Brief Intervention Services (SUS)

SUS may be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual who have been specifically trained to administer and review the screening tool and make a clinically appropriate referral.

Substance Use Diagnostic Assessment (SUDA)

The assessment must be provided by qualified clinical professionals as defined in the Staff Qualifications section of this manual who have been specifically trained to provide and review the assessment tool and make clinically appropriate recommendations and referrals.

Substance Use Counseling (SUC)

SUC services must be provided by a qualified clinical professional or under the supervision of a qualified clinical professional as defined in the Staff Qualifications section of this manual.

In group services (SUG), there must be at least one professional per 16 members (1:16).

Substance Use-specific Community Support Services

Skills Training and Development Services for Children (ST)

ST services are provided by qualified staff under the supervision of qualified clinical staff as defined in the Staff Qualifications section of this manual. Staff providing the service must have a bachelor's degree or above or be a certified SAS.

The service can be rendered in groups of one staff to 12 members (1:12), as appropriate, based on the needs of the member.

Medical Services

Vivitrol® Injection (VI)

A qualified health care professional who is authorized in South Carolina to administer injectable medication can render this service.

Intensive Community-based and Residential Treatment Services

Services are provided by qualified clinical professionals and paraprofessionals within their scope of practice as listed in the Staff Qualifications section of this manual.

The staff-to-client ratio must not exceed the allowed ratio set by the specific services listed in this manual that make up the bundled or all-inclusive rates.

4
COVERED SERVICES AND DEFINITIONS

Definitions

1. **Covered Services** are medical services, including those coverable through the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program, which meet the following criteria:
   - **a.** Are medically necessary.
   - **b.** Are provided to an eligible member by a participating provider.
   - **c.** Are the most appropriate supply or level of care consistent with professionally recognized standards of medical practice within the service area and applicable policies and procedures.
   - **d.** Are not rendered for convenience, cosmetic or experimental purposes.

2. **Face-to-Face Services** are those delivered in person with the member ***or*** via video through telehealth; the term ***in-person*** is used in this manual to designate services that require the provider and member to be physically present in the same location and are not allowable via telehealth.

3. **Provider** refers to an individual, firm, corporation, association, or institution providing, or approved to provide, medical assistance to a member pursuant to the State Medical Assistance Plan and in accordance with Title XIX of the Social Security Act, as amended.

4. **EPSDT** services is a benefit for persons under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a)(4)(B) and 1396d(r), and 42 C.F.R. Part 441, Subpart B to ascertain children's individual physical and mental illnesses and conditions discovered by screening services, whether such services are covered.

5. **Medically Reasonable and Necessary** signifies procedures, treatments, medications, or supplies, (the provision of which may be limited by specific provisions, bulletins and other directives [42 CFR 440.230 (d) and SC Code of Regulations 126-300 (D)]), ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury which per [S.C. Code of Regulations 126-425(9)]:
   - **a.** Must be provided at appropriate facilities, at the appropriate levels of care and in the least costly setting required by the member's condition.
   - **b.** Must be administered in accordance with recognized and acceptable standards of medical and/or surgical discipline at the time the member receives the service.
   - **c.** Must comply with standards of care and not for the member's convenience, experimental, or cosmetic purposes.

d. Medical necessity or any referral information must be documented in the member's health record and must include a detailed description of services rendered. The fact that a provider prescribed a service or supply does not deem it medically necessary.

COVERED SERVICES

State Plan Services

Rehabilitative behavioral health services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under state law, for maximum reduction of physical or mental disability and restoration of a member to his or her best possible functional level. RBHS is delivered under the State Plan authority in accordance with 42 CFR 440.130 (d). The determination of medically necessary treatment must be:

- Based on information provided by the member, the member's family and/or collaterals who are familiar with the member.
- Based on current clinical information. If the diagnosis has not been reviewed and evaluated in 12 or more months, the diagnosis shall be confirmed immediately and prior to rendering services; the determination of eligibility for services must include a diagnostic assessment or evaluation.
- Determined by an LPHA enrolled in the Healthy Connections Medicaid program.

Organization of Rehabilitative Behavioral Health Services

RBHS state plan services are organized into the following five categories:

1. **Screening and Assessment Services**

Screening and Assessment Services provide the foundation for medically necessary treatment, encompassing the identification of behavioral health risk factors, diagnoses, and treatment needs. Specifically:

- **Screening** is a brief, focused intervention used to determine an individual's risk of behavioral health issues. It can be conducted by trained staff, self-administered, or via clinician interview. Screening requires use of validated tools, and while it is not diagnostic, it serves to guide a more detailed assessment. Screening can also provide baseline measurement of symptoms/conditions and subsequent improvement (or lack of improvement) in the symptoms/conditions after a course of treatment.
- **Assessment** is an in-depth biopsychosocial evaluation of multiple domains, including a member's psychosocial well-being, physical/behavioral health history, mental status and behavior patterns, severity of symptoms, and functional impairments. Assessment is diagnostic in nature and provides the foundation for recommended medically necessary behavioral health care.

Covered services include:

- Behavioral health screening (BHS)
- Diagnostic assessment (DA) and DA follow-up
- Psychiatric medical assessment (PMA)
- CALOCUS-CASII

- Psychological Testing and Evaluation/Psychological or Neuropsychological Test Administration and Scoring (PTE/PTA)

2. **Service Plan Development (SPD) of the Individual Plan of Care (IPOC)**

Development of the IPOC is a person-centered planning process that engages the member (or their parent/guardian/legal representative) in developing their course of treatment. This includes identifying their chosen supports and decision-making preferences, providing explanations and informed choice options for services, considers the member's cultural needs, and alternative home/community settings, where applicable.

A written plan reflects both services and supports needed based on assessment of functional needs and individual preferences for how and by whom services are delivered. As per 42 CFR § 441.468, service plans must include the scope, amount, frequency, and duration of each service.

Service plans must be individualized, dynamic, and centered around the member, balancing their needs and preferences. They are not generic medical orders, but comprehensive, living documents shaped by the person receiving care.

Covered services include:

- SPD – Interdisciplinary team with client/family
- SPD – Interdisciplinary team without client/family
- SPD by Non–physician

3. **Core Treatment Services**

Core treatment services consist of the primary therapeutic behavioral health interventions necessary to support and maintain a member's emotional and psychological well-being. These services include the prevention, identification, and treatment of mental health and substance use disorders, and represent the primary therapeutic components of an individualized behavioral health treatment plan.

Core treatment services encompass a structured set of clinical interventions delivered by a trained and qualified behavioral health professional. Services may be provided at the individual, family, or group level, and may include insight-oriented psychotherapy, evidence-based treatment models, management of psychotropic medications, and other clinically indicated therapeutic modalities. Core treatment may be delivered in person or via telehealth, as specified by service definition. It also includes the coordination and integration of behavioral health services within the member's broader care plan to ensure continuity and effectiveness of care.

Covered services include:

- Individual Psychotherapy (IP)
- Family Psychotherapy (FP)
- Group Psychotherapy (GP)
- Multiple Family Group Psychotherapy (MFGP)
- Medication Management

4. **Community Support Services**

Community support services are the psychosocial supports and therapies required to address the emotional, social, behavioral, and environmental factors that affect a member's overall health and functioning. These services are adjunct therapies to core treatment services and address the interaction between psychological factors (thoughts, emotions, behaviors) and social factors (family, housing, employment, education/vocation, relationships) that influence health.

Community support services are non-medical interventions that help the member build emotional resilience, strengthen coping skills, improve social functioning, and access needed community resources. Supportive interventions help individuals maintain recovery, reduce relapse risk, improve functioning, and stay engaged in treatment.

Covered services include:

- Psychosocial Rehabilitation Services (PRS)
- Behavior Modification (BMOD)
- Family Support (FS)
- Therapeutic Childcare (TCC)
- Therapeutic Foster Care (TFC)
- Community Integration Services (CIS)
- Peer Support Services (PSS)

5. **Crisis Management Services**

Crisis management services involve a process of timely, trauma-informed, clinical responses delivered in non-hospital settings to individuals experiencing an acute mental health or substance use crisis.

Key elements include a de-escalation focused approach that is accessible year-round, 24 hours per day, seven days per week and includes screening, evaluation, stabilization, and referral for more intensive interventions when necessary.

Covered services include:

- Crisis Intervention (CI)

Organization of Substance Use Services

State plan substance use services, including several of the above services identified for RBHS, are organized into the following six categories:

1. Screening and Assessment Services

The goal of screening and assessment services for substance use-specific providers is to facilitate early identification and accurate diagnosis of substance use and co-occurring disorders. The outcomes of screening and assessment allow the provider to identify the most appropriate course of treatment and thus engage the member in the pathway to recovery.

Covered services include:
- Behavioral Health Screening (BHS)
- Substance Use Screening and Brief Intervention (SUS)
- Substance Use Diagnostic Assessment (SUDA)
- Substance Use Diagnostic Assessment, Follow-Up
- Substance Use Nursing Assessment (SUN)
- Psychiatric Medical Assessment (PMA)
- CALOCUS-CASSI
- Psychological Testing and Evaluation/Psychological or Neuropsychological Test Administration and Scoring (PTE/PTA)

2. SPD of the IPOC

Service planning for substance use services includes a comprehensive review of the member's identified needs and potential care options while also considering the levels of care recommendations as defined by the most current edition ASAM guidelines.

Covered services include:
- SPD by non-physician

3. Medical Services

Medical services, which are required for medication-assisted therapy (MAT), are professional clinical interventions directed by a licensed qualified health care provider aimed at maintaining, improving, or protecting health, or lessening illness, disability, or pain. Medical services are preventive, diagnostic, therapeutic, and/or rehabilitative in nature.

Covered services include:
- Evaluation & Management of New and Established Patients (E&M)
- Medication Management (MM)
- Medication Administration (MA)
- Vivitrol Injection (VI)

4. Psychotherapy and Community Support Services

This category encompasses the core treatment and adjunctive therapies for substance use services. Goals and outcomes include reducing or safely managing substance use, prevention of relapse, improvement in well-being and overall functioning and sustaining recovery over time. Services are recovery-oriented and focused on whole-person care.

Psychotherapy includes a structured set of clinical interventions delivered by a trained and qualified behavioral health professional. Services may be provided at the individual, family, or group level, Primary interventions include medication-assisted treatment (MAT), insight-oriented therapy, skill-building (teaching coping mechanisms, relapse prevention strategies, emotional regulation, daily living skills, etc.), psychoeducation, motivation enhancement, and evidence-based therapies.

Covered services include:

- Individual Psychotherapy (IP)
- Individual Substance Use Counseling (SUC)
- E&M with Psychotherapy
- Family Psychotherapy (FP)
- Group Psychotherapy (GP)
- Substance Use Counseling Group (SUG)
- Multiple Family Group Psychotherapy (MFGP)
- Psychosocial Rehabilitation Services (PRS)
- Skills Training and Development Services (ST)
- Peer Support Services (PSS)
- Family Support (FS)

5. Crisis Management Services

Crisis management services provided in an outpatient setting involve a timely response to a member's urgent behavioral health needs, as noted above. Additionally, members with substance use disorders may have marked distress and escalating needs requiring a crisis level of care when navigating a destabilizing event that results in active substance use (or triggers intrusive thoughts of and/or behaviors toward active substance use).

Covered services include:

- Crisis Intervention (CI)

6. Intensive Community-based and Residential Treatment Services

This service array, which follows the levels of care as determined by the American Society of Addiction Medicine (ASAM), is intended for members with more intensive needs who have not benefited from traditional outpatient substance use services or are otherwise determined as appropriate for this level of care based on medical necessity.

Intensive community-based services are distinct and organized intensive ambulatory treatment programs that offer less than 24-hour care other than in a member's home or in an inpatient or residential setting.

Residential services utilize structured living environments with varying levels of clinical intensity, including medically or clinically managed treatment settings and withdrawal management, depending on a member's assessed clinical need and medical necessity.

Covered services include:

- Substance Use – Intensive Outpatient Programs (IOP): Level 2.1
- Substance Use – Day Treatment/Partial Hospitalization Programs (PHP): Level 2.5
- Sub-Acute Withdrawal Management — Clinically Managed Residential Withdrawal Management: Level 3.2WM
- Clinically Managed High-Intensity Residential Treatment: Level 3.5

- Acute Withdrawal Management — Medically Monitored Inpatient Withdrawal Management: Level 3.7WM
- Medically Monitored Intensive Inpatient Treatment: Level 3.7

This manual provides the service criteria, documentation required, and benefit limitations for each covered service in subsequent sections.

EPSDT Benefit

Children under the age of 21 are eligible for medically necessary services as part of the EPSDT benefit. Federal law at 42 U.S.C.§1396d(r), §1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide EPSDT for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers services that are medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether the service is covered under the State Plan. The EPSDT benefit includes services provided at intervals that meet reasonable standards of medical practice and at intervals necessary to determine the existence of a suspected illness or condition. EPSDT is detailed on the SCDHHS website.

Telehealth Services Delivered by RBHS Organizations

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.

Telehealth services 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 HIPAA compliant. SCDHHS reimburses only for services conducted synchronously, using both audio and video components, unless otherwise specified.

Telehealth services are not an addition to the array of Medicaid-covered services, but a mode of delivery for certain covered services. Quality of health care must be maintained regardless of the mode of delivery.

Telehealth Definitions:

1. Synchronous telehealth: Synchronous telehealth is real-time, audio-video communication that connects physicians/other qualified providers and patients in different locations (referring site and consulting site).
2. Referring provider: The referring provider is the provider who has evaluated the member, determined the need for a consultation and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment.
3. Consulting provider: The consulting provider is the provider who evaluates the member 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 Healthy Connections 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 Healthy Connections Medicaid program.

Referring Sites

A referring site (also called the patient site) is the location of an eligible Medicaid member at the time of the telehealth session. Medicaid members 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 include:

- RBHS organizations
- County substance use authorities
- The office of a qualified practitioner defined as a physician, NP, certified nurse midwife, PA, or licensed independent practitioner
- Hospital (inpatient and outpatient)
- RHCs
- FQHCs
- Community mental health centers
- Public schools
- OSUS-affiliated behavioral health centers
- 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 Healthy Connections Medicaid program and provide services in accordance with the licensing board and their scope of practice.

Practitioners in an RBHS organization able to furnish services via telehealth are:

- Physicians
- NPs
- PAs
- Licensed independent practitioners (and associates)
- Other qualified master's level or bachelor's level providers as identified in the Eligible Providers section of this manual.

Note: Services rendered via telehealth must include a GT modifier; the GT modifier is always secondary when a primary modifier for the procedure code denotes education/credentials of provider.

Office and other outpatient visits that are conducted via telehealth are counted towards the applicable service limits for these services. Medicaid allows the service to be delivered via telehealth when the service meets the following criteria:

- The member must be notified of and agree to the telehealth visit when the provider appointment is scheduled.
- The member must be present and participating in the telehealth visit, unless otherwise specified in the procedure code description.

Interactive audio and video telecommunication must be used, permitting encrypted communication between the distant site physician or practitioner and the Medicaid member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted and must include the following considerations:

- 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.
- When provided in a setting such as a school or outside agency office, a trained professional at the referring site (patient site presenter) is required to present the member 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 member is not of the age to consent to medical treatment (under 16 years old), a parent and/or guardian must present the minor for the 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 member 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 member 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 authorization for services prior to delivering when a PA is required based on service type or diagnosis.
- The service is individualized, specific and consistent with symptoms or confirmed diagnosis under treatment, and not in excess of the member's need.
- The service can be safely furnished via telehealth.
- No equally effective, more conservative or less costly treatment is available statewide.

NON-COVERED SERVICES

Certain activities conducted to facilitate the provision of RBHS services are not Medicaid-reimbursable under the RBHS policy. Professional judgment must be exercised in distinguishing between billable and non-billable activities. The following is not an exhaustive list, but serves as a guide to identify activities that shall not be billed as RBHS, including:

- Transportation of members.
- Transportation and/or travel time.
- Any activities to attempt contact with members (i.e., attempted phone calls, home visits, and face-to-face contacts, etc.).

- "Outreach" activities in which an agency or a provider attempts to contact a potential Medicaid recipient.
- Medical record audits or chart reviews. Review of a clinical record to become familiar with a member's case.
- Staff meetings, trainings and supervision.
- Activities provided by anyone other than a professional who meets the qualifications to render a service.
- Completion and provision of any documentation regarding members for administrative purposes.
- Any social or recreational activities, or the supervision of such activities (i.e., playing basketball, watching movies, etc.).
- Life coaching.
- Mentoring members.
- Documentation of clinical service notes or other required form.
- Unstructured client time; periods of inactivity and/or unstructured free time may be necessary for a client 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 (i.e., GED, adult development), or tutorial services in relation to a defined education course.
- Educational interventions that do not include individual process interactions.
- Services provided to teach academic subjects or as a substitute for educational personnel (i.e., a teacher, teacher's aide, an academic tutor, etc.).
- Shadowing members in the classroom.
- Assisting members with homework or other educational assignments.
- Any childcare services or other services provided as a substitute for the parent or other primary caretaker responsible for the member.
- When prior authorization is required, dates of services not covered in the range of the QIO approval letter.
- Services not identified on the IPOC (excluding those not required to be listed on the IPOC per policy).
- Services provided to children, spouse, parents, or siblings of the member receiving treatment, or others in the member's life, when addressing problems not directly related to the member's issues and not listed on the member's IPOC.
- Any art, movement, dance, drama, or equine therapies.
- Filing, mailing and/or faxing reports to other entities or individuals on behalf of the member.
- Medicaid eligibility determinations and re-determinations.
- Medicaid intake processing.
- Completion of and monitoring of prior authorization requests for Medicaid services.
- Required Medicaid utilization review.
- EPSDT administrative activities.
- Participation in job interviews.
- The on-site instruction of specific employment tasks.
- Staff supervision of actual employment services.

- Assisting members in obtaining job placements.

- Assisting clients in filling out applications (i.e., employment, disability, etc.).
- Assisting clients in their work-related activities or performing jobs for clients.
- Drawing client's blood and/or urine specimen, and/or taking the specimen(s) to the lab.
- Visiting members while they are participating in another treatment program where another provider is billing services, unless for a special authorized treatment activity. RBHS is not allowable for members residing in an Institution for Mental Disease.
- Retrieving medications for a member and/or handing out prescriptions or medications.
- Scheduling appointments with the member or other providers.
- Staffing cases between clinicians in the same office/program for the purpose of supervision.
- Waiting for and/or spending time with a member in waiting rooms.
- Respite care (to include peer support services provided as respite care).
  - Services provided to Medicaid-eligible members who do not fall within a population generally eligible for rehabilitative behavioral health services, with the exception of services provided to those Medicaid-eligible members who are also dually enrolled in Medicare.

For this population, Medicaid will reimburse the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by South Carolina Healthy Connections Medicaid. Reimbursement for these services will be consistent with the State Plan.

RBHS SERVICE-SPECIFIC MEDICAL NECESSITY CRITERIA

In order to be covered under the Healthy Connections Medicaid program, a service must be medically necessary.

The following medical necessity criteria must be met for each service:

Screening and Assessment Services	
Behavioral Health Screening (BHS) **Diagnostic Assessment (DA) Services**	• All Medicaid-eligible members who have been identified as having or at risk of a mental health disorder and/or SUD are eligible for this service.
Psychological Testing and Evaluation (PTE) **Psychological or Neuropsychological Administration and Scoring (PTA)**	• All Medicaid-eligible members who have been identified as having or at-risk of a mental health disorder and/or SUD are eligible for this service, provided there is a clear, documented reason testing is needed (i.e., differential diagnosis, atypical symptomatology, prior/current mental health treatment is ineffective, etc.).
Service Plan Development of the Individual Plan of Care	

Service Plan Development (SPD)	• Members eligible for these services must have a diagnosis of a behavioral health disorder. The results of the DA and/or screening tool must support the need for services.
Core Treatment Services	
Individual Psychotherapy (IP) **Group Psychotherapy (GP)** **Multiple Family Group Psychotherapy (MFGP)** **Family Psychotherapy (FP)**	• Members eligible for these services must have a diagnosis of a mental health disorder and/or SUD. • The results of the assessment and/or screening tool must indicate functional deficits that support the need for services. At least two of the following areas must reflect functioning below normal limits for age: daily living skills (self-care), interpersonal relationships, ability to work/attend school, ability to interact effectively in the community, and appropriately engaged in recreational activities/settings.
Medication Management (MM)	• Members eligible for these services must have a diagnosis of a mental health disorder and/or SUD. • The results of the assessment and/or screening tool must indicate functional deficits that support the need for these services. The member must be on medication prescribed by a Physician or receiving education on how to take their medication(s) appropriately.
Community Support Services	
Psychosocial Rehabilitation Services (PRS) • Admission Criteria for Adults (age 21 and older)	**All criteria (A-G) must be met for admission:** A. The member has received a DA and is diagnosed with an SMI which includes one of the following: bipolar disorder, major depressive disorder, a diagnosis within the spectrum of psychotic disorders, and/or SUD. B. The member has an SMI and/or SUD and the symptom-related problems interfere with the individual's functioning in their daily living skills, the home, interpersonal relationships, work and/or educational environment, recreational settings, and community. C. As a result of the SMI and/or SUD, the member demonstrates moderate to severe functional impairment that interferes with at least three of the following domains: Daily living skills, housing, interpersonal relationships, work/educational capability, navigating within the community and/or engaging in recreational activities. D. Traditional MH services (i.e., individual/family/group therapy, MM, etc.) alone are not clinically sufficient to prevent the member's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and the benefits of receiving the treatment outweigh any potential harm.

	E. Member meets three or more of the following criteria as documented on the DA: 1. Is not functioning at a level that would be expected of typical individuals their age. 2. Is at risk of psychiatric hospitalization, homelessness, jail, and/or isolation from social supports due to the member's SMI and/or SUD. 3. Exhibits behaviors that require repeated interventions by the mental health, social services, and/or legal systems. 4. Demonstrates impaired ability to recognize personal and/or environmental dangers and/or exhibits significantly inappropriate social behavior. 5. Members are expected to benefit from the intervention and identified needs would not be better met by any other formal or informal system or support. F. The service is recommended by an LPHA acting within the scope of his/her professional licensure. **Continued Service Criteria for PRS (age 21 and older)** All criteria (A-E) must be met for continued services: A. The member continues to meet the admission criteria. B. There is documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the service description. C. Member has shown improvement in functioning in at least two of the following domains: Daily living skills, housing, interpersonal relationships, work/educational capability, navigating within the community, and/or engaging in recreational activities, and is expected to continue to benefit from PRS, which remains appropriate to meet the member's needs. D. The members and others identified during the treatment plan process are active members in the creation of the treatment and discharge plan and are actively participating in treatment. The member's designated others and treatment team agree 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 member's IPOC.
Psychosocial Rehabilitation Services (PRS) • Admission Criteria for Children (age 0–21)	**All criteria (A-I) must be met for admission:** A. The member 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 member has an SMI, serious emotional disturbance (SED), and/or SUD, and the symptom-related problems interfere with the individual's functioning in the home, community, educational/work environment, or recreational activities. (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 SMI, SED, or SUD, the member experiences moderate to severe functional impairment that interferes with three or more of the following domains: Daily living skills, the home, interpersonal relationships, educational and/or work capability, navigating in the community, and/or engaging in recreational activities. D. Member meets three or more of the following criteria as documented on the DA: 1. Is not functioning at a level that would be expected of typically developing individuals their age. 2. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement (including DJJ or foster care). 3. In the last 90 days, exhibited behavior that resulted in at least one intervention by crisis response, social services, and/or law enforcement. 4. Experiences impaired ability to recognize personal or environmental dangers or exhibits significantly inappropriate social behavior. E. The family/caregiver/guardian agrees to be an active member in the treatment process, which involves participating in interventions to better understand and care for the member for the purpose of maintaining progress during and after treatment. F. Traditional mental health services (i.e., individual/family/group therapy, MM, etc.) alone are not clinically sufficient to prevent the member's condition from deteriorating. The level of care provided is determined by the clinician to be the least restrictive and the benefits of receiving the treatment outweigh any potential harm. G. The service is recommended by an LPHA acting within the scope of his/her professional license. H. Member is expected to benefit from the intervention and needs would not be better met by any other formal or informal system or support.

	I. The score on the age-appropriate assessment tool, as indicated below and completed by the LPHA, indicates need for PRS (private providers only): 1. For members ages 0-1.5, scores in the 81st percentile or above on the Parenting Stress Index (PSI). 2. For members ages 1.5–5, scores in the borderline to clinical range (minimum T score of 65) on at least one syndrome scale and one DSM-oriented scale on the Child Behavior Check List (CBCL). 3. For members ages 6–18, a minimum CALOCUS-CASII composite score of 17. **Continued Service Criteria for PRS (ages 0–21)** All criteria (A-E) must be met for continued services: A. The member continues to meet the admission criteria. B. There is documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the service description. C. The member has shown improvement in functioning in at least two of the following domains: Daily living skills, the home, interpersonal relationships, educational and/or work capability, recreational settings, community, and is expected to continue to benefit from PRS, which remains appropriate to meet the member's needs. D. The family/caregiver/guardian and others identified through the treatment plan process are actively participating in treatment. The member'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 member's IPOC.
Behavior Modification (BMOD) • Admission Criteria for Children and Adolescents (ages 0–21)	**All criteria (A–J) must be met for admission:** A. The member is under 22 years of age. B. The member has received a DA, which includes a current DSM diagnosis that requires and will respond to therapeutic interventions, and which documents the need for BMOD. C. The member has an SMI, SED, and/or SUD, and must be engaging in one or more of the following behaviors: physical aggression (towards others and/or property), verbal 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 member's behaviors interfere with three or more of the following domains: Daily living skills, the home, interpersonal relationships, educational and/or work capability, navigating in the community, and/or engaging in recreational activities. E. Member meets three or more of the following criteria as documented on the DA: 1. Is not functioning at a level that would be expected of typically developing individuals their age. Is deemed to be at-risk of psychiatric hospitalization or out-of-home placement (includes DJJ and foster care). 2. In the last 90 days, exhibited behavior that resulted in at least one intervention by crisis response, social services, and/or law enforcement/DJJ. 3. Experiences impaired ability to recognize personal and/or environmental dangers and/or exhibits significantly inappropriate social behavior. F. The member's behavioral needs require interventions to decrease identified behaviors and to facilitate the member's success in his or her home, school, and community. G. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the member's needs identified in the DA and IPOC for the purpose of maintaining progress during and after treatment. H. Member 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 an 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 BMOD (private providers only): 1. For members ages 0-1.5, scores in the 81st percentile or above on the PSI. 2. For members ages 1.5–5, scores 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. 3. For members ages 6–18, a minimum CALOCUS-CASII composite score of 17. **Continued Service Criteria for BMOD** All criteria (A–E) must be met for continued services: A. The member continues to meet the admission criteria.

	B. There is documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the member's IPOC. The progress summary must specifically capture progress on each goal listed on the IPOC. C. The member has shown improvement in functioning in at least two of the following domains: Daily living skills, the home, interpersonal relationships, educational and/or work capability, navigating in the community, and/or engaging in recreational activities, and is expected to continue to benefit from BMOD, which remains appropriate to meet the member's needs. D. The member's IPOC and treatment process should be youth-guided and family-driven. The member, the member's designated others, and treatment team agree 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 member's IPOC.
Family Support (FS) • Admission Criteria for Children and Adolescents (ages 0–21). .	**All criteria (A–I) must be met for admission:** A. The member is under the age of 22. B. The member has received a DA, which includes a current DSM diagnosis and identifies specific clinical needs that will respond to therapeutic interventions, and which documents the need for FS. C. The member has an SMI, SED, and/or SUD, and the symptom-related problems interfere with the individual's functioning in the home, school, community, and/or work 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 SMI, SED, or SUD, the member experiences moderate to severe functional impairment that interferes with three or more of the following domains: Daily living skills, the home, interpersonal relationships, educational and/or work capability, navigating in the community, and/or engaging in recreational activities. E. Member meets three or more of the following criteria as documented on the DA: 1. Is not functioning at a level that would be expected of typically developing individuals their age.

	2. Is deemed to be at-risk of psychiatric hospitalization and/or out-of-home placement (includes DJJ and foster care). 3. In the last 90-days, exhibited behavior that resulted in at least one intervention by crisis response, social services, or law enforcement/DJJ. 4. Experiences impaired ability to recognize personal and/or environmental dangers and/or significantly inappropriate social behavior. F. Family/caregiver agrees to be an active member in treatment; FS services must provide opportunities for the family/caregiver to acquire and improve skills needed to better understand and care for the needs of the member (i.e., managing crises, becoming educated about the member's diagnosis). G. Member 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 an LPHA acting within the scope of his/her professional licensure. I. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for FS (private providers only): 1. For members ages 0-1.5, score in the 81st percentile or above on the PSI. 2. For members ages 1.5–5, score 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. 3. For members ages 6–18, a minimum CALOCUS-CASII composite score of 17. **Continued Service Criteria for FS** All criteria (A-E) must be met for continued services: A. There is documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals specific to the treatment needs stated in the member's IPOC. B. The desired outcome or level of functioning has not been restored or sustained over the time frame outlined in the member's IPOC. C. The member has shown improvement in functioning in at least two of the following areas: Daily living skills, the home, interpersonal relationships, educational and/or work

	capability, navigating in the community, and/or engaging in recreational activities, and is expected to continue to benefit from FS, which remains appropriate to meet the member's needs. D. The member continues to meet the admission criteria. E. The member's IPOC and treatment process should be youth-guided and family-driven. The member, the member's designated others, and treatment team agree on treatment goals, objectives and interventions.
Therapeutic Child Care (TCC) • Children age 0 up to their 6th birthday.	**All criteria (A-H) must be met for admission:** A. The member must under age 6 (up to their 6th birthday). B. The member has been diagnosed with a serious emotional disturbance (SED) or an applicable Z-code per the current DSM. C. The member requires and is expected to respond to therapeutic interventions specific to the TCC service description. D. The member must be exhibiting moderate to severe behavioral problems that significantly impair the member's ability to function at an age-appropriate developmental level. E. The family or caregiver agrees to be an active participant, which involves participating in interventions to better understand the member's needs identified in the DA and IPOC, for the purpose of maintaining progress during and after treatment. F. 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 member is exhibiting behavioral problems that prohibit placement in a traditional preschool or childcare setting and/or the behaviors, coupled with parental stress levels, leave the child at risk for abuse and/or neglect. H. The score on the age-appropriate assessment tool, completed by the LPHA, indicates need for TCC: 1. For members ages 0-1.5, score in the 75th percentile or above on the PSI. 2. For members ages 1.5–5, scores 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 TCC** All criteria (A–E) must be met for continued services: A. The member continues to meet the Admission Criteria.

	B. There is documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the member's IPOC. C. The member has shown improvement and is expected to continue to benefit from TCC, which remains appropriate to meet the member's needs. D. The family and/or caregiver are active members in the creation of the treatment and discharge plans and are actively participating in treatment. The member' designated others and treatment team agree on treatment goals, objectives, and interventions. E. Desired outcome or level of functioning has not been restored or sustained over the timeframe outlined in the member's IPOC.
Community Integration Services (CIS) • Ages 18+ only.	**All criteria (A-H) must be met for admission:** A. The member is 18 years or older. B. The member has been diagnosed with an SMI, which includes one of the following diagnoses: bipolar disorder, major depression, a diagnosis within the spectrum of psychotic disorders, or an SMI with a co-occurring SUD. C. As a result of the SMI or co-occurring SUD, the member has a moderate to severe functional impairment that limits role performance and/or has skills deficits in three or more of the following areas: Daily living skills/self-care, housing, interpersonal relationships, work/educational capability, navigating within the community, and/or engaging in recreational activities. D. Traditional mental health services alone (i.e., individual/family/group therapy, MM, etc.) are not clinically appropriate to prevent the member's condition from deteriorating. E. Member meets three or more of the following criteria as documented on the DA: 1. Is not functioning at a level that would be expected of typical individuals their age. 2. Is at-risk of psychiatric hospitalization, homelessness, or isolation from social supports due to the member's SMI or co-occurring disorders. 3. Exhibits behaviors that require repeated interventions by the mental health, social services, or judicial systems. 4. Experiences impaired ability to recognize personal or environmental dangers or exhibits significantly inappropriate social behavior.

	F. Without the support of a CIS program, the member will be unable to function in the community. G. The member is not at imminent risk of harm to self, others, and/or property. H. The member is expected to benefit from the interventions and needs would not be better met by any other formal or informal system or support. **Continued service criteria for CIS** All criteria (A–E) must be met to continue services: A. The member continues to meet the admission criteria. B. There is adequate documentation from the provider that the member is receiving the scope and intensity of services required to meet the program goals stated in the service description. C. The member has shown improvement in at least two of the following domains: Daily living skills/self-care, housing, interpersonal relationships, work/educational capability, navigating within the community, and/or engaging in recreational activities. D. The member is expected to continue to benefit from CIS, which remains appropriate to meet the member's needs. E. Withdrawal of CIS may result in loss of rehabilitation gains or goals obtained by the member.
Peer Support Services (PSS) • Ages 18+ only.	**Admission Criteria:** A. Member has been diagnosed with an SMI and/or an SUD. B. Member meets two or more of the following criteria as a result of their diagnosis. C. Has had significant difficulty independently and consistently accessing behavioral health services (i.e., relies on emergency department services, has had two or more inpatient admissions over the last year). D. Is being released from incarceration or being discharged from a hospital or facility-based program. E. Has had severe functional impairment that interferes with activities of daily living, including hygiene, nutrition, finances, home maintenance, childcare, or difficulties with other community service needs, such as housing, transportation or legal issues. F. Has experienced significant challenges meeting educational or employment goals. G. Lives in unsafe or temporary housing.

	H. 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. I. Member is assessed to be at low risk of serious harm to self or others. J. Member has demonstrated a need for assistance with community living and the service is recommended by an LPHA acting within the scope of his/her professional licensure. K. The service, including frequency of the service, is recommended as a result of the DA. L. Member has an IPOC that addresses mental health concerns and any co-occurring general medical condition. M. Member 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 for PSS:** Member is eligible to continue this service if: A. The member continues to meet admission guidelines for this level of care. N. 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 member's progress notes. B. Member is actively involved in the Peer Support process and participating in interventions. C. Member does not require a higher level of care, and no other intervention level would be appropriate. D. Member is making some progress, but the interventions need to be modified so that greater gains can be achieved.
Crisis Management Services	
Crisis Intervention (CI)	**Members eligible for this service must:** A. Have a diagnosis of a mental health disorder and/or SUD. B. Be experiencing acute psychiatric symptoms or psychological and/or emotional disturbances that result in increased interpersonal distress; may include suicidal ideation/intent or desire/intent to harm others. C. Services are also allowable for members who: 1. Require assessment for meeting imminent risk criteria for psychiatric hospitalization; may be at risk of other out-of-home placement or law enforcement detainment due to threat of harm.

	2. Be represented by a family member or other individuals who have extensive knowledge of the member's capabilities and functioning, the current crisis situation, and potential safety concerns for members and/or others and/or in the home. **A DA is required prior to rendering core services.**

SERVICE-SPECIFIC MEDICAL NECESSITY CRITERIA FOR SUBSTANCE USE SERVICES

Substance use services may be medically necessary for members diagnosed with (or at risk of having) an SUD or co-occurring substance use and mental health disorders. SUS providers will utilize the RBHS medical necessity criteria from the categories above, where applicable; additional medical necessity criteria is specified for the following:

Core Treatment Services	
Vivitrol® Injection (VI)	• Members must be prescribed Vivitrol® or have a medical order from a qualified health care professional for this service.
Substance Use Counseling (SUC)	• The results of the screening and/or assessment tool must indicate a functional level that supports the need for services. • Problematic behavior must interfere with the ability of the member to function in at least two of the following areas: daily living skills, the home, interpersonal relationships, educational and/or work capability, navigating in the community and/or engaging in recreational activities.
Medication Administration (MA)	• Members must be prescribed medication(s) or have a medical order from a qualified health care professional for this service.
Community Support Services	
Skills Training (ST) and Development Services for Children	Members under the age of seven with impaired functioning due to risk factors of parental/familial SUD or co-occurring substance use and mental health disorders are eligible for this service and must meet the following: 1. The results of the screening and/or assessment tool must indicate a functioning level that supports the need for services. 2. The behavior must interfere with the ability to function in at least two of these areas: Daily living skills, the home, interpersonal relationships, educational capability, navigating

	in the community, and/or engaging in recreational activities. 3. It is expected that ST will restore functioning to a previous level or to the appropriate developmental level.
Intensive Community-based and Residential Treatment Services	
Substance Use: Intensive Outpatient Treatment Program (IOP): *Level 2.1*	The member must meet ASAM criteria for this level of care, with documentation reflecting applicable medical necessity on each of the ASAM dimensions listed below: 1. Direct admission to Level 2.1 is warranted for the member who meets specifications on Dimension 2 (if any biomedical conditions or have existing substance use problems), on Dimension 3 (if any emotional, behavioral, cognitive conditions or problems exist), and on one specification of Dimension 4, 5 or 6. 2. Transfer to Level 2.I is warranted for a member who has met essential treatment objectives at a more intensive level of care and requires Level 2.I service intensity in at least one dimension. 3. Transfer to Level 2.I *may* be warranted when services provided at Level 1 have been insufficient to address the member's needs or when motivational interventions provided at Level 1 have prepared the member for participation in a more intensive level of service, and the member meets criteria for that level.
Substance Use: Day Treatment/Partial Hospitalization (PHP): *Level 2.5*	The member must meet ASAM criteria for this level of care, with documentation reflecting applicable medical necessity on each of the ASAM dimensions below: 1. Direct admission to Level 2.5 is warranted for the member who meets specification on Dimension 2 (if any biomedical conditions or problems exist) and specifications in one of Dimensions 4, 5 or 6. 2. Transfer to Level 2.5 is warranted for the member who has met treatment objectives at a more intensive level of care and requires Level 2.5 service intensity in at least one dimension. 3. Transfer to Level 2.5 may be warranted when services provided at Level 1 or Level 2.1 have been insufficient to address the member's needs. In addition, transfer to this level is appropriate when motivational interventions

	provided have prepared the member for participation in a more intensive level of care.
Sub-acute Withdrawal Management: Clinically Managed Residential Withdrawal Management: *Level 3.2WM*	The member must meet ASAM criteria for this level of care, with documentation reflecting applicable medical necessity on each of the ASAM dimensions: 1. Experiencing signs and symptoms of withdrawal or there is evidence that withdrawal is imminent. 2. Assessed as not being at-risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service. 3. Assessed as not requiring medication but requires this level of service to complete withdrawal management and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure.
Acute Withdrawal Management: Medically Monitored Inpatient Withdrawal Management Services: *Level 3.7WM*	The adult member must meet ASAM criteria for this level of care, with the appropriate documentation reflecting applicable medical necessity on each of the ASAM dimensions: • Experiencing signs and symptoms of severe withdrawal, or there is evidence that a severe withdrawal syndrome is imminent and assessed as manageable at this level of care. • There is strong likelihood that the member (who requires medication) will not complete withdrawal management at another level of care, enter continued treatment, or self-help recovery.
Clinically Managed High Intensity Residential Treatment: *Level 3.5*	The adult member must meet ASAM criteria for this level of care, with documentation reflecting applicable medical necessity on each of the ASAM Dimensions: A. No withdrawal signs or symptoms, or withdrawal can be safely managed at this level of care. B. Biomedical problems are stable or not severe enough to warrant hospital treatment but are sufficient to distract from treatment or recovery efforts. C. Emotional, behavioral, or cognitive conditions render the member unable to control substance use and the resulting level of dysfunction precludes participation in a less structured level of care.

	D. Has not reached the motivational stage of change required due to intensity and chronicity of the substance use problem. E. Has not developed insight into connection between substance use and life problems and blames external factors for his or her problems. F. Does not recognize relapse triggers and is not committed to continuing care. G. Is unable to control substance use; little ability to interrupt the relapse process. H. Is experiencing addiction symptoms and is unable to employ skills to prevent a relapse. I. Is in a crisis situation with imminent danger of a relapse. J. Continues to use substances despite recent active participation in the treatment program at a less intensive level of care. K. Living environment is characterized by high risk of victimization, criminal behavior, antisocial norms and values, or other factors that make it unlikely he or she will be able to achieve or maintain recovery at a less intensive level of care.
Medically Monitored Intensive Inpatient Treatment: *Level 3.7 (*Adults and Adolescents)	The adolescent or adult member must meet ASAM criteria for this level of care, which requires the member to meet specifications in at least two of the six dimensions: A. At least one criterion must be met in Dimension 1 (acute intoxication and/or withdrawal potential), Dimension 2 (biomedical conditions and complications) or Dimension 3 (emotional, behavioral, or cognitive conditions and complications). B. Members with a greater severity of illness in these dimensions require use of more intensive staffing patterns and support services due to functional deficits. C. The member may have medical issues that require direct medical or nursing services; problems in Dimension 3 are the most common reason for admission to Level 3.7. D. Additionally, at least one criterion must be met in Dimension 4 (higher risk of engaging in substance use behaviors), Dimension 5 (relapse potential and readiness to change) or

	Dimension 6 (recovery potential—environment/support system). E. At least one problem in Dimension 4, 5, or 6 puts the member at risk of continued use of substance(s). F. This combination of deficits results in the member being at risk of harm to themselves or from others. G. Placement decisions are based on the symptomatic functional impairment rather the any specific categorical diagnosis. H. The member may be admitted directly to Level 3.7. programs or transferred from a less intensive level of care as symptoms become more severe, or I. The member may be transferred from a Level 4 program when that level of intensity is no longer required.

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UTILIZATION MANAGEMENT

For general policies regarding program integrity, utilization management, or fraud, waste and abuse, providers must refer to the Provider Administrative and Billing Manual.

PRIOR AUTHORIZATION

This section applies to private RBHS providers required to obtain approval for CSS through the SCDHHS designated Quality Improvement Organization (QIO) for FFS members. Providers must follow the prior authorization guidelines as outlined by SCDHHS before billing Medicaid. All services must be determined medically necessary as approved by the QIO.

Note: For Assertive Community Treatment, Multisystemic Therapy, and Homebuilders® authorization processes, please refer to Appendices 3, 4, and 5, respectively.

Authorizations are a utilization tool that require participating providers to submit documentation associated with certain services for a member either before the service is rendered (prior authorizations) or after service is rendered but prior to payment (post-service authorization). Participating providers will not be paid if this documentation is not furnished to SCDHHS or its designee. Participating providers must hold the member and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization.

General guidelines for prior authorization include the following:

- Providers must file a prior authorization request for RBHS services that require an approval prior to rendering service. The prior authorization request must be submitted with appropriate documentation that supports medical necessity for the service(s).
- Services that exceed frequency limitations must be justified through an EPSDT examination; if the examination confirms ongoing medical necessity, a request for a service limit exception must be submitted and pre-approved by SCDHHS or its designee.
- Providers must submit proper documentation with the claim for RBHS services that require review by SCDHHS or its designee for determination of medical necessity prior to reimbursement for the procedures. These claims are subject to pre-payment edits. If a prepayment edit is received, providers must file a new claim and submit documentation to support medical necessity.
- Under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.) and as per 42 CFR Subpart D, Medicaid is defined as the “payer of last resort.” This means Medicaid only pays for covered items and services if no other liable third-party payer is responsible for the same service. For Medicaid members with primary coverage (such as Medicare or commercial insurance) who are in need of services that require a prior authorization, providers must obtain a prior authorization only if Medicare or the primary carrier denied the service (or the service is not covered by the

primary payer). For further information on third party liability (TPL), please review the TPL supplement to this manual and the Provider Administrative and Billing Manual.

Service-specific Authorization Guidelines for Peer Support Services

All applicable forms for requesting prior authorization are posted on the QIO website:

- QIO customer service phone: (855) 326-5219
- QIO fax number: (855) 300-0082
- Provider Issues email: scproviderissues@acentra.com

Authorizations for physician administered drugs must be filed to Prime Therapeutic Management at:

- Telephone: (866) 254-1669
- Website: https://MRxGateway.com

The provider will be notified by the QIO of the approval or denial or services; approvals will cover a six-month period of time.

Medicaid FFS members must receive prior authorization from the QIO and reimbursement from SCDHHS. For members enrolled in an MCO, please refer to the individual MCO policy regarding its services and authorization policies. Failure to comply with these requirements may result in denial or recoupment of payment.

Please refer to chart below for prior authorization documentation requirements based on the referral source (state agencies, self or private provider) and service-specific authorization requirements for peer support services:

Referral for CSS from State Agencies	
Initial Prior Authorization	**Continued Services Authorization**
For the initial authorization period, Medicaid may cover up to 90 days for child and adolescent members, and up to 180 days for adult members, based on the medical necessity documented on: • The RBHS Referral Form. • The QIO prior authorization request form. • Any supporting documentation.	Medicaid may cover up to 90 days for child and adolescent members and up to 180 days for adult members, based on the medical necessity documented on: • The most recent 90-day progress summary. • The current IPOC. • The QIO prior authorization request form. • Parent/Caregiver/Guardian Agreement to Participate in CSS form (for members through age 15). • Any supporting documentation. **Note:** If a member needs continued services after 365 days, an updated Diagnostic Assessment is required to be submitted to the QIO.
Referral for CSS by Member or Private Provider	
Initial Prior Authorization	**Continued Services Authorization**

For the initial authorization period, Medicaid may cover up to 90 days for child and adolescent members and up to 180 days for adult members. Initial authorizations are required annually, and must be based on the following information: • The QIO Prior Authorization Request Form. • The DA. For members ages 0–18, results of the age-appropriate assessment tool: • Parent Stress Index (birth to 1.5 years). • The Child Behavior Check List (1.5–5 years). • CALOCUS-CASII administered by a qualified clinical professional with a CALOCUS-CASII SCDHHS Provider certification (ages 6–18).	Medicaid may cover up to 90 days for child and adolescent members and up to 180 days for adult members, based on the medical necessity documented on: • The QIO Prior Authorization Request Form. • The most recent 90-day progress summary. • A current IPOC. • Parent/Caregiver/Guardian Agreement to Participate in CSS' form (for members through age 15). • Any supporting documentation. **Note:** If a member needs continued services after 365 days, an updated DA is required to be submitted to the QIO.
Authorization Requirements for Peer Support Services *(does not apply to state agencies and OSUS-affiliated providers)*	
Initial Authorization	**Continued Service Authorization**
No initial prior authorization is required. Private providers may render PSS for up to 216 units (or 56 hours, approximately 90 days of services if rendered twice per week), without prior authorization.	Continuing services beyond 216 units must be authorized by the QIO. Providers are required to submit documentation supporting medical necessity for continued services, to include the following: • The QIO Prior Authorization Request Form. • Diagnostic assessment • The most recent 90-day progress summary. • A current IPOC. • Clinical service notes from the last 30 days of PSS • Any additional documentation that may support need for continued services (i.e., recent hospital discharge information, information related to a recent relapse, noted significant life stressors which may place the individual at risk for hospitalization or relapse, etc.).

Requests for each continued service authorization period must be submitted to the QIO 10 business days prior to the expiration of the current authorization. The QIO will process and either approve or deny service authorization(s) within five business days of receipt, pending complete submission of all required information.

When previously authorized services are transferred from one RBHS provider to another, the current provider is responsible for contacting the QIO to update the authorization to reflect the new provider. The new provider must follow the previously authorized set of services; if additional services are added or current services are changed, a new prior authorization may be required.

When CSS is added to a current approved course of treatment, each discrete service must be authorized by the QIO. Medicaid may cover additional services based on the medical necessity as per the documentation required above.

For state agency referrals: If a member's treatment plan is changed with respect to the type of and/or frequency of each CSS, the provider must receive confirmation from the referring state agency to change the service type and/or frequency. Evidence of the state agency's confirmation of such changes must be in writing and must be maintained in the member's health record.

Authorization Requirements for OSUS-affiliated providers

For FFS members, the South Carolina Department of Behavioral Health and Developmental Disabilities (BHDD), Office of Substance Use Services (OSUS) is responsible for issuing prior and continuing service authorizations for Intensive Community-based and Residential Treatment Services. Providers must obtain the prior authorization number to include on the claim from OSUS utilization management staff by calling (803) 896-4860. For other questions related to authorization of substance use services, providers may contact OSUS utilization management team toll-free at (800) 374-1390.

Coordination of Care: Avoiding Program Duplication

It is the responsibility of all service providers to coordinate care among all entities rendering services to members.

If a member is receiving treatment from multiple service providers, there shall be evidence of care coordination in the member's clinical record; minimally, efforts must be made to coordinate care, and this must be documented in the members record. Care coordination serves to promote continuity and ensure there is no duplication in services or billing.

Duplicated services cannot be reimbursed under Medicaid, and providers shall make every effort to contact other service providers (and document the contact) involved in the member's current course of treatment to ensure services are complimentary to one another and not duplicative in nature. In the event separate RBHS providers render services to the same member, care coordination is essential and must be evidenced in the record to ensure the treatment goals are not in conflict with one another or the desired outcomes of the member.

When a member changes providers during the course of services that have a prior authorization in place, the new provider must contact the QIO as referenced above to change the authorization number to reflect the new provider.

Service Limit Exception Process

There may be clinical exceptions to the service limits when the number of units or encounters allowed are not sufficient to meet the complex and intensive needs of a member. In these circumstances, requests for frequencies beyond the service limits may be submitted to the agency's QIO for approval if an EPSDT examination has deemed the services medically necessary. The following table identifies the required documentation for these requests:

Required Documentation for Service Limit Exceptions
• Most recent DA. • Most recent IPOC. • Most recent SPD service note. • CSNs for all services rendered to members during the previous 90-days of request, including PMA. • Parent/Caregiver/Guardian Agreement to Participate in CSS form, if applicable. • QIO approval letter. • RBHS Exception Request Form (found in Forms section of this manual).

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REPORTING/DOCUMENTATION

General policies for Medicaid members' health records requirements and documentation are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, RBHS providers must comply with specific policies for health records requirements and documentation detailed below.

Note: For Assertive Community Treatment, Multisystemic Therapy, and Homebuilders documentation requirements, please refer to Appendices 3, 4, and 5, respectively.

HEALTH RECORDS

In addition to providers' compliance with state and federal laws and regulations regarding health record retention requirements [i.e., Social Security Act 1902(a)(27), 42 CFR 431.107], SCDHHS requires RBHS providers to retain on site, all health and fiscal records pertaining to Medicaid members for a minimum period of four (4) years after the last payment was made for services rendered to facilitate audits and reviews of the member's health record. No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, and incomplete computer records.

Health Record Compliance Requirements

In addition to the requirements specified in the Provider Administration and Billing Manual, providers must:

- Document the rationale and justification of medical necessity for services, including all findings, diagnoses and supporting clinical information.
- Detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the CPT or the HCPCS nomenclatures and descriptors, or as indicated in SCDHHS policy.
- Ensure that all documentation included in health records is signed by the rendering provider (and when required, co-signed) and dated/time stamped, including the date and time, as appropriate to the media, prior to filing the claim for reimbursement. Information reported, including the rendering provider, supervising provider (if applicable), service performed, and date and time of the service must be verifiable. By signing the record, the signor attests to the completeness and accuracy of the information provided.

Medicaid services that are not properly documented in clinical notes are subject to denial or recoupment; CSNs and other required documentation filed in the health record that are not appropriately signed and dated with date of service by the rendering provider (and supervising LPHA, when applicable) are not considered complete and are not allowable for claims reimbursement.

Templates and forms used to document specific service components (such as the DA, IPOC, etc.) must be thoroughly completed with no blank space for any prompt on the form. If a particular template prompt is not relevant to the member for a specific reason (such as educational history due to member's age), this must be noted in the blank.

All required documentation must be present in the health record before the provider files for claims reimbursement. All services performed must be recorded in the member's health record, which must be available as required by the Participating Provider Agreement. Providers must also meet Medicaid service and documentation requirements to receive reimbursement for retroactively covered periods of time.

An index as to how the clinical record is organized must be maintained and made available upon request. Each provider is responsible for maintaining accurate, complete, and timely records and to ensure the confidentiality of the member's protected health information. The member's clinical record must include, at a minimum, the following:

- Diagnostic assessment(s).
- Other assessments (as applicable).
- Assessment tool(s), administered and scored by a qualified clinician (as applicable):
  - PSI (birth to 1.5 years)
  - The Child Behavior Check List (1.5–5 years).
  - CALOCUS-CASII administered by a qualified clinical professional with an SCDHHS CALOCUS provider certification (ages 6–18).
  - **Note:** Assessment tools are not required for state agencies rendering RBHS, nor for private or state agencies rendering direct services to members in foster care.

- Parent/Caregiver/Guardian Agreement to Participate in CSS' form, if applicable.
- IPOCs that include provider signature (with credentials/functional title) and date, initial and subsequent reviews or reformulations.
- Behavior Modification Plan, if applicable.
- 90-day Progress Summaries (PS) that include provider signature (with credentials/functional title) and date of completion.
- CSNs that include provider signature (with credentials/functional title) and date of completion.
- RBHS State Agency Referral Form (as applicable).
- QIO approval letter (as applicable).
- Court orders, if applicable.
- Copies of any evaluations and or tests, if applicable.
- Signed releases, consents and confidentiality assurances for treatment.
- Physician's orders, laboratory results, lists of medications and prescriptions (when a service is performed or ordered).
- Copies of written reports and other collateral information (relevant to the member's treatment).
- Medicaid eligibility information, if applicable.
- Any other documents relevant to the care and treatment of the member.

Consent to Examinations and Treatment

A consent form, dated and signed by the member, parent/legal guardian/primary caregiver (for minors through age 15 only), or legal representative, prior to any service delivery, must be obtained at the onset of treatment from all members and placed in the member's clinical record.

If the member or parent/legal guardian/legal representative cannot sign the consent form due to a crisis and the member is accompanied by a next of kin or responsible party, that individual may sign the consent form if the member is not age 16 or older. If the member is alone and unable to sign, a statement such as, "appropriate party is not present to sign for consent; client requires emergency treatment," must be noted on the consent form and signed by the LPHA and one other staff member as a witness. The member or parent/legal guardian/legal representative must sign the consent form as soon as circumstances permit and before any additional services are provided if consent is not already provided. In all such circumstances, efforts must be made to contact the parent/legal guardian/legal representative to obtain verbal consent; efforts to contact (if unable to reach) and verbal consent must be documented in the clinical record.

Note: IPOCs for members 16 years and older do not require a parent/guardian signature, but that of the member.

A new consent form must be signed and dated each time a member is readmitted for services after a previous discharge.

While consent forms are not required to conduct court-ordered examinations, it is a component of ethical practice to inform the member of the limits of confidentiality based on the court order and its application to any records and/or reports generated on their behalf as a result of the service rendered. A copy of the court order must be kept in the clinical record.

Confidentiality of Substance Use Clinical Records

Federal law (42 CFR Part 2) outlines more stringent rules for providers when disclosing information from the records of members with substance use disorders than when disclosing information concerning other behavioral health disorders. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found on the Code of Federal Regulations website.

Abbreviations and Symbols

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

Documenting Medical Necessity

Medical necessity must be documented in the DA administered by a qualified LPHA and a completed and signed DA must be in every member's record. The LPHA's name, professional title, signature and date must be listed on the document, confirming medical necessity. For private

providers, If the LPHA completing the DA is an LMSW, a co-signature by an independently licensed LPHA is required. With the exception of crisis intervention, the DA must be completed prior to rendering any other RBHS services.

Note: For those placed in therapeutic foster care, the DA must be completed within 14 days of placement. For duration of placement within the 14-day timeframe before DA completion, the Universal Application (submitted to the child-placing agency by DSS) is allowable for preliminary confirmation of medical necessity. Services provided during this time period must correspond to identified needs and diagnosis(es) on the universal application until completion of the DA.

The DA must document the presence of a serious behavioral health disorder from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual or related disabilities, and developmental disorders. If such conditions co-occur with a serious behavioral health disorder as defined and there is valid and reliable clinical rationale that the services will benefit the member given the contraindications, this must be fully documented in the member's record. The DA must include an interpretive summary with a case conceptualization that clearly states recommendations for treatment, including the services and the frequency for each service recommended. Additional required elements of the DA are referenced in the DA service description located in section eight of this manual.

Note: If the member has not received services for 45 consecutive calendar days, medical necessity must be re-established by completing a follow-up assessment. If a member is receiving medication management only through a psychiatric practitioner within an RBHS organization, the medical needs that require psychiatric care constitute medical necessity for those services. If the member re-engages in therapeutic services, a follow-up DA must be completed prior to rendering additional services.

Ongoing medical necessity must be documented in the CSNs and progress summaries, which must also be signed and dated by the provider. Progress summaries must address any change to the members' condition, diagnosis(es), progress on treatment goals, need for additional or new treatment goals and how further treatment will benefit the member (an addendum to the IPOC is then required if there are changes in diagnosis(es) or new and/or updated treatment goals).

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

RBHS SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS

Documentation of services requiring a start and end time must reflect the actual time the session starts and ends (ex., 10:03 A.M. a.m. to 10:56 a.m.); this cannot represent the appointment time or rounded "on-the-hour" times.

1. Screening and Assessment Services

Behavioral Health Screening (BHS)

BHS results shall be documented during or subsequent to the screening session with the member. The completed screening tool and written interpretation of the results must be filed in the member's clinical record within 10 working days from the date of service. Services must be documented on a CSN with a start time and end time.

Additionally, the documentation must meet all other SCDHHS requirements for CSNs. Documentation shall:

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

Diagnostic Assessment (DA)

The completed assessment tool and written interpretation of the results must be filed in the member's clinical record within 10 working days from the date of service. In addition to the assessment tool itself, the DA must be documented on a CSN with a start time and end time.

Additionally, the documentation must meet all SCDHHS requirements for CSN. The DA shall be completed in one day. If additional time is needed to complete a thorough assessment, billing must occur on another day utilizing the follow-up assessment code.

The following components must be included in the DA:

- Member's name and Medicaid ID number
- Date of the assessment
- Member's demographic information:
  - Age
  - Date of birth
  - Phone number
  - Address
  - Relationship/marital status
  - Preferred language, etc.
- Member's cultural identification, including gender expression, sexual orientation, ethnicity and cultural practices, spiritual beliefs, etc.
- Presenting complaint, source of distress, areas of need, including urgent needs (i.e., suicide risk, personal safety, and/or risk to others).
- Risk factors and protective factors, including steps taken to address identified current risks (i.e., detailed safety plan).
- For children and adolescents (and for others as relevant):
  - A developmental history (including pre- and postnatal condition, maternal substance use/post-partum depression or psychosis, attachment, developmental milestones, early diagnoses or concerns, enuresis/encopresis, etc.), and

  - Educational history, to include current grade level, suspensions/expulsions, disciplinary history, typical grades, and/or learning issues (including need for IEP, 504 accommodations, or Behavior Intervention Plan).
- For adults: Educational and vocational/employment history.
- Behavioral health history of member, including previous diagnoses, treatment (including medications), out-of-home placements and hospitalizations.
- Psychological history, including results of previous psychological testing, evaluations, reports, etc.
- Substance use history, including previous diagnoses, treatment (including medications), and hospitalizations/residential care.
- History of trauma, including witnessing or experiencing physical abuse, sexual assault, criminal acts, domestic violence, significant losses and separations (i.e., death of sibling, parent incarcerated), and/or other adverse childhood experiences and traumatic events.
- History of behavioral problems, aggression or other antisocial behaviors, including sexually reactive/problematic behaviors.
- Physical health/medical history, including current health needs and potential high-risk or chronic conditions; name of current primary care provider and date of last medical exam.
- Medication history, including past and current medications (i.e., those that are/were effective, ineffective, and/or any current or past side effects).
- Family history, including past and present relationships with family members, involvement of those individuals in treatment and services, family psychiatric and substance use history, and any history with social services.
- Results of full mental status exam (MSE).
- Housing/living situation and conditions.
- Clinical interpretive summary/case conceptualization including the following:
  - Diagnosis(es) of a serious behavioral health disorder (description and code must be identified for each) from the current edition of the DSM or ICD (excluding irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria).
  - Initial start date of RBHS.
  - Planned service type and frequency of each recommended rehabilitative service.
  - Referrals necessary for external services, support, or treatment.
- Signature or co-signature of the LPHA who can confirm medical necessity. The DA is not considered complete until the LPHA signs and dates the document.

CALOCUS-CASII Assessment — Required to Provide Community Support Services for Children and Adolescents

Assessments must be documented in a manner which addresses all of the necessary components and clearly establishes medical necessity.

When submitting a claim for the CALOCUS assessment, documentation of the scoring instrument and supporting clinical documentation is required. In addition to the CALOCUS form itself, the

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

Psychological Testing and Evaluation (PTE)
PTE 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 reference to the completed test; alternatively, the CSN can refer the reader to the written psychological evaluation report, which must be maintained in the medical record.

Additionally, the documentation must meet all SCDHHS requirements for CSNs. The completed tests and written interpretation of the results must be filed in the member's clinical record within 10 working days from the date the service was completed.

Note: Only one service note is required to be written for psychological testing and add-on code(s) if services are provided on the same day and by the same provider.

Documentation must support the number of units billed.

Documentation must include:
- Member's name and Medicaid/organizational ID number.
- Full name of the tests (with versions) that were conducted and acronyms used for reference in the report (i.e., MMPI-A, TAT, WISC-IV, BASC-2, etc.).
- Other manner of evaluation, which may include observation, teacher report, parent/guardian/caregiver report, etc.
- Collateral reports reviewed and considered during evaluation process.
- Test results and interpretation.
- An interpretive summary that incorporates all aspects of the evaluation.
- The diagnoses and appropriate diagnosis codes.
- Recommendations or referrals based on results of evaluation.

PTE is not intended to be a member's initial behavioral health service and is provided only when medically necessary. If the member has been referred by another provider who, after efforts have been made to assess and diagnose the member, requires the administration and interpretation of psychological tests to aid in the determination of diagnoses and level of impairment, the psychologist or LPES must complete the DA (using the follow-up DA procedure code).

Minimum standards require service note documentation in the member's record that includes the purpose of the session, the results of the psychological testing and evaluation and/or makes reference to the completed tests. If this information is available in the psychological testing report, the CSN may refer to the written report for further detail.

Assessments performed by unlicensed psychology supervisees are not separately reimbursable and must be signed by the licensed, supervising psychologist.

Note: Only one service note is required for the initial unit of PTE and the add-on code if services are provided on the same day and by the same provider.

2. Service Plan Development of the Individual Plan of Care

Service Plan Development

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

- The development, staffing, review and monitoring of the IPOC.
- Discharge criteria/achievement of goals.
- Confirmation of medical necessity.
- Establishment of one or more diagnoses.
- Recommended treatment.

3. Core Treatment Services

Individual, Family and Group Psychotherapy

The documentation for individual, family and group psychotherapy shall address the following items in order to provide a pertinent clinical description, to ensure that the service conforms to the service description, and to authenticate the charges:

- The specific objective(s) from the IPOC toward which the session is focused.
- The structured activities of the member in the session.
- The member's response to the intervention/treatment.
- The specific intervention(s) used.
- The member's progress or lack of progress made in treatment.
- Recommendation and future plans for working with the member.
- Service duration: Exact start and end time.

4. Community Support Services

All services must be listed on the IPOC with a specific, planned frequency to meet the individualized needs of the member. Services must be documented for each contact with the member. Documentation must clearly reflect the specific needs of the member and the therapeutic interventions rendered to address those needs. Additionally, the CSNs and other supporting documentation must meet all requirements as specified in this manual.

Qualified staff are responsible for completing and signing the CSN for each service delivered. CSNs must clearly identify the specific goal(s) from the IPOC for which the service is being provided.

For members up to age 15, the Parent/Caregiver/Guardian Agreement to Participate in CSS form (found in the FORMS section of this manual) must be completed prior to the initiation of services and maintained in the member's record. For members in foster care, this form must be signed by the foster parent.

Additional service-specific documentation requirements, as applicable, are outlined as follows.

Behavior Modification

For members receiving BMOD services, the therapeutic process must be youth-guided and family-driven; this is demonstrated in the interchange of feedback and identified insights between the BMOD provider, member, and family/caregiver regarding the targeted behaviors, response to interventions, and modifications needed to better guide the treatment process. The member, family/caregivers, and other treatment team members agree on the treatment goals, objectives, and interventions that drive the BMOD service.

In addition to planned interventions and strategies, documentation of CSNs for BMOD must also identify when the inappropriate or undesirable behavior is demonstrated in session, how the member was redirected by the provider, and member response to the intervention.

For members receiving BMOD services, a Behavior Modification Plan (BMP) must be included in the clinical record in addition to the IPOC.

Behavior Modification Plan

The BMP is developed from a comprehensive review of assessed behavioral challenges and supports the member in learning and utilizing positive behavioral strategies, interventions, and supports to support more prosocial, adaptive behavior. It may rely on behavioral, cognitive-behavioral, strengths-based, ecological or other theoretical frameworks to impact behavior and must conform to prevailing standards of practice based on peer-reviewed literature.

The BMP is developed by a team including the member, family/caregiver, and the BMOD provider. 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 is revised as needed and must always be current. It must be reviewed and updated as changes in behavior occur; changes in treatment must be communicated to the member/family/caregiver as demonstrated in the clinical documentation.

Required components of the BMP include the following:

REQUIRED COMPONENTS OF THE BEHAVIOR MODIFICATION PLAN	
1. Identifying information	• Member name, Medicaid or organizational ID number, age, date, and a brief statement of presenting concerns/purpose of BMP
2. Description of the target	• Observable, nonjudgmental description of behavior; may include example behaviors. Ex.: If target is “disrespect of others”, observed behaviors might include “raises voice, interrupts others, walks away when others are speaking, rolls eyes.”
3. Strengths and protective factors	• Highlight examples of what the member currently does well and the supports in place that support the goals of the BMP.
4. Baseline behavior information	• Includes what factors/situations improve or worsen the behavior, how long the problem has been present, and impact on functioning in home/school/work/community.
5. Hypothesized influencing factors	• This is approached with a holistic, biopsychosocial lens that can include identifying emotional triggers, environmental stressors, skills deficits, interpersonal dynamics, trauma history or life

	changes/stressful transitions, behavioral health symptoms, academic or job stress.
6. Behavioral and functional goals	• Behavioral goals include what change is desired. Ex.: "Reduce verbal outbursts during class." • Functional goals include what skill or improved outcome is the long-term target. Ex.: "Improve ability to manage frustration using learned coping strategies." • Includes a goal-specific timeline for completion, which is revised based on progress or continuation of goals.
7. Antecedent/environmental strategies	• This includes environmental adjustments or supports. Ex.: Predictable routines, visual schedules or checklists, reducing sensory overload, clear expectations and reminders, breaks built into tasks, teacher/parent check-ins, adjusting demands during stressful times.
8. Skill-building/coping strategies	• This includes cognitive-behavioral and relational approaches to increasing basic skills, including but not limited to: – Emotion regulation skills – Problem-solving steps – Communication or assertiveness skills – Conflict resolution – Mindfulness or grounding strategies – Organizational skills – Social skills coaching – Self-monitoring or journaling
9. Reinforcement and motivation	• Use of naturalistic, strengths-based, and relational motivators, ensuring the reinforcement is individually meaningful, but not transactional or token-based (unless clinically appropriate). This includes but is not limited to: – Verbal encouragement/reinforcement – Celebrating progress – Allowing choice (i.e., projects, break activities) – Privileges or meaningful individualized incentives – Positive attention and time with adults in member's life – Opportunities to lead or contribute
10. Responses to challenging behavior	• The BMOD provider must emphasize consistency and emotional safety, including but not limited to: – Deescalation strategies – Scripts or phrases adults should use in challenging situations – What not to do (i.e., escalators) – Safeguards to prevent power struggles – Logical and natural consequences rather than punitive measures • Examples include: "If work is not completed during class, it can be finished during study hall," and "if a peer is hurt, client participates in repairing the relationship (i.e., apology, restorative check-in)."

11. Communication and collaboration plan	• Defines who needs to be involved in the plan (parents/caregivers, teachers, coaches, other providers, and other relevant parties involved with the member), how they will engage (weekly snapshots or reports, brief check-ins, etc.) and how often.
12. Crisis or escalation plan	• This includes warning signs, stabilization strategies, safe person or safe space information, protocol for removal/isolation when warranted, and re-entry steps.
13. Monitoring and review	• How progress will be monitored (via logs or check-ins with others, self-report, teacher notes, observation, etc.) and the frequency of progress reviews (ex., every 4-6 weeks).
14. Signatures and date signed	• Includes all persons who participated in BMP development (i.e., member, family/caregiver, BMOD provider).

Therapeutic Foster Care (TFC)

TFC must be listed on the IPOC and identified by therapeutic level assigned by DSS; the DSS documentation must be maintained in the medical record. Specific goals for the TFC placement and criteria for achievement must be included on the IPOC. A "Parent/Caregiver/Guardian Agreement" is not required for TFC but is required for other CSS services rendered to the member in foster care, as specified in the documentation requirements described in this manual.

TFC Service Grid

Therapeutic foster parents must complete and sign daily entries on a TFC service grid that logs daily interventions and assessments. For services documented in this manner, the service grid functions as the CSN, capturing the billable activities rendered. For issues not accounted for in the service grid, a CSN must be completed in addition to the grid for that day. There must be no less than one service grid per date of service for a member's length of stay in TFC.

The following information must be captured in each TFC service grid:

REQUIRED ELEMENTS OF THE TFC SERVICE GRID
1. Name of the individual 2. Medicaid ID number 3. Full date [month/day/year] that the service was provided 4. The identifying letter (as specified in the grid's key) that reflects the intervention, activities, and/or tasks performed. 5. The identifying number or symbol (as specified in the grid's key) that reflects the assessment of the individual's progress toward goals. 6. Initials of the individual providing the service. The initials must correspond to the full signature and initials listed on the signature log section of the grid. 7. A comment section for entering additional or clarifying information (i.e., to further explain the interventions/activities provided and/or to further describe the individual's response to the interventions provided and progress toward goals). Each entry in the comment section must be dated. – Entries in the comment section are not required unless capturing documentation of nonroutine occurrences/activities or for activities not included in the grid's key.

5. Crisis Management Services

Crisis Intervention

A CSN must be completed upon contact with the member and must include the following:

- Start time and duration.
- All family members or collaterals included in the service.
- Summary of the presenting crisis.
- Steps taken to triage of the crisis, including consultation with other professionals.
- Interventions with the member rendered by the provider.
- The response of the member to the intervention(s).
- Member's mental status at the end of the session.
- Disposition of the member upon completion of the session (i.e., required sending to the emergency department, returned home with safety plan, etc.).
- If crisis intervention results in the member returning home, documentation must be present indicating an evidence-based safety plan was completed with the member and a copy was given to the member. A copy must be available in the member's record.
- The plan for member follow-up post-crisis and clinical steps for ongoing care at the next session.

SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS FOR SUBSTANCE USE SERVICES

For services that are common to both RBHS and substance use services (i.e., CALOCUS, SPD, psychotherapies, most CSS and CI), providers must refer to and follow the documentation requirements as described previously in this section. For services that are substance use-specific but also similar in structure to a previously described RBHS service, the following documentation guidance applies:

Substance Use Service	Follow Documentation Requirements for RBHS:
SUS	BHS
SUDA	DA
Follow-up SUDA	Follow-up DA
Skills Training and Development	General CSS guidelines; CSNs must also include any undesirable behaviors demonstrated in session and how provider redirected.

OSUS-affiliated providers may also document additional substance use-specific information to any of the above services to better capture history and condition of the target population served, when relevant.

Note: All CSNs must include exact start and end time of the session (i.e., 3:04 p.m. – 3:57 p.m.).

1. Screening and Assessment Services

Substance Use Nursing Assessment (SUN)

The appropriate medical documentation must appear in the member's medical record to justify medical necessity, including the illness, history, physical findings, diagnosis and prescribed treatment.

Services must be documented on the CSN or nursing progress form and signed by a qualified health care professional within the timeframe as per the service guidelines. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

A nursing discharge form must be completed when the member moves to another level of care.

2. Service Plan Development for Individual Plan of Care

SPD is documented as per guidance described earlier in this section.

3. Medical Services

Evaluation and Management of Medical Services (E&M)

Medical notes must be completed for each E&M visit and include the illness, history, physical findings, diagnosis and prescribed treatment. Medical orders must correspond to issues identified in the E&M visit and/or collateral information from other qualified providers.

Medication Administration (MA)

MA is billed for administering a Vivitrol® injection. MA must be listed on the plan of care and in the medical order.

The provider must include the following items on the CSN in order to provide a relevant clinical description, ensure the service conforms to the service description, and authenticate the charges:

- List of the member's current prescribed and over-the-counter medications, or a reference to the medical order (or other medical documentation in the record) that has a comprehensive list of all medications
- Quantity and strength of the dosage given
- Injection route (I.M., I.D., I.V.)
- Injection site
- Side effects or adverse reactions of medications
- All benefits of the medications being prescribed
- Any change in medications and/or dosing and the rationale for any change, if applicable
- Follow-up instructions for the next visit

Vivitrol® Injection (VI)

Injectable Medication is required to be listed on the PMO. The medication must be billed via the J-code; documentation of the service is included in the MA CSN.

4. Psychotherapy and Community Support Services

Substance Use Counseling (SUC)

Two widely accepted CSN formats for substance use counseling are SOAP (Subjective, Objective, Assessment, Plan) and DAP (Data, Assessment, Plan). Both formats facilitate clear, concise and clinically relevant documentation:

SOAP Notes	DAP Notes
Subjective: Client's self-report, mood, cravings, stressors **Objective:** Observable behaviors, appearance, affect, engagement, urine drug screen results **Assessment:** Clinical interpretation, progress toward goals, risk level **Plan:** Next steps, homework assignments, referrals, medication management	**Data:** Both subjective and objective information combined **Assessment:** Clinical impressions and diagnosis **Plan:** Intervention strategies and treatment direction

Providers may determine the most appropriate CSN format for their purposes, however, the following information must be captured in substance use counseling services, in addition to other requirements for CSNs as described in this section, whether group or individual:

A. Focus/reason for session
   - Subjective data (self-report) and objective clinical observations based on identified treatment goal

B. Interventions Used
   - Document specific strategies, focusing on techniques rather than theoretical framework: (Ex.: Motivational interviewing: "Used evocative questions to elicit change talk, reframing and reflecting client's statements when she struggled to see the need for treatment").
   - Documentation must reflect when evidence-based practices (EBPs), such as Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Contingency Management (CM), or Medication-Assisted Treatment (MAT), are used. Clearly describe interventions delivered and client response.

C. Client Response
   - Include client's response to intervention, their level of engagement in the session, and any insights or resistance to treatment.

D. Assessment of Progress Toward Goals
   - Clinical interpretation of presenting information which may include client's mental status, risk evaluation, and changes since last session; relevant components to document for ongoing assessment of members receiving substance use counseling, which include the following: Acute withdrawal, biomedical needs, emotional condition, motivation to change, relapse risk, and environmental factors impacting substance use.
   - CSNs must link interventions to treatment goals; provider tracks changes and documents measurable progress.

E. Plan / Next Steps
   - Document whether homework assigned, referrals made, changes to treatment approach needed, and anticipated goals for next session.

If standardized screening (i.e., UDS/other on-site lab screening, AUDIT, DAST, PHQ-9, GAD-7, etc.) is being used to quantify severity and track changes over time, providers must:

- Record baseline results/scores and update regularly.

- Integrate these results into progress notes and treatment planning.

For members receiving MAT or medications for other behavioral health conditions, counselors shall document any medication adherence issues or side effects presented by the member, if applicable, and coordinate care with the relevant medical provider, ensuring they receive information necessary for ongoing medical support.

Skills Training (ST) and Development Services for Children
The CSN must link interventions provided to the member's specific treatment goals. The service must be listed on the IPOC with a planned frequency. Documentation must also meet all SCDHHS requirements for CSNs.

The provider rendering the service is responsible for completing and signing the documentation. CSNs must be co-signed by the appropriately credentialed provider, as identified in the Eligible Providers section of the manual. When demonstrated in session, CSNs must include the inappropriate or undesirable behavior of the member and how the behavior was redirected.

5. Crisis Management Services

Crisis Intervention (CI)
CI is documented as per guidance described earlier in this section.

6. Intensive Community-Based and Residential Treatment Services

Unless otherwise specified, services provided within this category must be medically necessary, as confirmed by an LPHA and supported by the clinical assessment and other criteria indicating need for treatment at this level of care. To support medical necessity, an ASAM dimension summary must be completed, noting dimensions of concern and areas for targeted treatment.

CSNs must identify each independent service provided on the specified date, which must correspond to one of the allowable services encompassed in the bundled or all-inclusive reimbursement rate. CSNs for this category may be documented in one of two ways:

- An individual team member can document the specific independent service they rendered (ex., the CPSS documents 1 hour of the 3-hour IOP services provided on a specific date),
  or
- The day's services may be encompassed within a single service note template completed by the primary counselor assigned to the member that includes a comprehensive summary of each independent service rendered.

Acute and Sub-acute Withdrawal Management — Clinically Managed Residential *(Level 3.7WM)* and Medically Monitored Inpatient *(Level 3.2WM)* Withdrawal Management:
Initial triage and screenings provided to determine level of care must be documented and included in the medical record. Medical necessity must be substantiated through further assessment and a

medical evaluation upon admission. CSNs of ongoing daily activities and interventions must follow the above guidance.

A nursing admission history and physical exam must be documented as soon as possible after admission and within the allowable timeframe as per each service definition. Standardized clinical withdrawal scales will be used throughout the member's admission to assess the severity of withdrawal symptoms and measure progress toward discharge/transfer to treatment services. Documentation must reflect the outcomes of the withdrawal assessments and align with recommendations for transition and discharge.

Clinically Managed High-Intensity Residential Treatment: *Level 3.5*
Medically Monitored Intensive Inpatient Treatment (Adults and Adolescents): *Level 3.7*
Documentation of assessments, screenings, and other relevant information that supports the admission and level of care must be included in the member's medical record.

Medical necessity must be substantiated through assessment and a medical evaluation upon admission completed within the timeframe allowable as per the service definition. CSNs of ongoing daily activities and interventions must follow the above guidance.

OTHER SPECIFIC DOCUMENTATION REQUIREMENTS (ALL PROVIDERS): IPOC, PROGRESS SUMMARY, CLINICAL SERVICE NOTES AND DISCHARGE SUMMARY

Individual Plan of Care

The IPOC is an individualized comprehensive plan of care to improve the member's condition. The IPOC is developed based on information gathered in the screening and assessment process, in collaboration with the member and/or family. This process may also include an interdisciplinary team of the significant others, parent, guardian, primary caregiver, other state agencies and staff, or additional service providers. Multiple staff or members of an interdisciplinary team may participate in the process of developing, preparing, and/or reviewing the IPOC.

The assessment of the member is used to identify problems, needs, strengths and preferences, develop preliminary goals and objectives, and determine the appropriate rehabilitative behavioral health services and methods of intervention for the member. The IPOC outlines the services necessary to meet the identified needs of the member and improve overall functioning. While there may be certain treatment interventions commonly utilized within a specific modality, providers must ensure that services are tailored to the member's individual needs and that service delivery reflects knowledge and understanding of the particular treatment issues inherent to the individual.

The IPOC must be person and/or family centered. The member must be given the opportunity to determine the direction of his or her IPOC. If family reunification or avoiding removal of the child from the home is a goal for the member, the family, legal guardian, legal representative, or primary caregiver must be encouraged to participate in the treatment planning process. Documentation of compliance with this requirement must be located in the member's record.

Note: For all services provided to children, if the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the member's clinical record. For adults, the family or a legal representative should be included as appropriate. Providers must meet Medicaid service and documentation requirements to receive reimbursement for retroactively covered periods of time.

Each provider is responsible for developing the IPOC. The IPOC must include the following elements:

1. **Member Identification**
   - Name and Medicaid ID number.
2. **Presenting Problem(s)**
   - Statements that outline the member's specific needs that require treatment services.
   - Statements that validate the need for treatment services based on medical necessity.
   - It is important for overall health care and wellness issues to be addressed, as necessary.
3. **Psychiatric Diagnosis(es)**
   - The primary diagnosis (with corresponding current DSM or ICD code) that is the basis for treatment must be listed on the IPOC. For individuals who have more than one behavioral health diagnosis and/or medical condition, all diagnoses targeted with treatment goals must be included on the IPOC.
4. **Goals and Objectives**
   - Specific short and long-term goals with corresponding objectives addressing the expected outcome of treatment.
   - Goals and objectives shall reflect input from the member and member's family, as applicable, and must be written so that they are Specific (S) and observable, Measurable (M), individualized (specific to the member's problems and/or needs) and Achievable (A), Realistic and Relevant (R), and Time-bound (T) (i.e., SMART goals).
   - Goals are global statements that reflect positive resolution to the member's identified needs and include outcome measure(s) or identified, visible expectation(s) when met.
   - Objectives are similar to and directly related to goals but are highly specific actionable steps necessary to reach each identified goal. They should reflect small attainable steps necessary to achieve the goals. The member's culture, community, support systems, environmental factors, and developmental and intellectual factors are considered in the formulation of objectives.
5. **Therapeutic Interventions**
   - A list of specific therapeutic interventions used to meet the stated goals and objectives must be included (actions, activities, methods, and/or techniques, such as cognitive reframing, distress tolerance, mindfulness, behavioral activation, etc.).
   - Therapeutic modalities (i.e., CBT, DBT, Motivational Interviewing, TF-CBT, Psychoeducation, etc.) may be included to provide context for the intervention, but the intervention must reflect the specific techniques within the modality used to meet the identified goal.

6. **Clinical Services**
   - All services rendered to members and/or families must be identified on the IPOC (i.e., Individual Therapy, Group Therapy, Family Therapy, FS, etc.).
   - Services that do not have a specific, recurring frequency (such as BHS, DA, SPD, CI, etc.) need not be listed on the IPOC as they are expected to occur as necessary and when the member's condition and circumstances surrounding their care require them.
7. **Frequency of Services**
   - The frequency of services must be listed on the IPOC for each service.
   - Each service must be listed by its name or approved abbreviation with an individualized and specific planned frequency.
   - The frequency must be appropriate to the needs of the member and member's family, as applicable, and shall not exceed medical necessity. Vague or indeterminate timeframes must be avoided (i.e., "up to two hours per week.")
8. **Criteria for Achievement**
   - There must be a clear pathway discernible to any objective reviewer of the IPOC for how progress and attainment of each goal and objective will be demonstrated.
   - Criteria must be reasonable, attainable, relevant, and measurable, must include target dates specific to the particular goals/objective, and must indicate the desired outcome of the treatment.
9. **Target Dates**
   - A timeline for completion that is individualized to the member and their goals and objectives must be documented.
   - Target dates must reflect projected incremental change over the course of a year and shall not uniformly reflect the annual expiration date of the IPOC.
   - Target dates must vary appropriately based on time required to meet each goal.
10. **Contact Information**
    - Emergency contacts, including phone numbers, must be listed.
11. **Discharge Planning**
    - The IPOC must include a plan of action for discharge. This plan must include the anticipated date of discharge from services, member's and/or family's expected gains through participation in treatment and services, and anticipated aftercare needed (when applicable).
12. **Member Signature**
    - The member (and/or parent/guardian/caregiver for minors up to their 16th birthday) must sign the IPOC indicating their agreement with and understanding of the plan for treatment.
    - If the member/family refuses to sign the IPOC, the clinician must document the refusal (if the signature is illegible, the clinician shall document that the member did in fact sign the IPOC).
    - If it is not considered clinically appropriate for the member to sign the IPOC, clinical justification must be documented on the IPOC.
    - The provider must offer the member (and/or guardian/parent/caregiver for minors up to their 16th birthday) a copy of the IPOC upon signing it. The provider must document "copy provided" or "copy refused" and the date, if different from the date of signature, on the IPOC.

13. Authorized Signature(s)

- The completed IPOC must be signed by the appropriately qualified provider type as identified in this manual.
- All signatures must be dated and include the providers functional title/credentials.

Note: The IPOC must be completed (including provider signature, member signature, and date of signatures) and filed in the member's record within 30 days of the DA's date of completion; services provided beyond 30 days of the DA without a completed IPOC in the clinical record are not reimbursable.

The DA provides a case conceptualization in the clinical summary that posits the services necessary to address identified symptoms and needs and proposes preliminary treatment goals to reach the desired treatment outcome; while this provisional formulation provides the pathway for delivering initial services, it is intended to be for a brief and reasonable period of time (i.e., up to 30 days). Core treatment services may be rendered prior to the completion of the IPOC provided the services are medically necessary and correspond to the preliminary plan of care identified in the DA clinical summary.

Additional requirements related to documenting IPOC addenda and reformulation of the IPOC are included below:

IPOC Addenda and Reformulation
Addenda to the IPOC: • The IPOC is considered a "living document" and shall reflect and be updated based on changes in the life and circumstances of the member. • Changes made to the IPOC must follow a logical and obvious pattern in the member's medical record. • When services are added or frequencies of services are changed in an existing IPOC, the addendum must include the signature and title of the clinician who formulated the addendum and the date it was created. All service changes must meet medical necessity criteria for each discrete service to be added. • When space is unavailable on the current IPOC, a separate form must be added and labeled as "Addendum to IPOC" and the addendum must accompany the existing IPOC. • If changes and updates are made to the original IPOC, an updated copy shall be offered to the member within 10 business days or at the next subsequent session. • The original IPOC signature date stands as the date to be used for all subsequent progress summaries, IPOC reformulations **Reformulation of the IPOC**: • The maximum duration of the IPOC is 365 calendar days from the date of the signature of the LPHA on the IPOC. • Prior to termination/discharge or expiration of the IPOC, the LPHA must review the IPOC with the member and evaluate the member's progress with respect to each of the member's treatment goals and objectives. • The signature of the LPHA rendering or supervising the treatment is required.

- The IPOC must include the date of reformulation, the signature and title of the LPHA authorizing services, and the signature date.
- There should be evidence in the clinical record regarding the involvement of the member and the member's family, if applicable, in the reformulation of the IPOC, as evidenced by their signature on the new version of IPOC and/or inclusion in the SPD, as documented in the corresponding CSN.
- Provider shall offer a copy of the reformulated IPOC to the member within 10 business days or at the next subsequent session.

The reformulated IPOC is effective on the anniversary date of the previous IPOC and cannot be completed more than 30 days in advance of the due date. If changes or additions are being made to the IPOC, services must be documented in an Addendum to the IPOC if rendered prior to the anniversary date.

The following services are not required to be listed on the IPOC:
- Screening and Assessment Services
- SPD of the IPOC
- Crisis Management Services

90-day Progress Summary (PS)

The 90-day PS is a periodic evaluation and review of a member's progress toward the achievement of goals and objectives, overall response to treatment services, the appropriateness of services rendered and the member's need for continued treatment. The progress summary must be clearly documented and in sequential order representing the appropriate timeframe (i.e., 90 days) from the implementation of the IPOC. The PS may be completed at any time during the 30 days prior to the due date.

The PS shall be completed at least every 90 calendar days from the signature date on the initial IPOC, and at least every 90 days thereafter. The PS must be completed and signed by the provider, rendering treatment and co-signed as appropriate according to the provider qualifications specified in this manual.

It is the responsibility of the current treatment provider to complete the 90-day Progress Summary. If a member is transferred to a new provider within the same organization during the 90-day period, the transferring provider must complete the PS within 30 days of the due date; otherwise, the new provider is responsible for the next PS and shall maintain continuity of services in line with the IPOC and its corresponding timeline/due dates.

The provider will review and document the following:
- The member's name and Medicaid/organizational ID number.
- The member's progress toward treatment goals and objectives, any barriers identified, and strategies to address identified barriers.
- The appropriateness and frequency of the services provided. Inability to provide recommended services and/or at a different frequency than specified on the IPOC must also be explained.
- The need for continued treatment, confirmation of medical necessity and diagnosis.

- Recommendations for continued services or discharge from services as outlined in the success criteria for each objective.

PS documentation must be filed in the member's health record in sequential order following the IPOC (or easily located via a tab, etc., in electronic records) for ease of review and in consideration of the treatment goals and objectives targeted in that particular 90-day period.

Clinical Service Notes (CSNs)

The purpose of the CSN is to record the nature of the member's treatment, any changes in clinical presentation and/or treatment needs since last session, interventions provided and progress towards goal completion and/or discharge, crisis interventions required, and any other changes in medical, behavioral, or psychiatric status. Evidence of rendering services must be documented completely on CSNs.

Note: A CSN must be completed for diagnostic assessments, follow-up assessments, psychological testing and other services that may have a "template format" in the medical record for gathering extensive information; while the CSN does not require a full accounting of the content of the session/template, a reference to the accompanying document when one is completed is required (i.e., "Diagnostic Assessment completed. Biopsychosocial history gathered; medical necessity confirmed for continued services. See DA form in chart for further information and clinical detail").

A CSN is required for each contact or service, reflecting each date of service, for each member (if service was rendered in a group setting) and must be written and signed by the qualified staff who provided the service.

Each CSN must support both the type of service billed and the number of units billed and must be adequate for the length of time identified for service delivery. Documentation must justify the amount of reimbursement claimed to Medicaid. Every CSN must be individualized to reflect the treatment interventions provided, for each date of service, and for each service rendered to the member and/or family.

The content of a CSN cannot be duplicated from other completed records; this applies whether from the records of different members served by the provider or among the range of CSNs with different dates of service for the same member served by the provider, or from CSNs completed on other members from other providers. While group sessions may be similarly documented in all participating member's records (i.e., goal of group for that date and clinical interventions used), individualized information and clinical interpretation related to a specific member is required for the remaining necessary CSN components. If CSNs are not completed and maintained in accordance with the requirements in this manual, payments to the provider are subject to recoupment.

Services rendered on the same date to more than one family member (for example, siblings; individual and family session, same day) must be documented separately on a CSN specific to each member/service.

The CSN must include the following information:

- The member's name and Medicaid or organizational ID number.
- The date of service.
- The name of the rehabilitative service (or its approved abbreviation) and the corresponding procedure code (and modifier(s), if applicable).
- The number of units of service rendered.
- The date of service in a month/day/year format.
- The specific start time and end time for each service delivered; this cannot be rounded up or down but must represent the exact time of the service beginning and ending (such as "3:04 p.m. to 3:57 p.m.").
- Location where the service was rendered. (Refer to the Place of Service information in Section 7 for available options for RBHS).
- If a group service is provided, the number of members must be identified on the CSN.
- CSNs must be typed and/or legibly handwritten.
- CSNs must be kept in chronological order.
- A reference to the member by name (and if other professionals are present, title and agency or provider affiliation) at least once in each note, as applicable. For family therapy sessions, the CSN shall document the family members present and relationship to the member.
  - Identification of other members by name or ID number in group notes is not allowable.
- CSNs must be signed, using credentials or functional titles, and dated (month/date/year) when signed by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with the appropriate standards and service guidelines.
  - CSNs are not considered complete (and thus, not reimbursable) until signed by the appropriate provider.
- Procedure code modifiers must match the credentials of the individual rendering the service or correspond to the appropriate service being delivered.
- CSNs must be completed and available for review in the member's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service; CSNs must be completed and available in the member's clinical record when claims are submitted for the same services.
- Providers must maintain adequate documentation to (1) support the number of units or encounters billed and (2) accurately reflect each service billed.

Each CSN must address the following elements to provide a pertinent clinical description of the session and to ensure that the service conforms to the service description and documentation authenticates the charges, as outlined below:

REQUIRED ELEMENTS OF A CSN	
Element	**Description**
1. Focus and/or reason for the session or interventions	• Related to the treatment objective(s) and/or goal(s) on the IPOC, unless there is an unexpected event that needs to be addressed, in which case it must be identified as the reason for the diversion from the planned course of the session.

2. Detailed summary of the interventions	• Action steps, tools used, techniques utilized, etc., and involvement of qualified staff with the member and/or family during each contact or session (only time spent rendering the intervention or treatment can be billed. See the Covered Services section for additional information).
3. Individualized response of the member and/or member's family, as applicable	• Includes the statements made, information processed, actions taken, etc., by member and/or family to the interventions/treatment rendered in session.
4. Detailed statement of member's general progress	• Includes observations of the member's condition/mental status. Progress must reflect individualized information about the member over the course of treatment and shall not be vague categorizations or generalized statements of progress in treatment (i.e., phrases such as "moderate improvement" and/or "not making progress" will not meet this standard unless more detailed supporting information is provided).
5. Plan for the next session with the member and/or the member's family, as applicable	• This can reflect the plan of action for the next and/or foreseeable future sessions (such as "will continue to practice mindfulness exercises at the end of each session for the next four meetings to reinforce this newly learned skill;" statements such as, "will continue to meet with client as per IPOC," will not meet this standard).

If an evidenced-based practice was utilized, clearly indicate the model used.

Note: It is best practice to assess suicide risk at each behavioral health contact; for providers verbally assessing suicide risk or if tools such as the C-SSRS/Recent Self-Report are completed at each visit, this must be captured in the CSN for the treatment service provided with any necessary follow-up, depending on level of risk. This is part of ongoing care within the treatment process and is not separately billable as a Behavioral Health Screening unless completed independently of another billable clinical service.

Discharge Summary

Members shall be considered for discharge from treatment or transferred to another level of care when they meet any of the following criteria:

- The member's level of functioning has significantly improved.
- The member has achieved the goals as outlined in the IPOC or reached maximum benefit.
- The member has developed the skills and resources needed to transition to a lower level of care.
- The member requested to be discharged from treatment (and is not imminently dangerous to self or others).
- The member requires a higher level of care (i.e., more intensive outpatient treatment, PRTF, or inpatient treatment).

- The member displays the inability to actively participate in the program or no longer is working or participating toward their goals.
- The member has made limited or no progress with respect to the goals outlined in the IPOC and is only minimally engaged in the work of therapy.

The member shall be re-evaluated for other services before discharge from that particular service or level of care with recommendations documented in the discharge summary.

Discharge summaries must include:

- Date of discharge from services.
- Each RBHS service(s) the member received.
- Start and end date of each service.
- Presenting concerns/conditions and diagnosis(es) at time of admission and discharge.
- Description of the progress, or lack of progress, in achieving planned goals and objectives in the IPOC.
- Rationale for discharge from service(s).
- Summary of the member's status/presentation at last contact.
- Recommendations for possible services and support needed after discharge for continuity of care (i.e., medical care, personal care, self-help groups, peer support connections, etc.).
- Medications prescribed or administered, if applicable.
- Attempts to contact member/family, if discharge is unplanned.

7
BILLING GUIDANCE

BILLING REQUIREMENTS

General Billing Guidance, such as: Usual and Customary Rates; Timely Filing; Third Party Liability and COB; Adjustments and Refunds; Remittance Advice; and Electronic Fund Transfer, is detailed in the Provider Administrative and Billing Manual. Additional Billing Guidance specific to RBHS services is detailed in this manual.

Providers must follow the National Correct Coding Initiative (NCCI) edits for Medicaid programs and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI refer to the Provider Administrative and Billing Manual.

Procedure Codes

Providers must bill for services utilizing the procedure codes from the current editions of the HCPCS, CPT or the International Classification of Diseases (ICD), or as otherwise specified by SCDHHS in this manual.

Claim Type and Modifiers

Providers must bill for services using the CMS-1500 claim form and use the following modifiers:

Modifier	Professional Discipline
AF	Specialty Physician (Psychiatrist)
HP	Other Physician (MD/DO)
AM	Physician Assistant (PA)
SA	Nurse Practitioner (APRN)
TD	Registered Nurse (RN)
TE	Licensed Practical Nurse (LPN)
AH	Licensed Psychologist
HO	Master's level
HN	Bachelor's level
HM	Less than bachelor's level
GT*	Via interactive audio/video telecommunication

Note: *When services are delivered via telehealth, the GT modifier is listed as secondary on the claim when there is a primary modifier required for the procedure code.

Additional modifiers for specific services include the following:

Services	Modifier	Modifier Description
PRS (Individual) TCC (Individual)	U1 U2 U3 U4 U5 (PRS only)	Licensed Psychologist Master's level Bachelor's level Registered Nurse (RN) Less than bachelor's degree (PRS only)
PRS (Group) TCC (Group) CIS (Group)	U6 U7 U8 U9 UA (PRS only)	Licensed Psychologist Master's level Bachelor's level Registered Nurse (RN) Less than bachelor's degree (PRS only)
Peer Support Services (Individual and Group)	GT (individual only) HQ	No modifier for individual PSS unless delivered via telehealth. Group peer support services.

Evidence-based practices with modifiers (ACT, and Homebuilders only) include:

Service	Modifier	Modifier Description
Assertive Community Service (ACT)	U1 U3	Small Teams (up to 50 served) Larger Teams (51-129 served)
Intensive In-home Services — Homebuilders (IIHS-HB)	U4	Used for all services rendered under identified procedure code.

Service Unit Contact Time

SCDHHS has adopted the Medicare Eight-Minute Rule for services. This means that when indicated by any discrete RBHS service, a provider may not bill for a service of less than eight minutes. The actual minutes billed by any one provider in a day shall not exceed the daily unit limits. If any RBHS 15-minute service is performed for seven minutes or less on any day, the service is not reimbursable.

The expectation is that a provider's direct member contact time for each 15-minute unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

Units	Time
1	Equal to eight minutes but less than 23 minutes
2	Greater than/equal to 23 minutes, but less than 38 minutes
3	Greater than/equal to 38 minutes, but less than 53 minutes

4	Greater than/equal to 53 minutes, but less than 68 minutes
5	Greater than/equal to 68 minutes, but less than 83 minutes
6	Greater than/equal to 83 minutes, but less than 98 minutes
7	Greater than/equal to 98 minutes, but less than 113 minutes
8	Greater than/equal to 113 minutes, but less than 128 minutes
9	Greater than/equal to 128 minutes, but less than 143 minutes
10	Greater than/equal to 143 minutes, but less than 158 minutes
11	Greater than/equal to 158 minutes, but less than 173 minutes
12	Greater than/equal to 173 minutes, but less than 188 minutes
13	Greater than/equal to 188 minutes, but less than 203 minutes
14	Greater than/equal to 203 minutes, but less than 218 minutes
15	Greater than/equal to 218 minutes, but less than 233 minutes
16	Greater than/equal to 233 minutes, but less than 248 minutes

Use of Z Codes

Z codes, as defined in the DSM and allowable in the ICD for diagnostic purposes, capture situations where a patient may not have a current illness but requires medical attention for other reasons, such as social and environmental factors or other conditions affecting health. They are also known as “factors influencing health status and contact with health services”.

The use of Z codes for diagnoses is allowable for Medicaid reimbursement; however, Z codes are considered temporary for those age seven and older and shall not be used for a period of time greater than six months. After six months, medical necessity must be established by a psychiatric diagnosis for continuation of services.

Note: The use of Z codes is not time-limited for children 0 to 6 years of age and can be used for the duration of the episode of care to substantiate medical necessity.

Z codes can be used in any diagnosis field on the claim form.

Place of Service Billing Codes

The following list provides the location codes most commonly used:

03 — School

11 — Clinician or doctor's office

11 — Home

14 — Group home (for Qualified Residential Treatment Programs [QRTPs] only)

19 — Off-campus hospital

22 — Outpatient hospital

23 — Emergency room

55 — Residential substance use facility

57 — Non-residential substance use facility

99 — Other unlisted setting (excluding recreational settings)

Services must be administered in a setting that is appropriate for both the member and the professional that affords an adequate therapeutic environment and that protects the member's rights to privacy and confidentiality. Excluded settings include acute care hospitals, inpatient psychiatric hospitals, PRTFs, institutions with more than 16 beds and recreational settings (a place primarily used for play and leisure activities). See individual service definitions for information specific to places of service beyond this guidance.

Charge Limits and Reimbursements

For general policies regarding charge limits and reimbursements, providers must refer to the Provider Administrative and Billing Manual.

Payment for all approved services must be accepted as payment in full.

Providers must check the member's eligibility and service history at each billable service for any relevant changes in coverage.

Once a provider has accepted a member as a Medicaid patient, the provider must accept the amount paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the member, member's family, guardian, nor legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition, providers may not charge the member for the primary insurance carrier's co-payment.

Provider billing is also prohibited in the following circumstances:

- Billing for procedures prior to the date of service.
- Billing the member for any service that the member is eligible to receive under the Healthy Connections Medicaid program.
- Medicaid payments may only be made to a provider, a provider's employer, or an authorized billing entity. Payments will not be reimbursed to a member; seeking payment from a member is not allowable.
- Providers are prohibited from billing a member for coverable services denied due to:
  - Untimely filing (refer to the Provider Administrative and Billing Manual for timely filing guidelines).
  - Insufficient/lack of documentation of medical necessity.
  - Claims filed with clinical and/or administrative errors.
  - Failure to obtain prior authorization (when applicable).

8
BENEFIT CRITERIA AND LIMITATIONS

The criteria outlined in SCDHHS' RBHS provider manual are based on procedure codes as defined in the HCPCS and CPT Code sets (unless otherwise indicated in this manual).

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management.

This section will provide the criteria for service delivery and benefit limitations for each covered service.

RBHS SERVICE DEFINITIONS

1. Screening and Assessment Services

Behavioral Health Screening (BHS)

The purpose of this service is to aid in early identification of mental health and/or substance use concerns for further targeted assessment and treatment. BHS is a "wide net" process, designed to identify behavioral health issues and/or the risk of developing behavioral health issues for further exploration. Clinical areas to consider in a regimen of regular screening include trauma, suicide risk, depression and anxiety.

Screenings are conducted using a standardized tool, through interviews or self-report. Some common screening measures include (but are not limited to):

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-step Evaluation and Triage Protocol (SAFE-T)
- Strengths and Difficulties Questionnaire (SDQ)
- Child and Adolescent Trauma Screen (CATS)
- Trauma Screening Questionnaire (TSQ)
- Children's Depression Inventory-2 (CDI-2)
- Patient Health Questionnaire-9 (PHQ-9)
- Screen for Child Anxiety Related Emotional Disorders (SCARED)
- Generalized Anxiety Disorder-7 (GAD-7)
- Pittsburgh Sleep Quality Index

Frequency and Service Limitations

BHS is billed as an encounter and is based on an average of 30 minutes of screening.

Regular screening within the context of ongoing, scheduled sessions to gauge mental status or suicide risk, for example, are not separately billable as BHS. This is part of ongoing care within the treatment process and is not separately billable when conducted within the context of a treatment session. Member completion of self-report tools outside of the session (such as in the waiting room

prior to the session) is not billable. Only screenings that require direct provider intervention meet criteria for billing BHS.

Special Restrictions Related to Other Services

Regular screening within the context of ongoing, scheduled sessions to gauge mental status or suicide risk, for example, are not separately billable as BHS. This is part of ongoing care within the treatment process and is not separately billable as a behavioral health screening. Time the member spends completing self-report tools is not allowable for reimbursement.

BHS shall not be billed on the same date of service as the DA and/or CALOCUS-CASII.

Diagnostic Assessment

The purpose of face-to-face assessment is to determine the need for RBHS by rendering an initial diagnosis(es), confirming medical necessity, assisting in the development of a plan of care based upon the member's strengths and needs, and/or to assess progress in treatment and confirm the need for continued services. The assessment is also used to determine the member's mental status, social functioning, and identify any comorbid physical or medical conditions.

DAs must include the following:

- An evaluation of the member for the presence of a mental illness serious, emotional disturbance, and/or SUD.
- This assessment includes a comprehensive biopsychosocial interview and review of relevant psychological, medical and educational records.
- Clinical interviews with the member, family members or guardians as appropriate; a review of the presenting problems, symptoms and functional deficits, member's strengths and preferences, medical and educational records and a full patient history, including past psychological evaluations and other collateral records.

Initial assessments must include a clinical summary that provides a case conceptualization, including recommendations for and the prioritization of behavioral health and/or other needed services. When rendering a diagnosis, the assessment must identify the member's current symptoms which meet diagnostic criteria required by the current edition of the DSM or ICD (diagnoses must include documentation of the required DSM criteria).

As a best practice, diagnoses should be updated as the condition of the member changes. Once the initial assessment has been completed and services are deemed medically necessary, the development of the IPOC should follow in the course of the treatment process.

DA Follow-up

A follow-up DA occurs face-to-face with the member in the following circumstances:

- To complete the initial assessment, if the DA was not completed in the first session.
- After a period of intervention to re-evaluate the status of the member, their progress, response to treatment, any significant changes in behavior and/or condition, and to monitor and ensure

appropriateness of treatment. It must indicate the need for continued treatment and confirm medical necessity for any new or additional services being added to the course of treatment.

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

Frequency and Service Limitations for DA and Follow-up DA

The initial and follow-up DAs are billed as encounters. The initial assessment may be rendered once every six months. The follow-up assessment may be rendered up to 12 times in the year after admission date.

Special Restrictions Related to Other Services

The DA cannot be rendered or billed on the same day as the Psychiatric Medical Assessment. The follow-up DA shall be utilized only to complete the initial assessment, when necessary, or when documented behavioral changes have occurred and the member needs to be re-assessed based on new clinical information that impacts course of treatment. Efforts shall be made to determine whether another DA has been conducted in the last 90 days if members have changed providers; if so, efforts shall be made to access that information and include in the member's current record. If the recently completed DA is obtained, the provider shall complete a follow-up DA as the initial service and update the previous DA documentation as needed in the new medical record.

CALOCUS-CASII Assessment (Required for Community Support Services Only)

SCDHHS requires the use of the CALOCUS-CASII as the standardized pre-admission criteria for all children and adolescents being considered for CSS. The assessment must be face-to-face (in-person or via telehealth) with the member.

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

The CALOCUS-CASII tool considers four distinct types of potential co-morbid areas: psychiatric, substance use, developmental and medical. The level of care system can be viewed as a continuum ranging from medical maintenance/minimal treatment in a minimally restrictive environment to that of Psychiatric Residential Treatment Facilities (PRTF), a more restrictive and highly structured treatment environment.

The CALOCUS-CASII ranges from level one to level six where the frequency, intensity, location and duration of treatment are correlated to the severity of the child or adolescent's condition.

The child or adolescent is evaluated and rated on six dimensions:

1. Risk of Harm
2. Functional Status

3. Co-Morbidity
4. Recovery
5. Resiliency and Treatment History
6. Treatment Acceptance and Engagement

Treatment and/or services are recommended based on the composite score of the dimensions and the corresponding level of care. Services may include a community mental health system, a private therapist, an interagency community-based system of care, or other providers of psychiatric or behavioral health services, including residential facilities.

It is always preferable to keep children in their communities, when this is an option, and clinical professionals must determine if enhanced community services could be provided to support the child and his or her family as an alternative to out-of-home placement.

CALOCUS-CASII levels of care are as follows:
- Level 1: Recovery Maintenance and Health Management
- Level 2: Outpatient Services
- Level 3: Intensive Outpatient Services
- Level 4: Intensive Integrated Services without 24-hour Psychiatric Monitoring
  Level 5: Non-Secure 24-hour Services with Psychiatric Monitoring
- Level 6: Secure 24-hour Services with Psychiatric Monitoring

When the CALOCUS-CASII score indicates a level four, five or six, residential placement is not indicated. Other community resources at a higher frequency and/or intensity level, based on the needs of the individual, must be considered prior to contemplating out-of-home placement.

Frequency and Service Limitations for CALOCUS-CASII

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

Special Restrictions Related to Other Services

The CALOCUS-CASII cannot be billed on the same day as BHS.

Psychiatric Medical Assessment (PMA)

The PMA, completed by a psychiatrist or qualified psychiatric extender, provides a detailed overview of the presenting concerns, psychiatric condition, medical and behavioral health history and therapeutic needs of the member. The assessment must include a comprehensive biopsychosocial/diagnostic interview and encompass a review of relevant psychological, medical and educational records to obtain information necessary to establish or support a diagnosis. The PMA also includes a full mental status exam. The PMA may involve diagnosing, treating and monitoring chronic and acute health problems and completion of annual physicals and other health maintenance care activities as appropriate (e.g., ordering, performing and interpreting diagnostic studies such as lab work and x-rays).

It also serves to drive the development or revision of the treatment plan and development of discharge criteria.

Frequency and Service Limitations for Psychiatric Medical Assessment

PMA is billed as an encounter and may be billed once every six months.

Special Restrictions Related to Other Services

PMA cannot be billed on the same day as a DA.

Psychological Testing and Evaluation Services (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 (i.e., Minnesota Multiphasic Personality Inventory [MMPI], Rorschach and WAIS). Testing and evaluation must involve face-to-face interaction between a physician/APRN/PA or a licensed psychologist and the member for the purpose of evaluating the member'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 includes integration of member data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, reporting and interactive feedback to the member, family member or caregiver.

Psychological or Neuropsychological Test Administration and Scoring (PTA)

PTA services are utilized when the potential of a mental health or co-morbid condition is being considered and psychological testing may determine the presence or absence of such a condition. Test administration requires meeting medical necessity, which is based on the documented diagnostic impressions that justify the need for testing. PTA also requires administration of at least two tests, which may be administered by any method (i.e., paper, verbal, or electronic).

Frequency and Service Limitations for PTE and PTA

PTE is billed as a 60-minute unit with an add-on code for additional 60-minute units.

PTA is billed as a 30-minute unit with an add-on code for additional 30-minute units.

Special Restrictions Related to Other Services

The evaluating psychologist shall inquire about and review any prior testing (i.e., psycho-educational, psychological, developmental and/or neuropsychological) that may have been administered and request copies for review prior to conducting a new battery.

If prior testing cannot be reviewed, the provider must document their attempts to access the information and offer an explanation pertaining to the clear medical necessity for a new psychological evaluation. Attempts must be made and documented to determine when tests were previously administered to ensure that test exposure is not a factor in the outcome of the evaluation.

PTE includes contacts with family and/or guardians of children for the purpose of securing pertinent information necessary to complete an evaluation of the member. The DA must be completed before the PTE has been conducted. PTE and the DA can be billed on the same day, but cannot be combined (i.e., must be billed separately on the claim).

If an evaluation has been conducted in the last 90 days, it may be repeated only if a significant change in behavior or functioning has been noted. A repeated assessment must be added to the clinical records.

2. Service Plan Development of the IPOC

SPD includes the activities to develop, evaluate, or modify a member's plan of care and incorporates individualized treatment goals, clinical interventions designed to achieve the goals, and a timeline for achievement of the goals. SPD also includes the interaction between the member, his or her family and or/other significant individuals, and the treatment providers.

SPD-interdisciplinary Team: Conference with Client/Family

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

SPD-interdisciplinary Team: Conference without Client/Family

The purpose of this service is to allow the physician, LPHA, master's level staff or LBSW to review with other entities or support teams. In addition, this service will provide the interdisciplinary team with the opportunity to discuss issues that are relevant to the needs of the member without the member or family member being present. The components of the interdisciplinary team conference must be followed for this service. Effective service planning should include representation from all systems of support in which the member is engaged.

SPD by Non-physicians

The purpose of this service is to allow an LPHA master's level qualified clinical professional or LBSW to review, with other entities or support teams, the issues that are relevant to the needs of the member with the member or family member. Effective service planning includes representation from all systems of support in which the member is engaged.

Frequency and Service Limitations for SPD

SPD services are billed as encounters of 30 minutes. Six encounters (in total) of SPD are allowable over a rolling 12-month period.

Special Restrictions Related to Other Services

Providers shall ensure other service agencies or providers involved with the member receive a copy of the completed IPOC.

SPD with and without member/family cannot be billed on the same date of service. SPD cannot be billed on the same date of service as the assessment services and the DA must be completed prior to the development of the IPOC.

3. Core Treatment Services

Psychotherapy

Psychotherapy services are provided within the context of the goals identified in the member's plan of care. Medical necessity for psychotherapy is determined through the DA. The nature of the member's strengths, needs, abilities and preferences, diagnoses and resources determine the extent of the issues addressed in treatment, the therapeutic modalities used by the clinical professional and the length of the episode of care. Psychotherapy services are based on an empirically valid body of knowledge about human behavior. Psychotherapy services do not include educational interventions without therapeutic process interaction, or any experimental therapy not generally recognized by the profession. These services do not include drug therapy or other physiological treatment methods.

Psychotherapy is a planned face-to-face intervention intended to help the member achieve and maintain stability; improve physical, mental and emotional health; and cope with or gain control over the symptoms and effects of their behavioral health condition(s). Psychotherapy services should be used to assist members with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues and may be provided in an individual, group or family setting. The assessments, plans of care, and CSNs must justify, specify, and document the initiation, frequency, duration and progress of the therapeutic modality.

A. Individual Psychotherapy (IP)

IP is a joint process between therapist and individual, an interpersonal, relational intervention built on a foundation of trust, empathy and mutual respect. IP is directed towards increasing an individual's sense of emotional, psychological and social well-being and reducing subjective distress. Where the individual and/or collateral supports have identified maladaptive thoughts, emotions, or behaviors that interfere with or impact the individual's level of distress and/or ability to function at home, at school or work, and/or within the community, the therapist guides him or her in creating goals to address specific challenges. The work of IP focuses on achieving those goals through identifying healthier, more adaptive strategies in a safe, supportive, and confidential space.

IP may be psychotherapeutic and/or therapeutically supportive in nature. Interventions may be brief in length or long-term, depending on a variety of clinical factors and progress towards completion of treatment goals.

IP involves regular, planned therapeutic interventions that focus on the enhancement of a member's capacity to manage his or her emotions, thoughts and behaviors through effective decision making, developing and acquiring coping skills, improvement in self-confidence and sense of self and achievement of desired goals. Interventions should be designed to achieve specific identified objectives, such as improving medication adherence or reframing negative cognitions, for example.

Treatment should be strengths-based and person-centered and designed to positively affect the cognitive functioning, emotional responses and behavior associated with the psychological distress and/or impaired functioning that interferes with the member's ability to achieve a state of desired well-being.

Frequency and Service Limitations for Individual Psychotherapy

IP is billed as an encounter. There are three encounter types based on length of session (30 minutes, 45 minutes and 60 minutes). There is a limit of six encounters per month per service; providers must bill the specific single unit code that best represents the length of the session, as only one procedure code for individual psychotherapy may be billed per day.

B. Family Psychotherapy (FP)

The purpose of this face-to-face intervention is to facilitate the improvement of interfamilial relationships and behavioral patterns of the family unit as a whole, as well as among individual family members, for the benefit of the identified member's sense of well-being.

The therapist assists family members in developing a greater understanding of the member's psychiatric and/or behavioral disorder and the appropriate treatment for this disorder, identifying maladaptive relational patterns between family members and how they contribute to the member's level of functioning, and identifying and developing competence in utilizing more adaptive patterns of relating.

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

FP may be rendered to family members of the identified member with or without the member present as long as the session results in an outcome focused on the identified member. Only issues impacting on the well-being of the identified member may be addressed under this service.

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

FP helps families and individuals within that family understand and focus on improvement of the way they behave towards and communicate with each other, which then supports and encourages facilitation of the member's improvement. The goal of FP is to assist family members in recognizing and addressing the identified issues by establishing roles that promote individuality and autonomy, while maintaining a sense of family cohesion.

Interventions include, but are not limited to, the identification and the resolution of conflicts arising in the family environment, and the promotion of the family's understanding of the member's behavioral

health disorder, its dynamics and treatment. Services may also include addressing ways in which the family can promote recovery for the member from mental illness and/or co-occurring SUDs.

Frequency and Service Limitations for FP

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

Special Restrictions Related to Other Services

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

C. Group Psychotherapy (GP)

GP is a structured therapeutic process in which a small group of individuals with common issues meet under the guidance of one or two clinicians to address personal, emotional, or behavioral issues collectively. The primary goals are to provide emotional support, promote personal growth and facilitate behavioral and/or cognitive changes through the dynamics of group interactions. GP builds on the development of interpersonal relationships and the interaction among group members in a safe, confidential and professionally guided environment, while working towards a stated common goal.

The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, learn new strategies together and to hold each other accountable by challenging negative behaviors and cognitions. Benefits of GP (and key advantages over individual modalities) include:

- **Sense of Belonging:** Members realize they are not alone with their issues, which reduces isolation.
- **Sense of Hope:** Seeing other group members' successes can instill hope and motivation for one's own successes.
- **Learning from Others:** Observing peers' coping strategies and hearing their personal insights can enhance one's own self-awareness and problem-solving skills.
- **Improved Interpersonal Skills:** The group setting is a place to safely practice a variety of life skills, such as communication, empathy and relationship-building.
- **Mutual Support:** Members provide encouragement and accountability, fostering motivation and empowerment.

The therapist(s) guides the group with planned interventions, while maintaining the flexibility to address other presenting needs as necessary. The therapist(s) ensures that the group process is productive for all members and keeps an overarching focus on identified therapeutic issues and targeted goals.

The group service must be a part of an active treatment plan, and the goals of the group must be in line with the treatment goals of each individual member. The focus of the psychotherapy sessions must not be exclusively educational or supportive in nature. The intended outcome of such group-

oriented, psychotherapeutic services is the management, reduction, or resolution of the identified behavioral health problems and increased adaptive functioning, thereby allowing the member to operate more independently and competently in daily life.

D. Multiple Family Group Psychotherapy (MFGP)

MFGP treatment involves members with similar issues and their families to meet face-to-face in a group setting, led by one or more clinicians. The group's focus is to assist members and their family members in resolving or improving emotional difficulties, encourage personal growth and development, and to provide mutual support as they work towards an Improved sense of well-being.

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

MFGP involves a small therapeutic group that is designed to produce positive functional change. The goals of MFGP must match the overall treatment plan for the individual member. MFGP requires interpersonal relationships and interaction among group members in a safe and confidential environment and a stated common goal.

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

Frequency and Service Limitations for GP and MFGP

GP is billed as an encounter (minimum of one hour, one encounter per day) with a maximum of eight encounters per month. The staff to member ratio for group psychotherapy is one provider per eight members (1:8). While not required to bill this service, two group co-leaders are encouraged.

Those who meet the following criteria may benefit from GP and MFGP:

- Members with interpersonal problems related to their diagnoses and functional impairments. Interaction with peers in a group setting allows the member to develop and practice new skills and focus on the factors that impact their symptoms.
- Members with the same type of problem that may gain insight from being in a group of others with similar issues. This might include those who have had a similar distressing life experience, such as sexual trauma or loss of a sibling.
- Members must demonstrate a level of basic competency to navigate in a group setting, which the therapist must evaluate prior to inclusion of the member in a specific group service.

Medication Management (MM)

The purpose of MM services is to train and educate the member about his or her medication, to determine any physiological and/or psychological effects of medication(s) on the member, administer necessary medications, and to monitor the member's compliance with his or her medication regimen.

MM is focused on topics such as possible medication side effects, potential drug interactions and the importance of medication compliance. During assessments, attempts should be made to obtain necessary information regarding the member's health status and use of medications.

MM encompasses those processes through which medicines are selected, procured, delivered, prescribed, administered, and reviewed to optimize the contribution that medicines make to producing informed and desired outcomes of the member's care.

MM includes **two or more** of the following service components:

- **Management:** Involves prescribing and then reviewing medications for their side effects.
- **Monitoring:** Involves encouraging medication compliance and observing a member taking their medication as prescribed (frequently used with those with a poor compliance history).
- **Administration:** The actual giving of an oral medication by a licensed professional.
- **Training:** Educating members and their families on how to follow the medication regimen and the importance of doing so.
- **Assessing:** Determining the need for members to see the physician.

MM may also include the following:

- Determining the overt physiological effects related to any medication(s).
- Determining psychological effects of medications.
- Monitoring members' compliance with prescription directions.
- Educating members as to the dosage, type, benefits, actions and potential adverse effects of the prescribed medications.
- Educating members about psychiatric medications and substance misuse in accordance with nationally accepted practice guidelines.
- Monitoring and evaluating the member's response to medication(s).
- Identifying, resolving and preventing medication-related problems including adverse drug events.
- Documenting the care delivered and communicating essential information to the member and/or other service providers or family members, if appropriate. When the service is provided to children, the service should include communication and coordination with the family and/or legal guardian.
- Providing education and training designed to enhance the member's understanding and appropriate use of the medications.
- Providing information, support services, and resources designed to enhance member's adherence to medication regimen.
- Coordinating and integrating MM services within the broader health care management being provided to the member.

Frequency and Limitations for MM
MM is billed in 15-minute units.

Special Restrictions Related to Other Services
MM cannot be billed on the same day as physician evaluation and management codes for the same condition.

4. Community Support Services
Service-specific guidance for community support services can be found at the end of this section.

CSS must be authorized prior to being rendered (except for PSS, which has continuing stay criteria after 216 sessions)**.** Please refer to the utilization management section of this manual regarding prior authorization requirements.

Psychosocial Rehabilitation Services (PRS)
The purpose of PRS face-to-face service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the member'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 member's skills develop. Services are based on medical necessity, shall be directly related to the member's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the member's IPOC.

PRS includes activities that are necessary to achieve goals in the IPOC in the following areas:
- Independent living skills development related to increasing the member'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 develop in the understanding and practice of daily and healthy living habits and self-care skills.
- Interpersonal skills training that enhances the member'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 members 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 member should be offered PRS in a manner that is strengths-based and person-centered.
- PRS must provide opportunities for the member to acquire and improve skills needed to function as adaptively and independently as possible in the community and facilitate the member's community integration.

Behavior Modification (BMOD)
BMOD is provided to children and adolescents ages 0 to 21. The purpose of this face-to-face service is to provide the member 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 member in any setting is not reimbursable under Medicaid. BMOD 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 member's skills develop. Services are based upon a finding of medical necessity, shall be directly related to the member's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the member's IPOC.

The goal of BMOD is to alter patterns of behavior that are inappropriate or undesirable of the child or the adolescent. BMOD 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.

BMOD provides the member 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 member's ability to learn life skills.

BMOD 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 member must be used to develop, shape, model, reinforce and strengthen the new behaviors.

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

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

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 member's treatment team and to develop and/or improve the ability of the family or caregiver(s) to appropriately care for the member. 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 member's and family/caregiver's skills develop. Services are based upon a finding of medical necessity, must be directly related to the member's diagnostic

and clinical needs, and are expected to achieve the rehabilitative goals specified in the member's IPOC.

FS is intended to:

- Equip families with coping skills to independently manage challenges and crisis situations related to the member's behavioral health and/or SUD.
- Educate families/caregivers to advocate effectively for the member in their care.
- Provide families/caregivers with information and skills necessary to allow them to be an integral and active part of the member's treatment team.
- Model skills for the family/caregiver.
- FS is a service with the primary purpose of treating the member's behavioral health and/or SUD.
- FS does not include case management activities, nor does it include respite care or childcare services of any kind.

Therapeutic Childcare (TCC)

The purpose of this face-to-face service is to assist children ages zero to six with severe emotional and/or behavioral disturbances, and to promote or enhance appropriate developmental functioning which fosters social, emotional, and self-regulatory behavioral competence. Services incorporate a combination of psychotherapy and skill building.

TCC is a child-focused, family-centered intervention which targets the relationship between the child and the parent (or primary caregiver). Grounded in attachment theory, services are relationship-based, developmentally appropriate and trauma informed. Services must be evidence-based and include either TF-CBT, PCIT or CPP. The TCC must have documentation of staff certification to provide the evidence-based treatment being utilized as well as a documented plan for fidelity monitoring.

The child and child's family are expected to develop new behaviors and skill sets, such that the child will not require intensive treatment in the future.

TCC involves:

- Ongoing assessment, treatment activities, and therapeutic structure during program hours.
- Therapeutic group interventions that foster social and emotional competence and self-control.
- Parallel work with the primary caregiver, which is an essential component of this service. A minimum of one hour per week must be spent with the primary caregiver that includes parent-child interaction to encourage language and play, interpretation of child's behavior, and reinforcement of a primary caregiver's appropriate actions and interactions. Parallel work may include activities and services that are not specifically billed to TCC.

It is expected that:

- The child will demonstrate an improved ability to initiate and respond to social interactions in a developmentally appropriate manner.

- The child will show a significant reduction in intense and disruptive problem behaviors that interfere with the child's ability to successfully participate in normal developmental experiences or present a danger to self and/or others.
- The child will develop age-appropriate behavioral competencies that will result in enhanced problem-solving, coping strategies, self-control, and more successful interactions with other children and adults.
- The child will demonstrate an enhanced ability to meaningfully perform age-appropriate role functions and to learn from the home and educational environments.
- The child will show significant improvements in mood as evidenced by reductions in excessive irritability and/or sadness.
- The child will demonstrate a reduction in behaviors which previously made the child's behavior unmanageable in the home, school, and community. There will be an increase in the child's ability to be present, interact, and participate in various tasks for longer periods of time
- The child will demonstrate an increased capability to interact with adults in therapeutic and educational tasks, resulting in increased educational and emotional functioning.
- Improvements in mood will be accompanied by positive changes in self-worth and confidence.

It is expected that parents or primary caregivers of members will:

- Learn strategies for managing problem behaviors and interacting effectively with their children.
- Identify and reduce maladaptive patterns and stressors in the home that compound the child's behavioral and emotional challenges.
- Learn to recognize generational patterns impacting their parenting methods and relationship with their child and take active steps to modify those patterns to the benefit of the child and family.
- Understand the social-emotional needs being expressed through behavior and know how to respond to these appropriately.
- Reduce parenting stress and improve confidence in their parenting skills.
- Develop and/ or strengthen the attachment bond with their child.
- Recognize how traumatic experiences can impact their own behavior and their child's behavior and demonstrate ability to recognize potential risks and take action to keep their child safe.
- Demonstrate age-appropriate expectations for their child's social-emotional and behavioral development.
- Consistently and appropriately provide for the child's basic needs for health, safety, comfort, affection and stimulation.

Therapeutic Foster Care (TFC)

The purpose of this residential, face-to-face service is to enhance, restore, and/or strengthen the skills needed to promote and sustain independence and stability within the member's living, learning, social, and vocational environments. Therapeutic Foster Care (TFC) services are based on medical necessity, shall be directly related to the member's diagnostic and clinical needs, and are expected to support the achievement of the specific rehabilitative goals specified in the member's IPOC.

TFC is a treatment-focused form of foster care provided in a family setting by trained caregivers and is a family-based placement option for children and adolescents with serious emotional, behavioral, or medical needs who can be served in the community with additional intensive support. Youth receiving TFC require behavioral health services and supervision provided in a treatment foster home setting.

TFC services are individualized and trauma-informed, and provided to youth with psychological, emotional, and/or behavioral challenges. Eligible members are those who are at risk for disruption or have had disrupted placements in regular foster homes, are unable to live with their own families, or are going through a transitional period from residential care as part of the process of returning to family and community.

TFC provides a structured environment with a specially trained and clinically supervised therapeutic foster family. This family facilitates the development of skill acquisition and use of strategies and supports that address therapeutic treatment, prevention, recovery, and behavior change consistent with age and development for each child served. TFC services are necessary to assist the child in improving and maintaining functioning across life domains.

TFC services include:

A. Treatment planning. An individualized treatment plan is designed to guide and coordinate the provision of services. Following the creation of the IPOC, CPA treatment teams must meet every 90 days, or more often, if necessary, to help ensure that the services are responsive to the changing needs of the child being served. The treatment team will invite the therapeutic foster parents, case managers, biological or other family members as appropriate, clinicians, and others involved in the child's team.
B. Specialized training. Therapeutic foster care requires highly trained caregivers who are responsible for implementation of the child's treatment plan. Therapeutic foster parents receive additional preservice and ongoing training compared to traditional foster parents. They are also provided more frequent supervision by trained treatment coordinators and clinicians.
C. Family and crisis support. Therapeutic foster parents and children are provided with de-escalation support that can include crisis planning, respite care, and access to a treatment coordinator or clinician 24 hours a day.
D. Structured activities. Activities are designed to teach or reteach social skills and coping skills to help children in therapeutic foster care deal effectively with the circumstances or conditions that created the need for treatment.
E. Interventions. Strategies used by team members include but are not limited to role modeling in all social contexts, anger management skills-building, communication and conflict resolution skill development, crisis avoidance/planning/intervention, behavioral de-escalation, recovery, reinforcement of skill acquisition in the home and community, transition and discharge planning, and self-advocacy.

Community Integration Services (CIS)

The purpose of this face-to-face service is to assist adult members (18 or older), diagnosed with serious mental illness (SMI) or co-occurring mental health and substance use disorders, achieve identified behavioral health treatment goals in the environment of their choice.

CIS programs are appropriate for adults who meet diagnostic criteria but wish to participate in a structured program with staff and peers while working on identified treatment goals that can be achieved in a supportive and structured environment.

CIS requires that a member be actively involved in the development and management of their overall rehabilitation, including planned goals, objectives, and intervention activities included on the IPOC. A member meaningfully involved in CIS programs shall be able to articulate their individual goals and objectives and to identify ways in which their current activities are intended to assist them in achieving those goals and objectives and further their recovery.

There must be a collaborative and supportive relationship between the providers, member, and family (if family is involved) to work on IPOC goal achievement. The goals of the IPOC must address the following skills development, educational, and pre-vocational activities as necessary:

- Community living competencies (i.e., self-care, cooking, money management, personal grooming, and maintenance of living environment).
- Social and interpersonal competencies (i.e., conversational competency, developing and/or maintaining a positive self-image, regaining the ability to evaluate the motivation and feelings of others to establish, and maintain positive relationships).
- Personal adjustment competencies (i.e., developing and enhancing personal abilities in handling life experiences and crises, including stress management, leisure time management, and coping with symptoms of mental illness).
- Cognitive and adult role competencies (i.e., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn, and establishing the ability to develop empathy).
- Prevocational activities (i.e., development of positive work habits and participation in activities that would increase the member's purpose, confidence and re-engagement in meaningful activities and/or employment, time management; prioritizing tasks, taking direction from supervisors, importance of learning and following the policies/rules and procedures of the workplace, problem solving/conflict resolution in the workplace, communication and relationships with coworkers and supervisors, on-task behavior, and task completion skills).

Providers are encouraged to utilize evidence-based best practice models such as the following:

- The Boston Psychosocial Rehabilitation Approach
- The Lieberman Model.
- The International Center for Clubhouse Development approach.
- The Fountain House model.

or

- Blended models/approaches in accordance with current peer-reviewed research related to Psychosocial Rehabilitation.

Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in evidence-based models and best practices for Psychosocial Rehabilitation.

The facility where CIS is delivered must be open for a period of five or more hours per day, at least five days per week. CIS may be provided on weekends or in the evening.

Peer Support Services (PSS)
The purpose of this service is to assist members' recovery from mental health and/or substance use disorders by sharing similar lived experience and concepts of recovery.

This service is person-centered with a recovery focus and allows members 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 certified peer support specialist (CPSS) gives advice and guidance, provides insight, shares information on services, and empowers the member to make healthy decisions. The unique relationship between the peer support specialist and the member fosters understanding and trust in members who otherwise would be alienated from treatment. The member's plan of care determines the focus of PSS.

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

The CPSS actively engages the member to lead and direct the design of the plan of care and empowers the member to achieve their specific individualized goals. Members are empowered to make changes to enhance their lives and make decisions about the activities and services they receive.

Certified Peer Support Specialist Responsibilities:
- Knowledge of peer support principles, values, and ethics.
- Ability to share lived experience to support, encourage, and enhance a member's treatment and recovery.
- Possess recovery-oriented skills and knowledge to provide peer support services.
- Ability to collaborate with the program supervisor to assess their own strengths and areas of growth and develop a supervision plan.
- Ability to collaborate with a member to explore and identify barriers to accessing community resources or treatment providers.

- Ability to model and mentor recovery values, attitudes, beliefs, and personal actions to encourage wellness and resilience for members served and to promote a recovery environment in the community, residence, and workplace.
- Ability to explore with a member served the importance and creation of a wellness identity through open sharing and challenging viewpoints.
- Ability to promote a member's opportunity for personal growth by identifying teachable moments for building relationship skills to empower the member and enhance personal responsibility.
- Ability to model and share decision-making tools to enhance a member's healthy decision-making process.
- Ability to provide examples of healthy social interactions and facilitate familiarity with, and connection to, the local community.
- Ability to recognize and appropriately respond to conditions that constitute an emergency to include both physical and behavioral health crises, utilizing the emergency response protocol of their employer.
- Ability to provide support to the member in navigating systems (i.e., medical, social services, or legal).
- Ability to promote self-advocacy by facilitating each member's learning about his or her human and legal rights and supporting the member while exercising those rights in support of their empowerment. 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
  - Case management (linkage to services)
  - Education
  - Meaningful activity and work
  - Effective communications skills

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

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

Such methods actively engage and empower the member in leading and directing the design of the service plan, thereby, ensuring that the plan reflects the needs and preferences of the member in achieving their specific, individualized goals that have measurable results as specified in the service plan.

Service interventions include the following:

- Self-help activities that cultivate the member's ability to make informed and independent choices; activities that help the member develop a network for information and support from others with similar lived 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 members in making telephone calls and composing letters about issues related to SUDs, mental illness, or recovery.
- Individual advocacy includes discussing concerns about medications or diagnoses with a Physician or nurse at the member's requests. Further, it helps members arrange the necessary treatment when requested, guiding them toward a proactive role in their own treatment.
- Crisis support assists members with the development of a crisis plan. It teaches members:
  - 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 members in learning how to maintain stable housing or learning how to change an inadequate housing situation.
- Social network interventions assist members 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 members in obtaining information about going back to school or obtaining job training. Interventions give members an opportunity to acquire knowledge about returning to (or beginning) full-time or part-time work. Additionally, members are taught how to obtain reasonable accommodations under the Americans with Disabilities Acts (ADA).

Authorized Agencies for Peer Support Certification and Minimal Qualifications

SC SHARE or an Addiction Professionals of South Caroling (APSC)-approved organization are the only authorized providers of Peer Support Certification Training in the State of South Carolina. SC SHARE provides certification for those specializing in co-occurring mental health and substance use disorders, while APSC-approved organizations provide certification focusing on substance use disorders. The CPSS must be certified appropriately for the population served. Additional information about certification requirements may be found at:

- Peer Support Certification | SC SHARE | United States
- Peer Support Specialist Certification | Addiction Professionals of South Carolina

Presently no reciprocity exists with any other state or program for Peer Support Certification.

Peers eligible for certification in South Carolina must meet the following criteria to be considered for training through SC SHARE and/or APSC-approved organizations:

- At least 18 years of age at the time of application.
- Self-identify as a person diagnosed with mental illness, substance use disorder, or co-occurring disorder.
- Meet minimum education requirements of possessing a High School Diploma, GED, or in the process of completing in their final semester of high school.
- Have maintained a period of time of active, consecutive, self-directed recovery as evidenced by three professional references. SCSHARE and APSC are responsible for determining appropriateness of the length of recovery based on the individual applicant.
- Have completed a minimum of 100 hours of supervised, paid, or volunteer work providing peer support services for individuals who have mental illness, substance use, or co-occurring disorders. Note: This requirement can be waived/amended by the certifying organization on a case-by-case basis depending on the applicant's work history, education, recovery journey, or other relevant factors.

Additional Notes:

- Past or present justice system involvement **does not** automatically disqualify any applicant from being considered for Certification.
- Use of prescribed Medication to maintain mental health recovery **does not** disqualify any applicant from being considered for Certification.
- Use of Medication Assisted Therapy (MAT) to maintain recovery **does not** disqualify any applicant from being considered for Certification.

Recertification is mandatory for all Certified Peer Support Specialists and requires CEU completion to maintain certification (CPSSs must review their respective certification agencies for more information pertaining to recertification requirements).

Supervision for PSS

Supervision must be provided, at minimum, by a certified peer support specialist with at least five years of experience providing direct service to individuals seeking recovery. Supervision may also be provided by a bachelor's or master's level provider with a minimum of three years' experience with the population served.

Note: CPSSs who have obtained the APSC Certified Peer Supervisor certification do not need to also maintain their preliminary peer support certification in order to be reimbursed by Medicaid; the APSC Certified Peer Supervisor certification is recognized as encompassing the CPSS credential, and thus, Certified Peer Supervisors remain eligible to render PSS.

Peer Support Services Program Supervisor Responsibilities:

- Must be trained in quality supervisory skills.
- Possess knowledge of the CPSS role and work, as well as understand the principles and philosophy of recovery and the code of ethics of the SC Peer Support Specialist Certification Program.
- Understand and support the role of the CPSS.
- Understand and promote the member's recovery.
- Advocate for the CPSS and Peer Support across the organization and in the community.
- Promote both the professional and personal growth of the CPSS within established human resource standards.
- Coordinate assessments needed for the member. If appropriately licensed, the supervisor may conduct the assessments.
- Collaborate with member(s) and CPSS to develop recovery-oriented person-centered plan for the member that demonstrates consideration for integrated care.
- Conduct at least one in-person, telehealth, or telephonic, audio-only communication contact with the member within 90 days of CPSS being initiated and no less that every six months thereafter to monitor the member's progress and effectiveness of the program; and to review with the member the goals of their CPSS and document progress.
- Plan work assignments, monitor, review, and evaluate work performance of program staff and conduct routine reviews of service notes for quality assurance.
- Provide administrative and supportive supervision to program staff individually at least once per month or more if needed. Provision of supervision must be based on the experience of the individual staff; supervision must be documented and kept in the employee file, demonstrating increased support and supervision to newly trained or recently hired peer support specialists.
- Collaborate with program staff to assess strengths and areas of growth and develop an individual supervision plan.
- Collaborate and foster collegial roles with program staff.
- Determine team caseload size based on the level of acuity and needs of the member(s).
- Facilitate or co-facilitate skill building recovery groups based on the needs or request of members or assistance required by the CPSS.
- Ensure referrals for community resources requested by member(s) are completed.

The supervisor must be available to supervise the CPSS 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 CPSSs 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 member's needs. Issues relevant to the individual member will be documented in a staff note and noted in the member's medical record.

As noted above, the supervisor is also required to perform at least one evaluation of the member within 90 days after admission to the program. The evaluation shall be repeated every six months thereafter (or as requested by the member or CPSS, or sooner than every six months at the supervisor's discretion) to:

- Monitor the recovery process of the member.
- Monitor the focus of the services provided.
- Ensure that the member continues to meet the peer support criteria.

The evaluation must be kept in the member's file and may be billed separately as a follow-up assessment or if conducted by a non-LPHA, rendered under the Peer Support Services service code indicating the purpose of the service.

Billing Guidance for Community Support Services

Same-Day Service Restrictions

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

If multiple private RBHS providers are rendering different services to the same member, coordination must ensure that CSS are not provided on the same day; claims will reimburse for the first allowable claim that is submitted and any other same-day claims will be denied.

Exceptions:

- Children in foster care and TFC are exempt from the same-day service restriction.
- Individual PRS (1:1) may be provided on the same day as CIS.

For services rendered to members residing in a residential facility, Medicaid reimbursement is not allowable for activities that are specified as operational requirements of a licensed facility as per the South Carolina Department of Public Health (SCDPH) licensing guidelines. CSS provided to members in a residential setting must be above and beyond facility operations/programming requirements to meet service definition criteria. There must be clear delineation between license-required care and services billed for reimbursement documented and accessible in the member record.

Unless otherwise specified, Community Support Services are billed using a 15-minute unit.

Additional CSS Service-Specific Billing Guidance

Family Support (FS)

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

Therapeutic Childcare (TCC)

Billable Place of Service: Services must be rendered in an SCDSS licensed or approved daycare facility that affords an adequate therapeutic environment and that protects the member's rights to privacy and confidentiality.

When medically necessary, Group and Individual TCC may be provided to a member on the same day but cannot be billed concurrently. Concurrent billing of TCC individual and group is not allowable and is subject to recoupment.

Example of billable same-day TCC services:

- Member attends TCC-individual session from 9:00 a.m. to 9:30 a.m. and TCC-group session from 9:30 a.m. to 11:00 a.m. Provider completes two CSNs (one individual and one group) and may submit a claim for 30 minutes of TCC-individual and 1.5 hours of TCC-group.
  - Billable time does not overlap and documentation for each modality of TCC is distinct.
- If the member is removed from the group session to receive individual services and then returns to complete the group, the provider must bill the group service *only* for the total amount of time member was physically in the group;
  - Ex.: TCC group is scheduled by provider from 9:00 a.m. to 11:00 a.m.; member attends TCC-group from 9:00 a.m.-10:00 a.m., TCC-individual from 10:00a.m.-10:30 a.m. and returns to TCC-group for the final 30 minutes. Provider completes two CSNs as above and may submit a claim for 30 minutes of TCC-individual and 1.5 hours of TCC-group.

Community Integration Services (CIS)

Billable Place of Service: Services must be provided in a community-based facility that is open for operation at least 25 hours per week.

Therapeutic Foster Care (TFC)

TFC level is determined by SCDSS. TFC is billed as per diem and allowable up to 31 days per calendar month.

Billable Place of Service: TFC services must be rendered in a SCDSS licensed therapeutic foster home through a Child Placing Agency contracted by SCDSS. TFC providers are qualified staff under the supervision of qualified clinical professionals.
Same-Day Service Restrictions: TFC is an inclusive service and may not be provided on the same day as Psychosocial Rehabilitative Services (PRS). Conversely, PRS may not be provided on the same day as TFC.

Peer Support Services (PSS)

Billable Place of Service for PSS: PSS' are provided in settings appropriate and comfortable for the member. PSS may be provided in the home, in the community, or in the office. Certified Peer Support Specialists are ideal members of multidisciplinary teams that provide services in hospital emergency departments, within mobile crisis intervention teams, Crisis Stabilization Units, or Assertive Community Treatment teams.

While RBHS providers cannot independently bill PSS while a member is an inpatient in an acute care hospital, hospitals are encouraged to include CPSSs on their multidisciplinary teams for ED and psychiatric units. PSS can be rendered and reimbursed when provided in a community mental health center, substance use facility, as well as all other settings as noted above.

As a group service, PSS may operate in the same building as other day services. However, with regard to staffing, content, and physical space, a clear distinction must exist between day services during the hours a PSS group is in operation. PSS does not operate in isolation from the rest of the programs in the facility.

Crisis Management Services

An acute behavioral health crisis involves an individual's overwhelming inability to cope with current interpersonal stressors resulting in intrusive and pervasive negative thoughts, feelings, and behaviors that put them at risk of imminent harm to self or others. A crisis may also result when a person is unable to care for themselves due to a rapid and marked deterioration of functioning, resulting in the inability of the individual to remain safe and healthy without immediate intervention. Crisis situations, whether caused by a specific situational precipitant or event, chronic mental illness, or substance use, require immediate and precise intervention to ensure appropriate services and/or supports are put in place for the member's ongoing well-being. Crises may surface for any individual at any time--behavioral health conditions do not discriminate; thus, all providers must have a developed protocol for acute crisis management.

SCDHHS strongly encourages providers to maintain up-to-date continuing education on crisis prevention and intervention and to use best practice approaches to screening, assessment, intervention, and safety planning for those in crisis. Several best practice resources include:

- C-SSRS Screen Version
- Columbia Suicide Severity Rating Scale (C-SSRS) | SAMHSA
- The Lighthouse Project - The Columbia Lighthouse Project
- CALM: Counseling on Access to Lethal Means – Suicide Prevention Resource Center
- Stanley-Brown Safety Plan – Suicide Prevention Resource Center

Crisis Intervention (CI)

The purpose of this unplanned, face-to-face, or telephonic intervention is to triage, screen, and assess a member who is experiencing a behavioral health crisis. The overall goal of this service is to assist the member in resolving the crisis while ensuring they remain in the least restrictive, clinically appropriate level of care possible. CI includes the following:

- A preliminary evaluation of the member's specific crisis.

- An assessment of the level of suicide risk *(see resources above).*
- Therapeutic intervention and stabilization of the member.
- Reduction in the personal distress experienced by the member.
- Development of a safety plan with hope-instilling strategies and the terms of removing access to lethal means in the living environment.
- Referrals to appropriate resources, connecting the member to a higher level of care if required for safety.
- Follow-up with the member within 24-hours, when appropriate (i.e., if member remains in community).

Telephonic interventions are provided either to the member or on behalf of the member to collect an adequate amount of information to provide appropriate and safe services, stabilize the member, and prevent a negative outcome; telephonic time utilized within the context of the face-to-face crisis intervention is included in the total time billed for the CI service.

This may involve follow-up with a parent/caregiver/family member or other collaterals in order to facilitate safety planning, address member's access to lethal means, and/or establish next steps for stabilizing the crisis.

CI also includes identifying any new concerns of the member since last service (when applicable), member's current living situation and availability of supports, current medications and medication compliance, current use of substances, comorbid medical conditions, and when applicable, history of previous crises including response and results. Individuals in crisis who require this service may be using substances during the crisis; substance use must be assessed, recognized, and addressed in an integrated fashion as it generally increases risk, heightening the need for engagement in care. This coordination must be documented in the individual's clinical record.

Frequency and Service Limitations for Crisis Intervention

CI is billed in 15-minute units, up to 16 units per day. There is a maximum of 80 units annually per member.

Note: Members requiring the maximum allowable services for CI must be assessed for a higher level of care, additional supports, or the provider must complete and document a thorough review of IPOC goals, current services, and interventions, as this would indicate treatment as rendered per the current plan of care are not sufficient for the member's needs.

Special Restrictions Related to Other Services

Services provided to children must include coordination with family or guardians and other systems of care as appropriate. Providers rendering CI to members that remain in the community must have evidence of facilitating a safety plan with the member during the session that is clearly documented in clinical service notes.

EVIDENCE-BASED PRACTICES

Service definitions, billing guidance, and special restrictions for Assertive Community Treatment (ACT), Multisystemic Therapy (MST), and Homebuilders may be found in Appendices 3, 4, and 5, respectively.

REHABILITATIVE BEHAVIORAL HEALTH SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
Screening and Assessment Services					
H0002	Behavioral Health Screening (BHS)	AF HP AM SA AH HO HN GT	Psychiatrist Other physician *(MD/DO)* PA APRN Licensed Psychologist Master's level Bachelor's level Via interactive video/audio telecommunication	NO	Encounter = one unit. One encounter per day per member.
90791	Diagnostic Assessment (DA) • Initial	AH HO GT	Licensed Psychologist Master's Level Via interactive video/audio telecommunication	NO	Encounter = one unit. One encounter per rolling six months per member.
90792	Psychiatric Medical Assessment	AF AM SA GT	Psychiatrist PA APRN Via interactive video/audio telecommunication	NO	Encounter = one unit. One encounter per rolling six months per member.
H0031	Diagnostic Assessment (DA) • Follow-Up	AH HO GT	Licensed Psychologist Master's Level Via interactive video/audio telecommunication	NO	Encounter = one unit. 12 Encounters per rolling 12 months per member.
H2000	CALOCUS-CASII	AH HO GT	Licensed Psychologist Master's Level Via interactive video/audio telecommunication	NO	Encounter = one unit. One encounter per rolling six months per member.
96130	Psychological Testing and Evaluation (PTE) • Initial hour	AH	Licensed Psychologist	NO	First Hour = One unit. One unit per day per member; not to exceed 24 units per rolling 12 months in combination with 96131, 96136, and 96137.
96131	Psychological Testing and Evaluation (PTE) • Additional hour(s)	AH	Licensed Psychologist	NO	One additional hour = one unit. A maximum of seven hours per day per member; not to exceed 24 units per rolling 12

					months in combination with 96130, 96136, and 96137. Must be billed with 96130.
96136	Psychological/ Neuropsycho-logical Test Administration and Scoring (PTA) • First 30 minutes	AH	Licensed Psychologist	NO	First 30 minutes = one unit. One unit per day per member; not to exceed 24 units per rolling 12 months per member in combination with 96130 and 96131.
96137	Psychological/ Neuropsycho-logical Test Administration and Scoring (PTA) • Each additional 30 minutes	AH	Licensed Psychologist	NO	Additional 30 minutes = One unit. A maximum of six units per day per member; not to exceed 24 units per rolling 12 months in combination with 96130, 96131, and 96136. Must be billed with 96136.
Service Plan Development of the IPOC					
99366	Service Plan Development (SPD) – Team Conference with Client/Family	00	No Modifier	NO	Encounter = one unit. Six encounters per rolling 12 months per member.
99367	Service Plan Development (SPD) – Team Conference without Client/Family	00	No Modifier	NO	Encounter = one unit. Six encounters per rolling 12 months per member.
H0032	Mental Health Service Plan Development (SPD) – Non–Physician	AH HO HN GT	Licensed Psychologist Master's level Bachelor's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = 30 min. Six units per rolling 12 months per member.
Core Treatment Services					
90832	Individual Psychotherapy (IP) • 30 minutes	AF AM SA AH HO GT	Psychiatrist PA APRN Licensed Psychologist Master's level Via interactive	NO	Encounter = one unit. Unit = one session. One per date of service per member; not to exceed six sessions

			video/audio telecommunication		per calendar month.
90834	Individual Psychotherapy (IP) • 45 minutes	AF AM SA AH HO GT	Psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One per date of service per member; not to exceed six sessions per calendar month.
90837	Individual Psychotherapy (IP) • 60 minutes	AF AM SA AH HO GT	Psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One per date of service per member; not to exceed six sessions per calendar month.
90846	Family Psychotherapy (FP), without patient • 50 minutes	HP AH HO GT	Psychiatrist Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One per date of service per member; not to exceed four sessions per calendar month.
90847	Family Psychotherapy (FP), with patient • 50 minutes	HP AH HO GT	Psychiatrist Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit Unit = one session One per date of service per member; not to exceed four sessions per calendar month.
90853	Group Psychotherapy (GP)	AH HO	Licensed Psychologist Master's level	NO	Encounter = one unit. Unit = one session. One per date of service per member; not to exceed eight sessions per calendar month per member.
90849	Multiple Family Group Psychotherapy (MFGP)	AH HO	Licensed Psychologist Master's level	NO	Encounter = one unit. Unit = one session. One per date of service per member; not to exceed eight sessions per calendar month, per member.
H0034	Medication Management (MM)	AF HP AM	Psychiatrist Other Physician/ PA	NO	15 minutes = one unit.

		SA TD TE GT	APRN RN LPN Via interactive video/audio telecommunication		Maximum of eight units per day per member; not to exceed 80 units per rolling 12 months.
Community Support Services*					
**PA not required for state agencies*					
H2017	Psychosocial Rehabilitation Services (PRS) • Individual	U1 U2 U3 U4 U5	Licensed Psychologist Master's level Bachelor's level RN Less than bachelor's Degree *(TFC providers only)*	YES	15 minutes = one unit. 24 units per day per member per rolling seven days.
	Psychosocial Rehabilitation Services (PRS) • Group	U6 U7 U8 U9 UA	Licensed Psychologist Master's level Bachelor's level RN Less than bachelor's Degree (TFC providers only)		
H2014	Behavior Modification (BMOD)	AF HP AM SA AH HO TD HN HM TE	Psychiatrist Other Physician (*MD/DO)* PA APRN Licensed Psychologist Master's level RN Bachelor's level Less than bachelor's degree LPN	YES	15 minutes = one unit. 32 units per day per member per rolling seven days.
S9482	Family Support (FS)	AF HP AM SA AH HO TD HN HM TE	Psychiatrist Other Physician *(MD/DO)* PA APRN Licensed Psychologist Master's level RN Bachelor's level Less than bachelor's degree LPN	YES	15 minutes = one unit. 32 units per day per member per rolling seven days.
H2037	Therapeutic Childcare (TCC)	 U1 U2 U3 U4	<u>Individual</u>: Licensed Psychologist Master's level Bachelor's level RN	YES	15 minutes = one unit. 24 units per day per member.

		U6 U7 U8 U9	Group: Licensed Psychologist Master's Level Bachelor's Level Register Nurse		*Individual and group TCC may be provided same day, but cannot be billed concurrently*
S5145	Therapeutic Foster Care (TFC)	00 TF TG	TFC Level 1 TFC level 2 TFC level 3	YES	Encounter = one unit. One unit = one per diem. One unit per day per member, not to exceed 31 units per calendar month. *Cannot be billed concurrently with PRS for duration of stay in TFC.*
H2030	Community Integration Services (CIS)	U6 U7 U8 U9	Licensed Psychologist Master's Level Bachelor's Level Register Nurse	YES	15 minutes = one unit. 24 units per day per member.
H0038	Peer Support Services (PSS)	00 HQ GT	Individual – (*No Mod.)* Group Via interactive video/audio Telecommunication *(Individual only)*	*YES**	No initial PA required. **After 216 units, requires authorization for continued care from private providers.* Not to exceed 16 units per day per member.
Crisis Management Services					
H2011	Crisis Intervention (CI)	AF HP AM SA AH HO TD HN GT	Psychiatrist Other Physician *(MD/DO)* PA APRN Licensed Psychologist Master's level RN Bachelor's level Via interactive video/audio Telecommunication*	NO	15 minutes = one unit. Not to exceed 16 units per day per member; 80 units per rolling 12 months. **When submitting claims for telephonic CI only, do not use GT modifier.*
Evidence-Based Practices					
H0040	Assertive Community Treatment (ACT)	U1 U3	Small Teams (up to 50 served) Large Teams (51-129 served)	YES	Encounter = one unit. one unit = one per diem.

					Not to exceed 15 units of ACT per member, per month.
H2033	Multisystemic Therapy (MST)		Must be provided by a licensed MST team in good standing as verified through MST Services, Inc.	*YES**	No initial PA required; **Authorization for continued services after 48 units.* Encounter = one per diem. One per diem per member per date of service; not to exceed 48 per diems per member over rolling 120 days.
H2022	Intensive In-Home Services—Homebuilders (IIHS—HB)	U4	Must be provided by a certified team in good standing as verified through IFD.	*YES**	No initial PA required; **Authorization for continued services required after 20 units.* Encounter = One unit; One unit = one per diem. One unit per member per date of service; not to exceed 20 per diems over a period of no more than 6 week.

SUBSTANCE USE SERVICES (FOR OSUS-AFFILIATED PROVIDERS ONLY)

SCDHHS and BHDD-OSUS have implemented a statewide system to coordinate SUD services that are critical to serving eligible Medicaid members. SUD services are rendered by county (or multi-county) substance use authorities via an outpatient services system that may include general therapeutic and/or medically oriented care as well as intensive community-based services and residential treatment programs.

SCDHHS has adopted the American Society of Addiction Medicine's (ASAM) criteria for the treatment of substance-related disorders as the basis for the member's placement in the appropriate levels of care. This manual specifies the policies that SCDHHS requires providers to meet, in addition to the ASAM criteria.

Members must have a diagnosis of an SUD or co-occurring substance use and mental health disorders from the most recent DSM or ICD manuals and meet medical necessity requirements before being placed in an SUD outpatient or residential treatment program. Services must be authorized by a physician or other LPHA.

Outpatient and residential services may require a physical examination to be completed within a specified time frame by a qualified health care professional.

Coordination of care must occur when a member is being served by multiple agencies and/or providers. During the intake process, each provider is responsible for identifying whether a member is already receiving treatment from another Medicaid provider. Other Medicaid providers involved in the treatment of the member must be notified of the member's need for SUD services. Medically necessary services must never be denied to a member because another provider has been identified as the service provider; rather, providers shall make every effort to coordinate care and determine who is the primary provider for billing purposes when services are delivered concomitantly. Each provider shall notify other involved agencies or providers immediately if a member in an overlapping treatment situation discontinues their services.

Provider organizations must ensure that staff responsible for the provision of services meet the appropriate licensing, credentialing, certification, or privileging standards required for each service or level of care.

OSUS-affiliated providers may render specific services listed in the Screening and Assessment, Service Plan Development, Core Treatment, Community Support Services, and Crisis Management sections as defined for RBHS providers, in addition to specific substance use services**.** To be reimbursed for these services, OSUS-affiliated providers must follow the guidelines as specified in this section of the manual.

Some services rendered by OSUS-affiliated providers are allowable via telehealth. When rendered by LPHAs, associate-level licensed counselors, LMSWs, and certified or licensed addiction counselors or peer support providers, the following services are available via telehealth:

- Substance Use Screening and Brief Intervention
- Substance Use Assessment
- Substance Use Counseling (Individual)
- Service Plan Development
- Peer Support Services (Individual only)
- Psychotherapy (Individual and Family)

Further guidance on telehealth can be found in Section 4 of this manual.

Substance Use-Specific Services are arranged into the following six categories:

1. Screening and Assessment Services
2. Service Plan Development of the Individual Plan of Care
3. Medical Services
4. Psychotherapy and Community Support Services
5. Crisis Management Services
6. Intensive Community-Based and Residential Treatment Services

Note: For those services provided by both RBHS providers and Substance Use Services providers (i.e., CALOCUS-CASSI, Psychological Testing and Evaluation/Test Scoring and Administration Services, Psychiatric Medical Assessment, Service Plan Development, Individual, Family, and Group Psychotherapy, select Community Support Services, and Crisis Management Services), please refer to the set of service definitions previously defined in this Section of the manual. Pertinent procedural information specific to SUD providers is listed in this section.

SERVICE-SPECIFIC GUIDANCE FOR SUBSTANCE USE SERVICES

Place of Service. Unless otherwise stipulated, the only excluded settings for rendering outpatient substance use services are acute care hospitals. Services can be rendered in substance use treatment facilities, community mental health centers, outpatient clinics, or other settings that are convenient for both the member and the professional that affords an adequate therapeutic environment and protects the member's rights to privacy and confidentiality. Additional guidance relevant to specific services may be found after each service definition.

1. Screening and Assessment Services

Behavioral Health Screening (BHS)

The purpose of this service is to aid in early identification of mental health concerns for further targeted assessment and treatment. BHS is a "wide net" process, designed to identify behavioral health issues and/or the risk of developing behavioral health issues for further exploration. Clinical areas to consider in a regimen of regular screening include trauma, suicide risk, depression, and anxiety.

Screenings are conducted using a standardized tool, through interviews or self-report. Some common screening measures include (but are not limited to):

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage Protocol (SAFE-T)
- Strengths and Difficulties Questionnaire (SDQ)
- Child and Adolescent Trauma Screen (CATS)
- Trauma Symptom Screening (TSQ)
- Children's Depression Inventory-2 (CDI-2)
- Patient Health Questionnaire-9 (PHQ-9)
- Screen for Child Anxiety Related Emotional Disorders (SCARED)
- Generalized Anxiety Disorder-7 (GAD-7)
- Pittsburgh Sleep Quality Index

Service-Specific Guidance for Behavioral Health Screening

BHS is billed as an encounter and is based on an average of 30 minutes of screening.

Special Restrictions Related to Other Services

BHS shall not be billed on the same date of service as Substance Use Screening and Brief Intervention, the Diagnostic Assessment, and/or the CALOCUS-CASII.

Substance Use Screening and Brief Intervention (SUS)

The purpose of this service is to facilitate early identification of SUDs or co-occurring substance use/mental health disorders and to facilitate appropriate referrals for focused substance use assessment and treatment.

SUS requires completion of a brief questionnaire (such as the DAST [Drug Abuse Screening Test]) to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized tool through interviews or self-report. Some of the common tools used for substance use screening are (but are not limited to):

- Screening to Brief Intervention (S2BI)
- Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
- Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)
- Opioid Risk Tool – OUD (ORT-OUD) Chart
- Drug Abuse Screening Test (DAST-10)
- Drug Abuse Screening Test (DAST-20: Adolescent version)
- Brief Addiction Monitor (BAM)
- Visual Analog Scale (VAS)
- Treatment Effectiveness Assessment (TEA)

Screeners shall be scored utilizing the tool’s scoring methodology. Outcomes of the screening, clinical interventions, and referrals must be documented in the clinical service note based on the interpretation of the results.

Screenings shall focus on patterns of behavioral health and/or SUD and associated factors such as legal problems, mental health status, educational functioning, and living situation. The member's awareness of the problem, feelings about his or her mental illness and/or SUD, and motivation for changing behaviors may also be integral parts of the screening.

Prior to conducting 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 shall be made to access the record. A screening may be repeated as clinically appropriate or if a significant change in behavior or functioning has been noted.

Service-Specific Guidance for Screening and Assessment Services

BHS and SUS are both billed as encounters. Each service allows for twelve encounters per member, per year; only one encounter code is allowed per day.

Special Restrictions in Relationship to Other Services

BHS and SUS cannot be provided on the same date of service; likewise, neither BHS nor SUS can be provided on the same date of service as the Substance Use Diagnostic Assessment. Questionnaires used for general monitoring (such as checking mental status) within the context of ongoing services cannot be billed independently as BHS or SUS.

Substance Use Diagnostic Assessment (SUDA)

The purpose of this biopsychosocial assessment is to determine the need for rehabilitative services by confirming medical necessity, to establish and/or confirm a diagnosis, and to provide the basis for the development of an effective course of treatment. The initial assessment process may include, but is not limited to, psychological assessment/testing to determine accurate diagnoses or to determine differential diagnoses.

Initial assessments must be conducted face-to-face with the member and include an evaluation of the member for the presence of a behavioral health disorder or SUD. The information obtained during the assessment must lead to a diagnosis that identifies the member's current symptoms or disorder by using the current edition of the DSM or ICD.

Diagnoses shall be updated, as necessary, as the condition of the member changes. Information relating to a diagnosis that has not been reviewed in the previous 12 months or longer must be confirmed immediately.

The assessment is used to determine the member's mental status, functioning level, and to identify any physical or medical conditions. It shall include clinical interviews with the member, family members, or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, needs, medical and educational records, and behavioral health history, including past psychological evaluations, hospitalizations, out-of-home placements, and collateral records review.

Once the assessment has been completed and services are deemed to be medically necessary, the development of the IPOC begins, using the information gathered in the initial assessment including recommended treatments and interventions.

The assessment services identify the member's needs, concerns, strengths, and deficits and allow the member and his or her family/significant others to make informed decisions about the treatment. Patient condition, characteristics, or situational factors may require services with interactive complexity. The assessment must gather information that establishes or supports a diagnosis, provides the basis for the development or modification of the treatment plan, and development of discharge criteria.

Follow-up Substance Use Diagnostic Assessment
A follow-up assessment occurs after an initial assessment to re-evaluate the status of the member, identify any changes in behavior and/or condition, and to monitor and ensure appropriateness of the treatment. Follow-up assessments may also be rendered to assess the member's progress, response to treatment, and the need for continued treatment, and to establish ongoing medical necessity.

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

Service-Specific Guidance for Substance Use Diagnostic Assessment and Follow-Up SUDA

The initial and follow-up assessments are billed as encounters. A session must last a minimum of 60 minutes.

One encounter is allowed every six months, and coordination of care must occur between providers. Services must be documented on the CSN with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Special Restrictions in Relationship to Other Services

A Medical Assessment provided by a physician (or physician extender) cannot be billed on the same date of service as the SUDA. Efforts should be made to determine whether another diagnostic assessment has been conducted in the last 90 days; if the documentation of the assessment is available, then the member information shall be updated as needed. A follow-up assessment shall be billed in such cases.

Substance Use Nursing Assessment Services (SUN)
SUN is a face-to-face interaction between a qualified nursing professional and the member.

SUN may be rendered to members as a discrete service but is also included in the bundled service packages rendered at more intensive levels of care unless otherwise specified.

Components of the service include, but are not limited to:

- Medical assessment(s) of the member.
- Assessing and/or monitoring the member's physical status.
- Assessing and/or monitoring the member's response to treatment.
- Providing Medication Management.
- Assessing the need for referrals to other health care systems.
- Monitoring the member's mental status.
- Verifying the member's medications (oral and injectable).
- Assessing for and identifying the need for the member to see the Physician.
- Monitoring for overt side effects related to prescribed medications.
- Monitoring for psychological effects of prescribed medications.
- Monitoring for interactions of psychiatric medications, prescribed medications, and other substances.

Service-Specific Guidance for Substance Use Assessment Nursing Services

When billed as a discrete service, SUN services are billed in 15-minute units.

Special Restrictions in Relationship to Other Services

Nursing services may be billed on the same day when providing other discrete services, IOP, or day treatment/partial hospitalization services.

2. Service Plan Development of the IPOC

Providers are referred to the RBHS Service Definition section for required information on SPD.

3. Medical Services

Evaluation and Management (E&M)

The purpose of these services is to facilitate medical decisions for treatment and/or referral for additional needed services. E&M is delivered face-to-face, which includes performing an examination to obtain the member's medical history, including current and past use of medications.

Physical Examination

A physical examination is a component of the initial interaction between the qualified medical health care professional and the member. The professional must assess the member's status and provide diagnostic evaluation and screening. The physical examination is one component included in the evaluation of the member to facilitate making necessary treatment decisions and referrals required for comprehensive rehabilitative substance use services.

The physical examination may include a tuberculosis test as deemed necessary by the health care professional.

The examination may also be used to determine the following:

- Medical necessity for initiating more intensive SUD rehabilitative services.
- The need for additional specialized medical assessment.
- The need for referral to other health care providers for identified comorbidities.

Physical examinations must include the following:

- A brief medical history of the member to include prior hospital admissions and surgeries; allergies; present medication information (including history of shared needles), current and past sexual activity (including high risk sexual behaviors) and sexual orientation, and history of hepatitis, cirrhosis, other liver diseases, or other medical issues related to substance use.
- Member and family history of substance use.
- An assessment of the member's nutritional status.
- The assessment of vital signs; inspection of the ears, nose, mouth, teeth, and gums; inspection of the skin for recent or old needle marks and/or tracking; and abscesses or scarring from healed abscesses.
- A general assessment of the member's cardiovascular system, respiratory system, gastrointestinal system, and neurological status.
- A screening for anemia (a hematocrit or hemoglobin test is encouraged when accessible).

Evaluation of New Patients

A new patient is one who has not received any professional services from the qualified health care professional (or another qualified health care professional of the exact same specialty and sub-specialty who belongs to the same group practice) within the past three years.

The evaluation of a new patient requires the following three components:

- A detailed history
- A detailed examination
- Medical decision making

Counseling and/or coordination of care with other Physicians, other qualified health care professionals, or agencies consistent with the nature of the presenting problems are included and involve participation and engagement with the member and/or their family/support system.

The encounter must last ***at least 30 minutes***.

Evaluation of Established Patients

An established patient is one who has received professional services from a qualified health care professional (or another qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice) within the past three years.

The evaluation of an established patient requires two of the three key components below:

- An expanded problem-focused history.
- An expanded problem-focused examination.
- Medical decision making of low complexity.

Coordination of care, as noted above for new patients, is also included.

The encounter must last ***at least 20 minutes***.

Service-Specific Guidance for Evaluation and Management of Medical Services (E&M)

Services are billed as encounters; only one encounter is allowed per day. Evaluation of new patients must last a minimum of 30 minutes and evaluation of established patients a minimum of 20 minutes.

Special Restrictions in Relationship to Other Services

New patient and established patient services are allowed once per day, per service.

When a member receives an E&M service on the same day as a psychotherapy service* by the same medical professional, providers must document both the E&M and psychotherapy codes. The difference in the services must be significant and documented separately on the CSN.

Only one E&M encounter is allowed per day when individual psychotherapy services are also rendered. A nurse is responsible for assisting in monitoring the member's medical treatment and medication administration.

**When an E&M service is provided on the same day as an individual psychotherapy service rendered by a different provider, that provider must bill 90833 or 90836 as appropriate.*

Medication Administration (MA)

The purpose of this service is to allow a heath care professional to administer an injection to the member. The medical record must substantiate the medical necessity for this treatment and is rendered in response to a Physician, PA, or APRN order.

The order must be documented on a Physician Medication Order (PMO; in residential or inpatient settings) or a prescription (in outpatient settings). The qualified health care professional must ensure the form is properly completed and included in the medical record for the initial and any subsequent contacts with the member.

Service-Specific Guidance for Medication Administration

MA is billed as an encounter and must be billed in combination with the injection code.

Special Restrictions in Relationship to Other Services

MA must be billed in combination with the Vivitrol® injection procedure code.

Vivitrol® Injection (VI)

VI, often used for certain SUDs such as alcohol or opioid use disorders, may be part of a member's comprehensive treatment plan to restore, maintain, or improve a member's functioning related to their substance use.

The qualified health care professional must ensure the injection medication order is properly completed and included in the medical record to confirm the initial and any subsequent administration to the member.

Service-Specific Guidance for Vivitrol Injection

The injectable procedure code is billed as an encounter and is rendered only one time a month to the member.

Special Restrictions in Relationship to Other Services

A qualified healthcare professional must provide a prescription for the injection. The MA code is billed in conjunction with the injection code. Both services are documented on the same CSN but must be billed separately.

4. Psychotherapy and Community Support Services

Substance Use Counseling – Individual (SUC)

The purpose of this intervention is to assist and support members in their recovery from substance use disorders. SUC is focused on exploring and identifying the consequences of continued substance use, identifying triggers for substance use, and developing alternative coping strategies.

This service provides reinforcement of the member's ability to adaptively function within society without having to rely on addictive substances. SUC addresses goals and objectives identified in the plan of care that involves the member learning and strengthening basic coping strategies, understanding related psychological problems that trigger addictive behavior, and encouraging the member to recognize opportunities to change their behavior, and identify ways to achieve their goals.

SUC requires face-to-face and goal-oriented interactions between a member and a clinical professional. The interactions provide the member with the skills and supports needed to reduce the use of substances, obtain and sustain abstinence, and successfully manage their illness. This service supports the member in achieving and maintaining improved ability to function in his or her activities of daily living.

SUC serves to educate members about substance use and cultivate the skills needed to attain and sustain progress on identified goals, which could include tasks such as identifying new ways to manage anger, despair, loneliness, or other intense feelings, as well as to cope with the urge to use substances by altering thoughts and actions that lead to substance use.

Interventions must focus on helping the member develop the motivation to change substance-using behaviors and pursue life goals. Interventions shall also focus on improving communication and conflict resolution skills and developing healthy interpersonal boundaries.

SUC allows the clinical professional to listen to, interpret, and respond to the member's expression of physical, emotional, and/or cognitive distress and to help them develop the skills and supports needed to live a satisfying life without substance use. It explores issues coexisting with and contributing to substance use such as delinquent or maladaptive behavior and/or other behavioral health concerns (i.e., trauma, depression, anger, anxiety, interpersonal conflicts, poor sense of self).

A qualified clinical professional may meet with the member and one or more family members to identify and address substance use issues in a family setting. SUC-I should actively involve members of the member's immediate family, extended family, or significant others as determined appropriate.

Service-Specific Guidance for Substance Use Counseling (SUC) - Individual

Individual counseling is billed as a 15-minute unit.

Special Restrictions in Relationship to Other Services

There are no special restrictions around this service.

Substance Use Counseling – Group (SUG)

Groups serve as a forum to share and discuss information about managing daily life activities without using illicit substances while addressing issues that contribute to addiction, interfere with recovery, or contribute to relapse. This occurs within the context of processing such issues with other individuals who share similar life experiences, thus increasing the insight and understanding of one's own substance use disorder.

SUG allows the clinical professional to meet the needs of several members at the same time and mobilize this group support between members.

Service-Specific Guidance For SUG

Group counseling is billed as an encounter. A group session must last a minimum of 60 minutes. Only one encounter can be billed per day.

SUG requires at least one professional for each group of up to 16 members. Members in excess of the allowed ratio should not be present during service delivery. The ratio count applies to all members receiving services from a provider, regardless of whether or not the member is Medicaid-eligible.

Special Restrictions in Relationship to Other Services

There are no special restrictions around this service.

Skills Training (ST) and Development Services for Children

The purpose of this service is to provide ST and Development Services to Medicaid-eligible children 0 to 6 years of age with parents/caregivers who use substances. The service is intended to target those children with deficits in their development or to restore previous levels of functioning where the developmental trajectory has been impaired due to parental/caregiver SUD or co-occurring behavioral health disorders.

This face-to-face service provides activities that will restore or enhance prosocial, adaptive behaviors and improve the child's ability to function in his or her living, learning and social environments. ST and Development Services are a form of skills-building support. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the member's ability to learn and utilize needed life skills.

This service is not a form of psychotherapy or counseling.

ST and Development Services are a means to affect behavioral changes to reduce the risk of or ameliorate impaired functioning in school, family, and social environments. Services involve regularly scheduled interventions designed to optimize emotional and behavioral functioning in the natural environment through the application of clinically planned activities that promote the development of healthy coping skills, adaptive interactions with others, and appropriate responses to environmental stimuli. Goals include those that assist the member in attaining the level appropriate for their developmental trajectory by restoring or building new skills and adaptive behaviors appropriate for age and normative development.

Through interaction with appropriately trained and qualified staff, activities will focus on skill deficits and provide the member the opportunity to alter existing behaviors, acquire new behaviors, and function more effectively within his or her environment.

This service includes needs identified during the assessment and must be medically necessary to achieve the goals in the plan of care.

ST and Development Services include the following interventions:

- Skill-building activities designed to promote age-appropriate, adaptive developmental behavior and to improve the member's functioning within the home, educational, or social environments.
- Basic living skills designed to help the member learn and practice daily healthy living habits and age-appropriate self-care skills.
- Interpersonal ST designed for age-appropriate and normative development of the member to improve communication, problem-solving, and self-management.
- Successful delivery of ST and Development Services should result in the display of age-appropriate, desirable, prosocial behavior that has yet to be attained or was infrequently exhibited.

ST includes services provided in a small group based on the assessed needs and level of functioning of the member.

Service-Specific Guidance for Skills Training and Development Services

ST and Development is billed in a 15-minute unit.

Special Restrictions in Relationship to Other Services

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

5. Crisis Management Services

Providers are referred to the RBHS Service Definition section for required information on crisis management services.

6. Intensive Community-based and Residential Treatment Services

Service-specific billing guidance may be found at the end of this section.

All providers rendering this level of care must meet appropriate federal and state licensure as well as all requirements outlined in the SCDHHS Provider Enrollment Policy and this manual.
Providers with a facility that renders services 24 hours per day, seven days per week, are limited to 16 or fewer beds in order to receive Medicaid reimbursement (Federal law prohibits Medicaid payment to Institutions of Mental Disease as described in the Code of Federal Regulations, 42 CFR 435.1009-1011).

The purpose of this array of services is to provide intervention for the treatment and management of SUDs or co-occurring substance use and mental health disorders in an intensive treatment setting.

Services must have a rehabilitative and recovery focus designed to promote skills for coping with and managing behavioral health and/or substance use symptoms and behaviors. Services must address the member's lifestyle and environmental/behavioral issues that have the potential to undermine their participation and successful completion of treatment.

Intensive treatment services assist the member with managing withdrawal from substance use and achieving and maintaining abstinence, effectively responding to or avoiding identified precursors or triggers that would place the member at risk of returning to use in their natural environment.

Such treatment programs must include:

- Supportive counseling
- Focused therapeutic intervention
- Emotional and behavioral management
- Problem solving and social/interpersonal skills building
- Psychotherapy services, psychosocial rehabilitation, and family support
- Medication management
- Independent living skills and activities of daily living to improve the member's functional stability and adaptation to living free of substance use

The member must be assessed to confirm medical necessity for these levels of care; the member must also meet diagnostic criteria for an SUD or co-occurring disorders as defined by the current edition of the DSM or ICD. The provider shall refer to the ASAM criteria as the basis for recommended level of care.

Intensive Outpatient Treatment and Day Treatment/Partial Hospitalization for Substance Use includes the above array of interventions delivered in an outpatient setting and must be consistent with the member's individualized treatment needs. Services are delivered in individual and/or group formats. Biomedical conditions and complications are manageable at this level of care without requiring more intensive medical intervention/monitoring.

Residential Substance Use Treatment Services are designed to promote and enhance coping skills through managing substance use symptoms and the emotional/behavioral sequelae of the illness in a residential setting. Services include physician monitoring, nursing care, individual and/or group interventions (as the member is able to participate), and observation, as needed, based on clinical judgment and individualized need.

Note: Member's physical ability to participate in initial residential group activities may be limited, based on withdrawal or other medical symptoms, but must be offered, encouraged, and documented if there are deviations from the established plan of care.

Medicaid reimbursement rates for the services in this category are formulated in one of two ways, as follows:

All-inclusive hourly rate	Intensive Outpatient Treatment Program: Level 2.1
	Day Treatment/Partial Hospitalization: Level 2.5
Bundled per diem rate	Sub-Acute Withdrawal Management — Clinically Managed Residential Withdrawal Management: Level 3.2WD
	Acute Withdrawal Management — Medically Monitored Inpatient Withdrawal Management Services: Level 3.7WD
	Clinically Managed High-Intensity Residential Treatment: Level 3.5
	Medically Monitored Intensive Inpatient Treatment: Level 3.7 (Adults or Adolescents)

Medicaid will not reimburse for the following:

- Room and board services, including custodial care
- Educational, vocational, and job training services
- Habilitation services
- Services to inmates in public institutions as defined in 42 CFR §435.1010
- Services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010
- Recreational and social activities
- Services that must be covered in other settings as outlined in the Medicaid State Plan

Substance Use — Intensive Outpatient Treatment Program (IOP):
Level 2.1
IOP services are for members in need of a higher level of care than that of basic outpatient treatment services, and when appropriate, may be an alternative to residential treatment. This level of care takes into consideration the member's cognitive and emotional experiences that have contributed to substance use, which may be a distraction from recovery and requires monitoring. IOP allows the member opportunities to practice new coping skills and strategies learned in

treatment while in their natural environment yet while also remaining supported by the intensive treatment program.

IOP is comprised of the following services which are included in the bundled hourly rate:

- IP, FP, GP, SUC (group and individual), PSS, PRS, FS, and MM.

The following services may be billed as discrete services for members concurrently receiving IOP:

- BHS, Psychiatric Medical Assessment, PTE/PTA, SUDA, SUN, SUS, SPD, E&M, CI, VI, and MA.

Determining Length of Stay/Continued Stay

Based on the member's age and plan of care, IOP generally includes the following weekly programming options:

Age of Population	Hours per week
Adolescents up to age 18	Minimum of six hours*
Adults	Minimum of nine hours*
**Maximum of 19 hours per week for both adolescents and adults*	

Depending on the make-up of the treatment milieu, it may be more clinically appropriate for a member beyond age 18 to be admitted to (or remain in) an adolescent program (or, for a 17-year-old to be admitted to an adult program). This is allowable as necessary; documentation must justify the clinical decision-making.

The duration of treatment varies with the severity of the member's illness and response to treatment. The amount, frequency, and intensity of the services must reflect the needs of the member and must address the goals and objectives of the member's plan of care.

If services at this level have been insufficient to address the member's needs and the member meets the ASAM criteria for a higher level of care, the maximum number of IOP weekly hours can be exceeded (if authorized as per UM requirements in section 7) during the transfer to the higher level of care.

Substance Use — Day Treatment/Partial Hospitalization (PHP):

Level 2.5

Partial Hospitalization Programs are structured and medically supervised intensive treatment options with frequent monitoring/management of the member's medical and emotional needs and serve to divert from hospitalization as appropriate. PHP utilizes psychiatric, medical, and laboratory services. Intensive services at this level of care provide the highest level of clinical support in the community setting.

Like IOP, PHP allows the member opportunities to practice new coping skills and strategies learned in treatment in their natural environment while being supported by the intensive treatment provided.

The following services are included in the bundled hourly rate:

- IP, FP, GP, SUC (group and individual), PSS, PRS, FS, and MM

The following may be billed as discrete services for members also receiving PHP:

- BHS, Psychiatric Medical Assessment, PTE/PTA, SUDA, SUN, SUS, SPD, E&M, CI, VI, and MA

Determining Length of Stay/Continued Stay

Day Treatment/Partial Hospitalization generally provides ***a minimum of 20 hours of programming per week*** (for both adolescents and adults) based on the IPOC. The duration of treatment varies with the severity of the member's illness and response to treatment.

Discharge/Transition Criteria from IOP and PHP

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

- The member's level of functioning has significantly improved.
- The member has achieved the goals as outlined in the IPOC or reached maximum benefit.
- The member has developed the skills and resources needed to transition to a lower level of care.
- The member requests discharge from treatment and is not at imminent risk of danger to self or others.
  or
- The member has made limited or no progress with respect to the goals outlined in the IPOC.
- The member requires a higher level of care (i.e., inpatient hospitalization, PRTF, IOP to PHP, etc.).
- The member displays the inability to actively participate in the program or is no longer working or participating toward their goals.

The member must be re-evaluated for remaining service needs before discharge from any particular level of care.

Sub-Acute Withdrawal Management — Clinically Managed Residential Withdrawal Management:

Level 3.2WM

Clinically Managed Residential Withdrawal Management is a service directed by nonphysician addiction specialists rather than medical personnel. This level of care is appropriate for those who do not require the full resources of a medically monitored inpatient withdrawal management program. It relies on established clinical protocols and services delivered by staff which provide 24-hour supervision, observation, and support for members who are intoxicated or experiencing withdrawal and includes staff supervision of self-administered medications for the management of substance use or alcohol withdrawal.

The following services are included in the bundled daily rate:

- SUN, IP, FP, GP, SUC, PSS, PRS, FS, and MM, and also includes:

- 24-hour observation, monitoring, and treatment
- Emergency medical services available, as needed
- Laboratory screening, as needed
- Medication ordered by a qualified health care professional
- Physical examination within 48 hours after admission for members in 24-hour facilities (Exception: If a client is admitted after 5:00 pm on Friday, a 24-hour facility has until close-of business the next workday to obtain the admission physical examination.)
- Referral to Medically Monitored Inpatient Withdrawal Management when clinically appropriate.

The following may be billed as discrete services for members also receiving Clinically Managed Residential Withdrawal Management:

- BHS, Psychiatric Medical Assessment, PTE/PTA, SUDA, SUS, SPD, E&M, CI, VI, and MA

Determining Length of Stay/Continued Stay

For members whose level of intoxication and/or withdrawal is sufficient to warrant 24-hour support, treatment will typically last 3–5 days. The duration of treatment varies with the severity of the member's illness and response to treatment.

The following guidelines are used to determine length of stay:

- The member's withdrawal signs and symptoms are sufficiently resolved, and symptoms can be safely managed at a less intensive level of care.
- The member's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification is indicated.
- The transfer to a more intensive level of care or the addition of other clinical services are required when the following occurs:
- The Member is unable to complete withdrawal management at this level of care despite an adequate trial.
- Symptoms complicating substance use withdrawal indicate the need to transfer the member to another level of care.

Acute Withdrawal Management — Medically Monitored Inpatient Withdrawal Management: Level 3.7WM

Medically Monitored Inpatient Withdrawal Management provides 24-hour supervision, observation, and support in a medical setting for members who are intoxicated or experiencing withdrawal.

At this level of care, physicians are available 24 hours per day to assess the member, provide onsite monitoring of the member's condition, and provide any additional care necessary for medical stabilization. A physical examination must be provided as soon as possible but no later than 24 hours after admission.

Primary emphasis is placed on ensuring that the member is medically stable (including the initiation and tapering of medications used in the treatment of substance use withdrawal), assessing for

adequate biopsychosocial stability, immediate intervention to establish biopsychosocial stability, and facilitating effective linkage to other appropriate residential and outpatient services.

An RN or other qualified nursing specialist must be present to administer a nursing admission history. A nurse is responsible for overseeing the monitoring of the member's progress and managing the member's medications on an hourly basis, as needed.

The following services are included in the bundled daily rate:

- SUN, IP, FP, GP, SUC, PSS, PRS, FS, and MM, and also includes:
  - 24-hour medical observation, monitoring, and treatment
  - Emergency medical services available, as needed
  - Laboratory screening, as needed
  - Medication order by a qualified health care professional
  - Physical examination as soon as possible but no later than 24-hours after admission

The following may be billed as discrete services for members also receiving Medically Managed Inpatient Withdrawal Management:

- BHS, Psychiatric Medical Assessment, PTE/PTA, SUDA, SUS, SPD, E&M, CI, VI, and MA

Determining Length of Stay/Continued Stay for Acute Withdrawal Management—Medically Monitored

Treatment typically lasts 3–5 days, and duration of treatment varies with the severity of the member's illness and response to treatment. The five days may be exceeded when the member continues to meet medical necessity; transfer to another level of care shall be pursued when services provided at this level have been insufficient to address the member's needs and the member meets the ASAM criteria for another level of care. The following guidelines are used to determine length of stay:

- The member's withdrawal signs and symptoms are sufficiently resolved to be safely managed in a less intensive level of care.
- The member's withdrawal signs and symptoms have failed to respond to treatment and have intensified, requiring a more intensive level of care.

Clinically Managed High-Intensity Residential Treatment:

Level 3.5

Clinically Managed High-Intensity Residential Treatment is designed to serve individuals who, because of specific functional limitations, need safe and stable living environments in order to develop and demonstrate sufficient recovery skills so that they do not immediately return to substance use upon transfer to a less intensive level of care. Treatment promotes abstinence from substances and antisocial/maladaptive behavior and seeks to effect an overall change in the lifestyle, attitudes, and values of persons who have significant social and psychological problems. Oftentimes these members are identified to have significant functional deficits in their emotional, behavioral, and cognitive conditions (Dimension 3) and their living environments (Dimension 6).

This service provides comprehensive, multi-faceted treatment in a residential setting to members who have multiple or complex needs, including significant behavioral health problems (such as serious mental illness).

The following services are included in the bundled daily rate:

- SUN, IP, FP, GP, SUC, PSS, PRS, FS, and MM, and also includes:
  - 24-hour medical observation, monitoring, and treatment.
  - Emergency medical services available, as needed.
  - Laboratory screening, as needed.
  - Medication order by a qualified health care professional.
  - Physical examination within 24-hours after admission.
  - The provision of priority admission for pregnant women, as needed.

The following may be billed as discrete services for members also receiving Clinically Managed High-Intensity Residential Treatment:

- BHS, Psychiatric Medical Assessment, PTE/PTA, SUDA, SUS, SPD, E&M, CI, VI, and MA

The treatment program must provide at least six hours of therapeutic programming and clinical services Monday through Friday, and at least five hours of therapeutic programming and clinical services on Saturday and Sunday.

Determining Length of Stay/Continued Stay for Clinically Managed High-Intensity Residential Treatment

Admission and continued stay at Level III.5-R is based on the severity of the member's illness and their response to treatment. *With an average length of stay of three months, treatment at this level generally tends to be longer than more medically acute levels of care, where focus is on short-term medical stabilization.*

Transfer to a higher level of care is warranted when services are insufficient to address the member's needs and changes in their presentation indicate he or she meets the criteria for a higher level of care.

Discharge or transition to a lower level of care must be considered when the member no longer demonstrates the need for this level of supervision and oversight in order to maintain stability and could be managed in and benefit from a less intensive setting.

Medically Monitored Intensive Inpatient Treatment:

Level 3.7 (Adults or Adolescents)

Medically Monitored Intensive Inpatient Treatment, Level 3.7, provides a structured and planned array of professionally directed services based on individual need. This level of care is appropriate for members who do not need the full resources of an acute care general hospital but whose sub-acute biomedical and emotional, behavioral, or cognitive problems are so severe that residential care with medical oversight is required.

Those appropriate for this service have functional deficits impacting their ability to manage intoxication/withdrawal, bio-medical symptoms and/or complications, and/or complex emotional, behavioral, or cognitive conditions that interfere with or distract from their recovery efforts.

Medically Monitored Intensive Inpatient Treatment services may include the following:

- Activities designed to develop and apply recovery skills and promote development of a social network supportive of recovery.
- Interventions to enhance the member's understanding of addictions.
- Skills building to promote successful engagement in regular, productive, daily activity.
- Therapies that increase personal responsibility and developmental maturity.
- Skills building necessary to facilitate successful reintegration into community living.

The following services are included in the bundled daily rate:

- SUN, IP, FP, GP, SUC, PSS, PRS, FS, and MM, and also includes:
  - 24-hour medical observation, monitoring, and treatment.
  - Emergency medical services available, as needed.
  - Laboratory screening, as needed.
  - Medication order by a qualified health care professional.
  - Physical examination within 24 hours after admission and face-to-face evaluations at least once a week.
  - An RN responsible for oversight of the monitoring of the member's progress and managing their medications.

The following may be billed as discrete services for members also receiving Medically Monitored Intensive Residential Treatment:

- BHS, Psychiatric Medical Assessment, PTE/PTA, SUDA, SUS, SPD, E&M, CI, VI, and MA.

The treatment program must provide at least six hours of clinical services Monday through Friday, and five hours of clinical services on Saturday and Sunday.

Determining Length of Stay/Continued Stay

The duration of treatment varies with the severity of the member's illness and their response to treatment. The average length of stay is 30 days or less for adults and up to 6 months for children and adolescents.

Members must be discharged by the physician (or the physician must review the discharge) from Level 3.7 before the member is transferred to a less intensive level of care within the same treatment system.

Discharge/Transition Criteria from Residential Services

Discharge or transition to another level of care is considered when any of the following criteria are met:

- The member's level of functioning has significantly improved.

- The member has achieved the goals as outlined in the IPOC or reached maximum benefit.
- The member has developed the skills and resources needed to transition to a lower level of care.

or

- The member has made limited or no progress with respect to the goals outlined in the IPOC.
- The member requests to be discharged from treatment and is not imminently dangerous to self or others.
- The member requires a higher level of care (i.e., inpatient hospitalization/PRTF).
- The member displays the inability to actively participate in the program or no longer is working or participating toward their goals.

The member must be re-evaluated for ongoing service needs and necessary follow-up/aftercare prior to discharge from each level of care.

Service-Specific Guidance for Intensive Community-Based and Residential Treatment Services

Billable place of service for all residential services is a substance use facility with 16 beds or less.

Billable place of service for intensive community-based services is an outpatient substance use provider setting appropriate for service delivery.

Special Restrictions in Relationship to Other Services

All Intensive Community-Based and Residential Treatment Services must be authorized prior to service delivery except for the following independently billable services when rendered in residential levels of care:

- DA, SUDA, SUS, SUN, SPD, Crisis Intervention, and E&M Services.

Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
Screening and Assessment Services					
Screening and Assessment Services are not included in bundled rate packages.					
H0002	Behavioral Health Screening (BHS)	AF AM SA AH HO HN GT	Physician/Psychiatrist PA APRN Licensed Psychologist Master's level Bachelor's level Via interactive video/audio telecommunications	NO	Encounter = one unit. Unit = one session. One encounter per day per member. *Cannot be billed on same date of service as 99408 or H0001.*
99408	Substance Use Screening and Brief Intervention (SUS)	AF AM SA AH HO HN TD TE GT	Physician/Psychiatrist PA APRN Licensed Psychologist Master's level Bachelor's level RN LPN Via interactive video/audio telecommunications	NO	Encounter = one unit. Unit = one session. One encounter per day per member; 12 units per rolling 12 months per member. *Cannot be billed on same date of service as H0001 or H0002.*
H0001	Substance Use Diagnostic Assessment (SUDA) - Initial	AH HO HN GT	Licensed Psychologist Master's Level Bachelor's level Via Interactive video/audio telecommunication	NO	Encounter = one unit. Unit = 1.5-hour session. One encounter per rolling six months per member. *Cannot be billed on same date of service as 99408 or H0002.*
H0001	Substance Use Diagnostic Assessment (SUDA) - Follow-Up	TS GT	Follow-up Via Interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one hour session. One encounter per rolling six months, per member.
H0001	Substance Use Assessment (SUN) - Nursing Services	U2	LPN or higher degreed medical staff	NO	Encounter = one unit. Unit = one hour session. One encounter per rolling six months per member.
90792	Psychiatric Medical Assessment (PMA)	AF AM SA GT	Psychiatrist PA APRN Via interactive video/audio telecommunication	NO	Encounter = one unit. One encounter per six months per member.

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
96130	Psychological Testing and Evaluation (PTE) • Initial hour	AH HO	Licensed Psychologist LPES	NO	First hour = one unit. One unit per day per member; not to exceed 24 units per year, in combination with 96131, 96136, and 96137.
96131	Psychological Testing and Evaluation (PTE) • Additional hour(s)	AH HO	Licensed Psychologist LPES	NO	One additional hour = one unit. A maximum of seven units per day per member; not to exceed 24 units per rolling 12 months in combination with 96130, 96136, and 96137.
96136	Psychological/ Neuropsycho-logical Test Administration and Scoring (PTA) • First 30 minutes	AH HO	Licensed Psychologist LPES	NO	First 30 minutes = one unit. One unit per day, per member; not to exceed 24 units per rolling 12 months, per member, in combination with 96130, 96131, 96137.
96137	Psychological/ Neuropsycho-logical Test Administration and Scoring (PTA) • Each additional 30 minutes	AH HO	Licensed Psychologist LPES	NO	Additional 30 minutes = one unit. A maximum of six units per day per member; not to exceed 24 units per rolling 12 months in combination with 96130, 96131, 96136.
96138	Psychological or neuropsych-ological test administration and scoring (PTA), *by technician* • 2 or more tests, any method	AH HO	Licensed Psychologist LPES	NO	First 30 minutes = one unit. One unit per day per member. Billing for 96138 and 96139 cannot exceed 40 total units per rolling 12 months. *Cannot be billed same date of service as 96146.*

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
	• Initial 30 minutes				
96139	Psychological or neuropsych-ological test administration and scoring (PTA), *by technician* • 2 or more tests, any method • Additional 30 minutes	AH HO	Licensed Psychologist LPES	NO	30 minutes = one unit. One unit per day, per member; must be billed with 96138. Billing for 96139 and 96146 cannot exceed 40 total units per rolling 12 months. *Cannot be billed same date of service 96146.*
96146	Psychological or neuropsych-ological test administration (PTA), single automated, standardized instrument *via electronic platform* • Automated result only	AH HO	Licensed Psychologist LPES	NO	One test = one unit. One unit per day per member. Billing for 96138 and 96139 cannot exceed 40 total units per rolling 12 months. *Cannot be billed same date of service as 96138 or 96139.*
Service Plan Development of the IPOC					
H0032	Service Plan Development – Non-Physician (SPD)	00 HF GT	SPD *without* client. SPD *with* client. Via interactive video/audio Telecommunication.	NO	Encounter = one unit. Unit = 30 min. Six units per rolling 12 months per member.
Medical Services					
99213	E&M of Established Patient • 20-29 minutes • Low level medical decision-making	AF AM SA GT	Physician/psychiatrist PA APRN Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service. *This code is outside of the bundled rate packages.*

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
99203	E&M of New Patient: • 30+ minutes • Low level medical decision-making	AF AM SA GT	Physician/psychiatrist PA APRN Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service *This code is outside of the bundled rate packages.*
90833	E&M with Psychotherapy 16 to 37 minutes.	AF AM SA AH HO GT	Physician/psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service. *Billed in lieu of 90832 when E&M service provided on same date.*
90836	E&M with Psychotherapy 38 to 52 minutes.	AF AM SA AH HO GT	Physician/psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service. *Billed in lieu of 90834 or 90837 when E&M service provided on same date.*
H0034	Medication Management (MM)	UB AH HO HN TD TE GT	Pharmacist Licensed Psychologist Master's level Bachelors' level RN LPN Via interactive video/audio telecommunication	NO	15 minutes = one unit. Maximum of eight units per day per member. Up to 80 units per rolling 12 months. *Cannot be billed on same date of service as 90833, 90836, 99203, or 99213.*
96372	Medication Administration (MA)		*Must be provided by Medical staff within their scope of practice.*	NO	Injection = one unit. One unit per date of service; billed in combination with J2315.
J2315	Vivitrol Injection (VI)		*Must be provided by Medical staff within their scope of practice.*	NO	380 units allowable. One service per calendar month per member.
Psychotherapy and Community Support Services					

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
90832	Individual Psychotherapy (IP) • 30 minutes	AF AM SA AH HO GT	Psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = 1 session. One unit per date of service per member, not to exceed six sessions per calendar month *Cannot be billed on same date of service as E&M code; must use 90833.*
90834	Individual Psychotherapy (IP) • 45 minutes	AF AM SA AH HO GT	Psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service per member, not to exceed six sessions per calendar month *Cannot be billed on same date of service as E&M code; must use 90833 or 90836.*
90837	Individual Psychotherapy (IP) • 60 minutes	AF AM SA AH HO GT	Psychiatrist PA APRN Licensed Psychologist Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service, per member, not to exceed six sessions per calendar month. *Cannot be billed on same date of service as E&M code; must use 90836.*
H0004	Individual Substance Use Counseling (SUC)	-- GT	Via interactive video/audio telecommunication	NO	15 minutes = one unit. 32 units per rolling week per member.
90846	Family Psychotherapy (FP) *without* patient, 60 minutes	AF AM AH SA HO GT	Physician/psychiatrist PA Licensed Psychologist APRN Master's level Via interactive video/audio	NO	Encounter = one unit. Unit = one session. One per date of service, per member; not to exceed four sessions per calendar month.

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
			telecommunication		
90847	Family Psychotherapy (FP) *with* patient, 50 minutes	AF AM AH SA HO GT	Physician/psychiatrist PA Licensed Psychologist APRN Master's level Via interactive video/audio telecommunication	NO	Encounter = one unit. Unit = one session. One unit per date of service per member; not to exceed four sessions per calendar month.
90853	Group Psychotherapy (GP)	AF AM SA AH HO	Physician/psychiatrist PA APRN Licensed Psychologist Master's level	NO	Encounter = one unit. Unit = one hour. Eight encounters per calendar month per member.
H0005	Substance Use Counseling Group (SUG)	00 GT	No modifier, all provider types. Via interactive video/audio telecommunication.	NO	Encounter = one unit. Unit = one hour. Three encounters per calendar week per member.
90849	Multiple Family Group Psychotherapy (MFGP)	AF AM AH SA HO	Physician/psychiatrist PA APRN Licensed Psychologist Master's level		Encounter = one unit. Unit = one hour. Eight encounters per calendar month per member.
H2017	Psychosocial Rehabilitation Services (PRS)	00 HQ	Individual – No Modifier Group	NO	15 minutes = one unit. Maximum of 32 units per calendar week per member. *Documentation must be co-signed by the appropriately credentialed staff.*
H2014	Skills Training and Development (ST)	00	*For children age 0 through their 6th birthday.*	NO	15 minutes = one unit. Maximum of 32 units per day per member.
S9482	Family Support (FS)	00	No Modifier	NO	15 minutes = one unit. Maximum 32 units per day per member.

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES					
Procedure Code	Procedure Code Description	Modifier/ Description		PA	Coverage Limitations Frequency/Timespan/ Criteria
H0038	Peer Support Services (PSS)	00 HQ GT	Individual - No Modifier Group Via interactive video/audio Telecommunication *(Individual only)*	NO	15 minutes = one unit. Maximum of 16 units per day per member. *Documentation must be co-signed by the appropriately credentialed staff.*
Crisis Management Services					
H2011	Crisis Intervention (CI)	00 HF GT	In-Person – No Modifier Telephonic Via interactive video/audio telecommunication	NO	15 minutes = one unit. Maximum of 16 units per day per member; not to exceed 80 units per rolling 12 months. *Documentation must be co-signed by the appropriately credentialed staff.*
Intensive Community-Based and Residential Treatment Services for Substance Use					
H0015	Substance Use–Intensive Outpatient Program (IOP): *Level 2.1*	No Modifier		YES	Encounter = one unit. All-inclusive hourly rate. Adol.: 6–19 hours of programming per week. Adults: 9–19 hours of programming per week. *(Max of 19 hours per week for adol.or adult)*
H2035	Substance Use–Day Treatment/ Partial Hospitalization Program (PHP): *Level 2.5*	No Modifier		YES	Encounter = one unit. All-inclusive hourly rate; minimum of 20 hours of programming per week *(adol. or adult).*
H0010	Sub-Acute Withdrawal Management — Clinically Managed Residential Withdrawal Management: *Level 3.2WM*	No Modifier		YES	Encounter = one unit. Per diem bundled rates; one per day per member.
H0011	Acute Withdrawal Management —	No Modifier		YES	Encounter = one unit.

RBHS SUBSTANCE USE-SPECIFIC SERVICES PROCEDURE CODES				
Procedure Code	Procedure Code Description	Modifier/ Description	PA	Coverage Limitations Frequency/Timespan/ Criteria
	Medically Monitored Inpatient Withdrawal Management: *Level 3.7WM*			Per diem bundled rates; one per day per member.
H0019	Clinically Managed High-Intensity Residential Treatment: *Level 3.5*	No Modifier	YES	Encounter = one unit. Per diem bundled rates; one per day per member.
H0018	Medically Monitored Intensive Inpatient Treatment: *Level 3.7 (Adults or Adolescents)*	00 Adults – No Mod. HA Adolescents	YES	Encounter = one unit. Per diem bundled rates; one per day per member.