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POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

The South Carolina Department of Health and Human Services (SCDHHS) provides Medicaid reimbursement for medically necessary services provided to Medicaid-eligible individuals in the Local Education Agency (LEA). This includes, but is not limited to, children under the age of 21 who have or are at risk of developing sensory, emotional, behavioral, or social impairments, physical disabilities, medical conditions, mental retardation, or developmental disabilities or delays.

Each Local Education Agency (LEA) recognized as such by the South Carolina Department of Education has contracted with SCDHHS to provide Medicaid-reimbursable School-Based Services to Medicaid-eligible children with special needs. Individual service providers employed or contracted by an LEA must meet the specified Medicaid provider qualifications.

Medicaid reimbursement is available for the following School-Based Services:

- Audiological
- Physical Therapy
- Occupational Therapy
- Speech and Language Pathology
- Orientation & Mobility
- Behavioral Health Services
 - Therapeutic Behavioral Services (Center Based)
 - Therapeutic Behavioral Services (Home Visit)
 - Psychosocial Rehabilitation Services
 - Psychological Testing and Evaluation
- Nursing Services for Children Under 21
- Administrative Claiming
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Non Emergency Transportation

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GENERAL INFORMATION

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) AND MEDICAID

The development of an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP) is a requirement of the Individuals with Disabilities Education Act (IDEA). Medicaid requires School-Based Services to be indicated on the IEP, IFSP, or the Individualized Treatment Plan (ITP). However, Medicaid will not reimburse for any administrative or direct services performed for pre-IEP/IFSP activities. Medicaid will not reimburse for the IEP team member meetings or the cost related to attendance at those meetings by medical professionals.

The following policies apply when an LEA relies upon Social Security Act §1903(c) (42 U.S.C. 1396b(c)) as its basis for billing Medicaid:

- Medicaid-reimbursed School-Based Rehabilitative Therapy Services must be included in the Individual Education Program (IEP) or Individual Family Service Plan (IFSP). Rehabilitative Therapy Services include Audiology, Nursing Services, Orientation & Mobility Services, Occupational and Physical Therapy Services, School Psychology Services, and Speech Language Pathology Therapy.
- Medicaid-reimbursed School-Based Rehabilitative Behavioral Health Services **are required** to be included in the IEP, IFSP, or Individual Treatment Plan (ITP). Rehabilitative Behavioral Health Services include Therapeutic Behavioral Services (Center Based) (formerly Therapeutic Child Treatment), Therapeutic Behavioral Services (Home Visit), and Psychosocial Rehabilitation Services (formerly Clinical Day Programming).
- Medicaid-reimbursed Medicaid Adolescent Pregnancy Prevention Services (MAPPS) are not required to be included in the IEP, IFSP, or ITP.

LEAs must adhere to the applicable IDEA requirements when Medicaid-reimbursed School-Based Services are included in the IEP or IFSP. However, Rehabilitative Behavioral Health Services must be indicated on an ITP. The IEP or IFSP may be used as the ITP if all of the minimum components are indicated. If IDEA permits the Medicaid-reimbursed School-Based Service to be

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) AND MEDICAID (CONT'D.)

documented in attachments to the IEP file, then such documentation meets these requirements.

PROVIDER QUALIFICATIONS

LEAs and/or sub-contractors must meet all applicable Medicaid provider qualifications as well as the applicable state licensure regulations in addition to any specified requirements by the State Department of Education for the provision of Medicaid School-Based Services. The contracted LEA is responsible for ensuring the individuals rendering Medicaid School-Based Services are approved, credentialed, or licensed.

LEAs may contract with any qualified provider for School-Based Services. The LEA must utilize the subcontract format approved and provided by SCDHHS. This can be found in the applicable appendix of the LEA contract. This format includes the federal and state contractual components that are required to ensure that Medicaid reimbursement is available. There may be additional state and/or federal requirements for approval by SCDHHS. LEAs may include other terms and conditions necessary to fully define the responsibilities of both parties.

All subcontracts (*i.e.*, billing contracts, contracted providers, etc.) are subject to the terms of the LEA's contract with SCDHHS and the LEA provider is held solely responsible for the performance of the subcontractor. Additionally, a copy of the LEA's contract with SCDHHS, if applicable, must be provided to the subcontractor by attachment to the subcontract. Please contact your Medicaid program manager if a copy of the current SCDHHS subcontract format is needed.

Medicaid reimbursement is available for School-Based Rehabilitative Services (*i.e.*, Speech-Language Pathology, Audiology, Physical Therapy, Occupational Therapy, and Orientation & Mobility Services) when provided by or under the direction of the qualified rehabilitative therapy provider for which the beneficiary has been referred. Referrals must be made by a physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law.

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Supervision

In accordance with Centers for Medicare and Medicaid Services (CMS) directives, CMS has interpreted the term “under the direction of” to mean that the provider is individually involved with the patient and accepts ultimate legal responsibility for the services rendered by the individuals that he or she agrees to direct. The supervisor is responsible for all the services provided or omitted by the individual that he or she agrees to directly supervise.

At no time may the individual being supervised perform tasks when the supervisor cannot be reached by personal contact, phone, pager, or other immediate means. The supervisor must make provisions, in writing, for emergency situations including designation of another qualified provider who has agreed to be available on an as-needed basis to provide supervision and consultation to the individual when the supervisor is not available. **All Clinical Service Note entries made by staff who require supervision must be cosigned by the supervisor (unless otherwise indicated for a specific Medicaid reimbursement service).**

The supervisor must be readily available to offer continuing supervision. “Readily available” means that the supervisor must be physically accessible to the individual being supervised within a certain response time based upon the medical history and condition of the beneficiary and competency of personnel. Supervision should involve specific instructions from the supervisor to the individual regarding the treatment regimen, responses to indications of adverse beneficiary reactions, and any other issues necessary to ensure the appropriate provision of the Medicaid-reimbursable services.

All supervisory staff licensed by Labor, Licensing and Regulation (LLR) must adhere to any provisions as required by LLR.

In addition to the above requirements, SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25-mile radius of the SC border.

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GENERAL INFORMATION

Referrals

Referral by Other Licensed Practitioners of the Healing Arts for Rehabilitative Therapy Services Only (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Orientation & Mobility Services, and Audiology)

Referral means that the physician or other LPHA has asked another qualified health provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on behalf of the beneficiary being referred. It includes any necessary supplies and equipment.

When the IEP/IFSP multidisciplinary team is used as the referral source for Rehabilitative Therapy Services, the team must include an individual who meets the other LPHA as defined by Medicaid. The other LPHA initial referral must be obtained from a Licensed Practitioner of the Healing Arts other than the individual direct provider of the Rehabilitative Service.

The referral documentation must occur prior to the provision of the initial Medicaid Rehabilitative Therapy Service. The referral must meet the following requirements:

- Be updated no later than the annual renewal of the IEP and re-evaluation
- Be obtained from an LPHA other than the direct provider of services
- Be clearly documented in the clinical record with the name, date, and title of the provider
- Explain reason for referral

The following list indicates the professional designations of those considered as Licensed Practitioners of the Healing Arts for the purpose of Medicaid reimbursement of School-Based Services (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Orientation & Mobility Services, and Audiology):

- Licensed Physician Assistant
- Licensed Psychologist
- Certified School Psychologist II or III
- Registered Nurse (RN)

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GENERAL INFORMATION

Referrals (Cont'd.)

- Licensed Practical Nurse (LPN)
- Advanced Practice Registered Nurse
- Speech-Language Pathologist
- Licensed Audiologist
- Licensed Physical Therapist
- Licensed Occupational Therapist
- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Other staff as approved in writing by SCDHHS

Please refer to other sections of this manual for LPHAs for services other than Rehabilitative Therapy Services.

The following list indicates the professional designations of those considered as Licensed Practitioners of the Healing Arts for the purpose of Medicaid reimbursement of Children's Behavioral Health Services (Psychosocial Rehabilitative Services and Therapeutic Behavioral Services):

- Physician
- Licensed Psychologist
- Registered Nurse with a Master's Degree in Psychiatric Nursing
- Advanced Practice Registered Nurse with Certification in Psychiatric Nursing
- Advanced Practice Registered Nurse
- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Physician Assistant
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

Please refer to the Children's Behavioral Health Services section of this manual for applicable service standards.

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GENERAL INFORMATION

Referrals (Cont'd.)

All Community-Based Service Providers must ensure that staff members working directly with clients successfully complete a course from a certified trainer in the prevention and management of aggressive behavior with an emphasis on de-escalation skills. In addition, annual refresher courses must be provided. For more information, refer to the subsection on Emergency Safety Interventions.

Please refer to Other Medicaid-Covered School-Based Services and other standards sections of this manual for other Licensed Practitioners of the Healing Arts requirements, if applicable.

Prior Authorization

School districts that refer children to private therapists/audiologists must provide their seven-digit prior authorization number (beginning with “ED”) to the private therapist/audiologist (see Medicaid Bulletin dated July 20, 1998). The private therapist/audiologist then must enter this number in field 23 on the CMS-1500 claim form.

Evaluations

Evaluations must occur prior to the provision of the initial Medicaid Rehabilitative Therapy Service. Evaluations must be completed by the enrolled Medicaid provider of services after receiving the referral from another Licensed Practitioner of the Healing Arts (LPHA).

If the evaluation findings indicate a Medicaid Rehabilitative Therapy Service is determined to be medically necessary, the evaluation must result in the development of an IEP or IFSP and the service must be indicated on the IEP or IFSP. Psychological Testing and Evaluation Services may be billed without the requirement of an IEP or IFSP.

If the evaluation findings do not indicate the need for provision of a Medicaid Rehabilitative Therapy Service, then the results of the evaluation must be indicated on the IEP, IFSP, ITP, or the evaluation instrument in order to be reimbursed by Medicaid. The ITP may be developed as a separate document or may appear as a Clinical Service Note. **The results of the evaluation must include a narrative summary. The documentation must justify the number of units billed.**

Medicaid will not reimburse for providers attending an IEP or an IFSP meeting.

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GENERAL INFORMATION

Re-evaluations

A re-evaluation is performed subsequently to the initial evaluation and relates to the disorder. A re-evaluation should be conducted annually for each beneficiary; however, a re-evaluation can be within a six-month time frame. A re-evaluation must be completed when enough time has passed to accurately assess the beneficiary's progress. This service may be performed twice a year.

Documentation Requirements

Clinical Records

As a condition of participation in the Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid beneficiary. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality medical care. Providers must be aware that these records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS. It is essential that an internal records review be conducted by each LEA to ensure that the services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policy and procedure.

LEAs are required to maintain a clinical record on each Medicaid-eligible child that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid payment. Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of the services provided and progress toward treatment goals. The information in the clinical services notes must be clearly linked to the goals listed on the IEP/IFSP. For example, descriptions should be used to clearly link information from goals to the interventions performed and progress obtained in the clinical service notes. Clinical records should be arranged logically so that information may be easily reviewed, copied, and audited.

The provider of services is required to maintain clinical records on each Medicaid-eligible child. Each clinical record must include the following:

- A Release of Information form signed by the

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Clinical Records (Cont'd.)

child's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims and requesting payment of government benefits on behalf of the child (this may be incorporated into a Consent for Treatment form)

- A referral for services by a physician or other Licensed Practitioner of the Healing Arts, if applicable
- A current and valid Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) indicating the child's need for services
- Test results and evaluation reports
- A current and valid ITP, when applicable
- Clinical Service Notes
- Progress Summary Notes

Clinical Service Notes

Services should be documented in Clinical Service Notes. A Clinical Service Note is a written summary of each treatment session. The purpose of these notes is to record the nature of the child's treatment by capturing the services provided and summarizing the child's participation in treatment. In the event that services are discontinued, the provider must indicate the reason for discontinuing treatment on the Clinical Service Notes.

Clinical Service Notes must:

1. Provide a pertinent clinical description of the activities that took place during the session, including an indication of the child's response to treatment as related to stated goals listed in the IEP, IFSP, or ITP
2. Reflect delivery of a specific billable service as identified in the physician's or other LPHA's referral and the child's IEP, IFSP, or ITP
3. Document that the services rendered correspond to billing as to date of service, type of service rendered (i.e. minutes or hours), and length of time of service delivery
4. Be individualized with patient's level of

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Clinical Service Notes (Cont'd.)

participation and response to intervention when documenting group services

When completing Clinical Service Notes:

1. Each entry must be individualized and patient-specific. Each entry must stand on its own and may not include arrows, ditto marks, "same as above," etc.
2. All entries must be made by the provider delivering the service and should be accurate, complete, and recorded immediately.
3. All entries must be typed or legibly handwritten in dark ink. Copies are acceptable, but must be completely legible. Originals must be available if needed.
4. All entries must be dated and legibly signed with the provider's name or initials and professional title.
5. All entries must be filed in the child's clinical record in chronological order by discipline.

All Clinical Service Notes used must include a narrative summary. The documentation must justify the number of units billed.

Error Correction Procedures

The child's clinical record is a legal document. Therefore, extreme caution should be used when altering any part of the record. Appropriate procedures for the correction of errors in legal documents must be followed when correcting an error in a clinical record. Errors in documentation should never be totally marked out and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature/initials and date next to the correction. If warranted, an explanation of the correction may be appropriate.

Medical Necessity

Medicaid will pay for service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Medical Necessity
(Cont'd.)

of illness or disability. A provider's medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.

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SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Medicaid reimbursement is available for the following School-Based Rehabilitative Therapy Services:

- Audiological
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Orientation & Mobility

BENEFICIARY REQUIREMENTS

Eligibility for Services

In order to be eligible for School-Based Rehabilitative Therapy Services, a Medicaid-eligible individual must:

- Be under the age of 21
- Have a current and valid Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or an Early & Periodic Screening, Diagnosis, & Treatment (EPSDT) examination that identifies the need for rehabilitative therapy services

Training Requirements

Providers must maintain adequate documentation to support the number of units billed. For Psychosocial Rehabilitation Services, the LCS should place a “P” in the appropriate blocks on the Progress Summary Note for each day the child received treatment. An “A” should be used for each day the child is absent. This denotes a non-billable day. The date of discharge should be annotated with a “D”. Psychosocial Rehabilitation Services “Transition” days should be documented with a “T”. Treatment services are billable from the date of admission.

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

AUDIOLOGICAL SERVICES

Program Description

In accordance with 42 CFR 440.110(c)(1), Audiological Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. It includes any necessary supplies and equipment. Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use.

Audiological Services include diagnostic, screening, preventive, and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts, within the scope of his or her practice under state law, must refer individuals to receive these services. A referral occurs when the physician or other LPHA has asked another qualified health care provider (Licensed Audiologist) to recommend, evaluate, or perform therapies, treatment, or other clinical activities for the beneficiary. It includes any necessary supplies and equipment.

Program Staff

The following requirements are cited from Section 440.110(c)(3) of the Code of Federal Regulations:

(c) [**Audiological Services** are] services for individuals with speech, hearing, and language disorders.

(1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

A “qualified audiologist” means an individual with a master’s or doctoral degree in audiology that maintains

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff (Cont'd.)

documentation to demonstrate that he or she meets **one** of the following conditions:

(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, **and** the individual is licensed by the State as an audiologist to furnish audiology services.

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet **one** of the following conditions:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

Supervision

See Supervision under Provider Qualifications earlier in this section.

Hearing Aids

Hearing aids may be provided for individuals under the age of 21 when the need is established through an audiological evaluation. The attending Audiologist may send a request for a hearing aid or aids, along with a physician's statement completed within the last six months indicating that there is no medical contraindication to the use of a hearing aid, to the South Carolina Department of Health and Environmental Control's (DHEC) local Children's Rehabilitative Services (CRS) office. DHEC will arrange for the requested hearing aids. Children birth to 21 years of age should be enrolled in the CRS program. Requests for hearing aids for children birth to 21 years of age should be

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SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Hearing Aids (Cont'd.)

sent to:

CRS Central Office
Robert Mills Complex
Box 101106
Columbia, SC 29211

For more information, call CRS at (803) 898-0784.

Service Description

Pure Tone Audiometry

92552: Pure tone audiometry (threshold), air only

In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies in each ear. **This service may be performed six times every 12 months.**

Audiological Evaluation

92557: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

In comprehensive audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies on each ear. Bone thresholds are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sounds. The patient is also asked to repeat bisyllabic (spondee) words. The threshold is recorded for each ear. The word discrimination score is the percentage of spondee words that a patient can repeat correctly at a given intensity level above speech reception threshold in each ear. **This service may be performed once every 12 months.**

92557-52: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

An audiological evaluation is when appropriate components of the initial evaluation are re-evaluated and provided as a separate procedure. The necessity of an audiological evaluation must be appropriately documented. **This service may be performed six times every 12 months.**

SECTION 2 POLICIES AND PROCEDURES**SCHOOL-BASED REHABILITATIVE THERAPY SERVICES**

| | |
|--|---|
| Tympanometry (Impedance Testing) | 92567 Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. This service may be performed six times every 12 months. |
| Acoustic reflex testing; threshold | 92568 Acoustic reflex testing, threshold is used in determining the differential diagnosis between, sensory, conductive or central hearing loss. Acoustic reflex test results give the clinician valuable information regarding the severity of a hearing loss and the possible cause of a hearing loss. It is also a valuable test in detecting problems in the auditory pathway. This service may be performed two times every 12 months. |
| Electrocochleography | 92584 An electrocochleography tests the internal components of the implanted receiver and connected electrode array. This procedure verifies the integrity of the implanted electrode array and is completed immediately after the operation. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team. This service may be performed once per implantation. |
| Hearing Aid Examination and Selection | 92590: Hearing aid examination and selection; monaural History of hearing loss and ears are examined, medical or surgical treatment is considered if possible, and the appropriate type of hearing aid is selected to fit the pattern of hearing loss. This service may be performed six times every 12 months. |
| Hearing Aid Check | 92592: Hearing aid check; monaural The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. This service may be performed six times every 12 months. 92592-52: Hearing aid recheck; monaural The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are |

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

| | |
|---|--|
| Hearing Aid Check(Cont'd) | checked using a special stethoscope, which attaches to the hearing aid. This service may be performed six times every 12 months. |
| Evaluation of Auditory Rehabilitation Status | <p>92626: Evaluation of auditory rehabilitation status; first hour</p> <p>This service involves the measurement of patient responses to electrical stimulation used to program the speech processor and functional gain measurements to assess a patient's responses to his or her cochlear implant. Instructions should be provided to the parent/guardian, teacher, and/or patient on the use of a cochlear implant device to include care, safety, and warranty procedures. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed 10 times a year.</p> |
| Fitting/Orientation/ Checking of Hearing Aid | <p>V5011: Fitting/orientation/checking of hearing aid</p> <p>Includes hearing aid orientation, hearing aid checks, and electroacoustic analysis. The service may be provided six times every 12 months.</p> |
| Dispensing Fee | <p>V5090: Dispensing fee, unspecified hearing aid</p> <p>The dispensing fee is time spent handling hearing aid repairs. This service may be performed six times every 12 months.</p> |
| Ear Impression | <p>V5275: Ear impression, each</p> <p>Taking of an ear impression; please specify one or two units for one or two ears. This service may be performed six times every 12 months.</p> <p>Modifiers LT and RT have been removed from V5275. If you are billing this procedure code, instead of using the modifiers to identify the right and left ear impression, SCDHHS asks that you put one unit with no modifier if you are billing only one ear impression. If you are billing both ear impressions, SCDHHS asks that you put two units with no modifier.</p> |
| Documentation | See Documentation Requirements under General Information earlier in this section. |

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

PHYSICAL THERAPY SERVICES

Program Description

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Physical Therapist. It includes any necessary supplies and equipment. Physical Therapy Services involve evaluation and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Specific services rendered: Physical Therapy Evaluation, Individual and Group Therapy (a group may consist of no more than six children).

Physical Therapy Services involve evaluation and treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems. Physical Therapy involves the use of physical agents, mechanical means, and other remedial treatment to restore normal physical functioning following illness or injury.

Program Staff

Physical Therapy Services are provided by or under the direction of a Physical Therapist.

Physical Therapist

In accordance with 42 CFR 440.110(a)(2)(i)(ii), a qualified physical therapist is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. (i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and (ii) where applicable, licensed by the State.

Physical Therapist Assistant

A **Physical Therapist Assistant (PTA)** is an individual who is currently licensed by the South Carolina Board of Physical Therapy Examiners. A physical therapy assistant provides services under the direction of a qualified physical therapist.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Supervision of Physical Therapy Assistants

Physical Therapist Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Physical Therapist. Additionally, the supervising therapist must review and initial each Summary of Progress completed by the assistant. These licensed individuals must adhere to any provisions as required by the South Carolina Department of Labor Licensing and Regulations (LLR).

Service Description

Physical Therapy Evaluation

97001-GP

A Physical Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Physical Therapy Association and South Carolina Board of Physical Therapy Examiners guidelines, the physician or other LPHA, the Physical Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records, an observation of the patient, and an interview, when possible. The evaluation must include diagnostic testing and assessment, and a written report with recommendations.

Individual and Group Physical Therapy

Individual 97110-GP: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility

Group 97150-GP: Therapeutic procedure(s), group (two or more individuals)

Individual or Group Physical Therapy is the development and implementation of specialized Physical Therapy programs that incorporate the use of appropriate modalities; performance of written and/or oral training of teachers and/or family regarding appropriate Physical Therapy activities/therapeutic positioning in the school or home environment; recommendations on equipment needs; and safety inspections and adjustments of adaptive and positional equipment. Physical Therapy performed on behalf of one child should be documented and billed as Individual Physical Therapy. Physical Therapy performed on behalf of two or more clients should be documented and

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

*Individual and Group
Physical Therapy (Cont'd.)*

billed as Group Physical Therapy. A group may consist of no more than six children.

Documentation

See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Initial Treatment Plan

If an evaluation indicates that therapy is warranted, the Physical Therapist must develop and maintain a treatment plan that outlines long-term goals, short-term objectives, as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service the child should be receiving (*i.e.*, individual or group therapy). Indicating the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the Physical Therapist and the date signed. If the evaluation indicates treatment is needed for the beneficiary, the Medicaid provider of service must write his or her own Treatment Plan upon completion of the evaluation.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed and a new referral for services by a physician or other Licensed Practitioner of the Healing Arts must be obtained annually.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the physical therapy practitioner every three months from the start date of treatment. The purpose of the Progress Summary is to record the longitudinal nature of the child's treatment, describe the child's attendance at therapy sessions, document progress toward treatment goals, and establish the need for continued participation in therapy.

The Progress Summary must be written by the physical therapy practitioner, contain the therapist's signature and title as well as the date written, and must be filed in the child's clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled "Progress Summary."

OCCUPATIONAL THERAPY SERVICES

Program Description

In accordance with 42 CFR 440.110(b)(1), Occupational Therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified Occupational Therapist. It includes any necessary supplies and equipment. Occupational therapy services are channels to improve or restore functional abilities for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Occupational Therapy Services are related to Self-Help Skills, Adaptive Behavior, Fine/Gross Motor, Visual, Sensory Motor, Postural, and Emotional Development that have been limited by a physical injury, illness, or other dysfunctional condition. Occupational Therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance. Specific services rendered: Occupational Therapy Evaluation, Individual and Group Occupational Therapy (a group may consist of no more than six children), Fabrication of Orthotic, Fabrication of Thumb and Finger Splints.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Staff Occupational Therapy Services are provided by Occupational Therapists or Occupational Therapy Assistants.

Occupational Therapist

Occupational Therapist (OT). In accordance with 42 CFR 440.110(b)(2)(i)(ii) a qualified occupational therapist is – (i) certified by the National Board of Certification for Occupational Therapy; or (ii) a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before certification by the National Board of Certification for Occupational Therapy.

Occupational Therapy Assistant

An **Occupational Therapy Assistant (OTA)** is an individual who is currently licensed as a Certified Occupational Therapy Assistant (COTA/L or OTA) by the South Carolina Board of Occupational Therapy who works under the direction of a qualified occupational therapist pursuant to 42 CFR 440.110(b)(2)(i) or (ii).

Supervision of Occupational Therapy Assistants

Occupational Therapy Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Occupational Therapist. Additionally, the supervising therapist must review and initial each Progress Summary completed by the assistant. These licensed individuals must adhere to any provisions as required by South Carolina Department of Labor, Licensing and Regulation (LLR).

Service Description

Occupational Therapy Evaluation

97003-GO

An Occupational Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Occupational Therapy Association and South Carolina Board of Occupational Therapy guidelines, the physician or other LPHA referral, the Occupational Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records and an observation of the patient and interview, when possible. The evaluation must

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Occupational Therapy Evaluation (Cont'd.)

include diagnostic testing and assessment and a written report with recommendations.

Individual and Group Occupational Therapy

Individual 97530-GO: Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Group 97150-GO: Therapeutic procedure(s), group (two or more individuals)

Individual or Group Occupational Therapy involves the development and implementation of specialized Occupational Therapy programs that incorporate the use of appropriate interventions, occupational therapy activities in the school or home environment, and recommendations on equipment needs and adaptations of physical environments.

Occupational Therapy performed directly with one child should be documented and billed as Individual Occupational Therapy. Occupational Therapy performed for two or more individuals should be documented and billed as Group Occupational Therapy. A group may consist of no more than six children.

Fabrication of Orthotic

Fabrication of Orthotics for upper and lower extremities and Thumb and Finger Splints: Fabrication of Orthotic is the fabrication of orthotics for lower and upper extremities, and the Fabrication of Thumb Splint and Finger Splint is the fabrication of orthotic for the thumb and likewise, the fabrication of Finger Splint is the fabrication of orthotic for the finger.

L2999: Fabrication of Orthotic

Lower extremity orthoses, not otherwise specified (NOS)

L3999: Fabrication of Orthotic

Upper limb orthosis, not otherwise specified (NOS)

Wrist Hand Finger Orthosis (WHFO)

L3808: Wrist hand finger orthosis

Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Documentation See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Initial Treatment Plan

If an evaluation indicates that therapy is warranted, the Occupational Therapist must develop and maintain a treatment plan that outlines long-term and short-term goals, as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care that outlines the services required to address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service(s) the child should be receiving (*i.e.*, individual or group therapy). Indicating the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the Occupational Therapist and the date signed. If the evaluation indicates treatment is needed for the beneficiary, the Medicaid provider of service must write his or her own Treatment Plan upon completion of the evaluation.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed and a new referral for services by a physician or other Licensed Practitioner of the Healing Arts must be obtained annually.

Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the occupational therapy practitioner every three months from the start date of treatment. The purpose of the Progress

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Progress Summary Notes (Cont'd.)

Summary is to record the longitudinal nature of the child's treatment, describe the child's attendance at therapy sessions, document progress toward treatment goals, and establish the need for continued participation in therapy.

The Progress Summary must be written by the occupational therapy practitioner, contain the therapist's signature and title as well as the date written, and must be filed in the child's clinical record. The Progress Summary may be developed as a separate document or may appear as a Clinical Service Note. If a Progress Summary is written as a Clinical Service Note, the entry must be clearly labeled "Progress Summary."

SPEECH-LANGUAGE PATHOLOGY SERVICES

Program Description

In accordance with 42 CFR 440.110(c)(1), Speech-Language Pathology Services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a Speech-Language Pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment. Speech-Language Pathology Services means evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (*i.e.*, Curriculum-Based Assessments, Portfolio Assessments, Criterion Referenced Assessments, Developmental Scales, and Language Sampling Procedures) may be used. Tests or measures described as "teacher-made" or "informal" are not acceptable for purposes of Medicaid reimbursement. Specific services rendered: Speech Evaluation, Individual Speech Therapy, and Group Speech Therapy (and group may consist of no more than six children).

Speech-Language Pathology Services involve the evaluation and treatment of speech and language disorders for which medication or surgical treatments are not indicated. Services include preventing, evaluating, and treating disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition/communication, auditory and/or visual

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Program Description (Cont'd.)

processing and memory, and interactive communication; as well as the use of augmentative and alternative communication systems (sign language, gesture systems, communication boards, electronic automated devices, mechanical devices) when appropriate.

Program Staff

Speech Language Pathology Services are provided by or under the direction of a Speech-Language Pathologist. We recognize that some individuals in the school setting will be licensed through LLR as Speech-Language Pathologists, Speech-Language Pathology Assistants, Speech-Language Pathology Interns, or Speech-Language Pathology Therapists. These licensed individuals will need to adhere to any provisions as required by LLR. The licensed Speech-Language Pathologist can supervise the licensed Speech-Language Pathology Intern and Speech-Language Pathology Assistant or Speech-Language Pathology Therapist.

A **Speech-Language Pathologist** in accordance with 42 CFR 440.110(c)(2)(i)(ii)(iii) is an individual who meets one of the following conditions: (i) Has a certificate of Clinical Competence from the American Speech and Hearing Association. (ii) Has completed the necessary equivalent educational requirements and work experience to qualify for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

A **Speech-Language Pathology Assistant** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology. The Speech-Language Pathology Assistant works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

A **Speech-Language Pathology Intern** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology and is seeking the academic and work experience requirements established by the American Speech and Hearing Association (ASHA) for the Certification of Clinical Competence in Speech-Language Pathology. The Speech-Language Pathology Intern works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

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|---|---|
| Program Staff (Cont'd.) | A Speech-Language Pathology Therapist is an individual who does not meet the credentials outline in the 42 CFR 440.110(c)(2)(i)(ii) and (iii) that must work under the direction of a qualified Speech-Language Pathologist. |
| Supervision | See Supervision under Provider Qualifications earlier in this section. |
| Service Description | |
| <i>Speech-Language Pathology Services</i> | Reimbursable Speech-Language Pathology Services are evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (<i>i.e.</i> , curriculum-based assessments, portfolio assessments, criterion referenced assessments, developmental scales, and language sampling procedures) may be used. Tests or measures described as “teacher-made” or “informal” are not acceptable for purposes of Medicaid reimbursement. The following services are components of Speech-Language Pathology Services. |
| <i>Speech Evaluation</i> | <p>92506-HA: Evaluation of speech, language, voice, communication, and/or auditory processing</p> <p>Upon receipt of the physician or other LPHA referral, a Speech Evaluation is conducted. A Speech Evaluation is a face-to-face interaction between the Speech-Language Pathologist and the child for the purpose of evaluating the child’s dysfunction and determining the existence of a speech disorder. The evaluation should include review of available medical history records and must include diagnostic testing and assessment, and a written report with recommendations. This service may be performed once per lifetime.</p> <p>Note: Reimbursement is available for a subsequent evaluation if, and only if, it is conducted as the result of a <u>separate and distinct speech disorder</u>. Presentation of medical justification is required. Contact your Medicaid program manager for more information.</p> <p>S9152: Re-evaluation of speech, language, voice, communication, and/or auditory processing</p> |

SECTION 2 POLICIES AND PROCEDURES**SCHOOL-BASED REHABILITATIVE THERAPY SERVICES***Speech Evaluation (Cont'd.)*

Speech Re-evaluation includes a face-to-face interaction between the Speech-Language Pathologist/Therapist and the child for the purpose of evaluating the child's progress and determining if there is a need to continue therapy. Re-evaluation may consist of a review of available medical records and diagnostic testing and/or assessment, but must include a written report with recommendations.

Any evaluation performed subsequently to the initial evaluation and related speech disorder is considered a re-evaluation and should be billed under this code.

Individual Speech Therapy

92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

Individual Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps to a child whose speech and/or language patterns deviate from standard, based on evaluation and testing, to include training of teacher or parent with child present. Individual Speech Therapy Services may be provided in a regular education classroom.

Group Speech Therapy

92508: Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals

Group Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps in a group setting to children whose speech and/or language patterns deviate from standard, based on evaluation and testing, to include training of teacher or parent with child present. A group may consist of no more than six children. Group Speech Therapy services may be provided in a regular education classroom.

Speech Language Disorders

Reimbursement is available for assessment and treatment of the following categories of speech-language disorders.

1. A **developmental language disorder** is the impairment or deviant development of comprehension and/or use of a spoken, written, and/or other symbol system (*e.g.*, sign/gesture). A developmental language disorder ranges from mild delays to severe impairment. The disorder may

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Speech Language Disorders (Cont'd.)

evidence itself in the form of language (phonologic, morphologic, and syntactic systems), content of language (semantic system), and/or function of language in communication (pragmatic system) in any combination.

2. An **acquired language disorder** (non-developmental) occurs after gestation and birth with no common set of symptoms. Acquired language disorders may differ in the areas of language affected and in severity, and may occur at any age. Causes may include focal and diffuse lesions such as those associated with traumatic brain injury and other kinds of brain injury or encephalopathy.
3. An **articulation disorder** is incorrect production of speech sounds due to faulty placement, timing, direction, pressure, speech, or integration of the movement of the lips, tongue, velum, or pharynx.
4. A **phonological disorder** is a disorder relating to the component of grammar that determines the meaningful combination of sounds.
5. A **fluency disorder** is an interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. This may be accompanied by excessive tension, struggle behavior, and secondary mannerisms.
6. A **voice disorder** is any deviation in pitch, intensity, quality, or other basic vocal attribute which consistently interferes with communication, or adversely affects the speaker or listener, or is inappropriate to the age, sex, or culture of the individual.
7. A **resonance disorder** is an acoustical effect of the voice, usually the result of a dysfunction in the coupling or uncoupling of the nasopharyngeal cavities.
8. **Dysphagia** is difficulty in swallowing due to inflammation, compression, paralysis, weakness, or hypertonicity in the oral, pharyngeal, or esophageal phases.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Documentation See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Treatment Plan

If an evaluation indicates that treatment is warranted, the Speech-Language Pathologist must develop and maintain a treatment plan that outlines short- and long-term goals as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service the child should be receiving (*i.e.* individual or group therapy). Addressing the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the Speech-Language Pathologist and the date signed. If the evaluation indicates treatment is needed for the beneficiary, the Medicaid provider of service must write his or her own Treatment Plan upon completion of the evaluation.

Treatment Plan Review

The treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan. When long-term treatment is required, a new treatment plan must be developed annually. In the event that the services are discontinued, the Speech-Language Pathologist must indicate the reason for discontinuing treatment on the treatment plan.

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

ORIENTATION AND MOBILITY (O&M) SERVICES

Program Description

Orientation and Mobility (O&M) Services are provided to assist individuals who are blind and visually impaired to achieve independent movement within the home, school, and community settings. O&M Services utilize concepts, skills, and techniques necessary for a person with visual impairment to travel safely, efficiently, and independently through any environment and under all conditions and situations. The goal of these services is to allow the individual to enhance existing skills and develop new skills necessary to restore, maximize, and maintain physiological independence.

Program Staff

O&M Services are performed by an Orientation and Mobility Specialist.

An **Orientation and Mobility (O&M) Specialist** is an individual who holds a current and valid certification in Orientation and Mobility from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or an individual who holds a current and valid certification in Orientation and Mobility from the National Blindness Professional Certification Board (NBPCB).

Beneficiary Requirements

To be eligible to receive Medicaid-reimbursable O&M Services, an individual must meet all of the following requirements:

- Be a Medicaid beneficiary under the age of 21 whose need for services is identified through a current and valid Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP)
- Have a vision report completed by an Optometrist or Ophthalmologist that verifies visual impairment or blindness

Provider Qualifications

- The service must be recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

SECTION 2 POLICIES AND PROCEDURES**SCHOOL-BASED REHABILITATIVE THERAPY SERVICES****Provider Qualifications
(Cont'd.)**

- The service must be provided for a defined period of time, for the maximum reduction of physical or mental disability and restoration of the individual to his or her best possible functional level.
- The service must be furnished by individuals working under a recognized scope of practice established by the state or profession.

Assessment**T1024**

An Orientation & Mobility Assessment is a comprehensive evaluation of the child's level of adjustment to visual impairment and current degree of independence with or without assistive/adaptive devices, including functional use of senses, use of remaining vision, tactile/Braille skills, and ability to move safely, purposefully, and efficiently through familiar and unfamiliar environments. Assessment must include a review of available medical history records, diagnostic testing and assessment, and written report with recommendations.

Reassessment**T1024-TS**

An Orientation & Mobility Reassessment is an evaluation of the child's progress toward treatment goals and determination of the need for continued services. Reassessment may consist of a review of available medical history records and diagnostic testing and assessment, but must include a written report with recommendations. Reassessment must be completed at least annually but more often when appropriate.

Services**T1024-TM**

Orientation & Mobility Services is the use of systematic techniques designed to maximize development of a visually impaired child's remaining sensory systems to enhance the child's ability to function safely, efficiently, and purposefully in a variety of environments. O&M Services enable the child to improve the use of technology designed to enhance personal communication and functional skills such as the long cane, pre-mobility and adapted mobility devices, and low vision and electronic travel aids.

O&M Services may include training in environmental

SECTION 2 POLICIES AND PROCEDURES

SCHOOL-BASED REHABILITATIVE THERAPY SERVICES

Services (Cont'd.)

awareness, sensory awareness, information processing, organization, route planning and reversals, and training in balance, posture, gait, and efficiency of movement. O&M Services may also involve the child in group activities to increase their capacity for social participation, or provide adaptive techniques and materials to improve functional activities such as eating, food preparation, grooming, dressing, and other living skills.

Documentation

See Documentation Requirements under General Information earlier in this section.

Individual Treatment Plan

Initial Treatment Plan

If an assessment indicates that O&M Services are warranted, the O&M specialist must develop and maintain a treatment plan that outlines short- and long- term goals as well as the recommended scope, frequency, and duration of treatment. The child's IEP or IFSP may suffice as the treatment plan as long as the IEP or IFSP contains the required elements for a treatment plan as outlined below.

The treatment plan should serve as a comprehensive plan of care by outlining the service delivery that will address the specific needs of the child. The treatment plan must be individualized and should specify problems to be addressed, goals of treatment, types of interventions to be utilized, planned frequency of service delivery, criteria for achievement, and estimated duration of treatment. Each IEP should specify the exact service the child is receiving (*i.e.* individual or group therapy). Addressing the child's strengths and weaknesses in the treatment plan is recognized as good clinical practice and is strongly recommended. The treatment plan must contain the signature and title of the O&M specialist and the date signed. If the evaluation indicates treatment is needed for the beneficiary, the Medicaid provider of service must write his or her own Treatment Plan upon completion of the evaluation.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID- COVERED SCHOOL-BASED SERVICES

NURSING SERVICES FOR CHILDREN UNDER 21

Program Description

Nursing Services for Children Under 21 are those specialized health care services including nursing assessment and nursing diagnosis; direct care and treatment; administration of medication and treatment as authorized and prescribed by a physician or dentist and/or other licensed/authorized healthcare personnel; nurse management; health counseling; and emergency care. A Registered Nurse as allowed under state licensure and regulation must perform acts of nursing diagnosis or prescription of therapeutic or corrective measures.

The need for services must be appropriately documented in an Individualized Education Program (IEP), Individualized Family Services Plan (IFSP), Treatment Plan, or Clinical Service Notes, when appropriate.

Program Staff

A **nurse** is defined as an individual who is currently licensed as a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) by the State Board of Nursing for South Carolina.

Services performed by health room aides, nurses' aides or any other unlicensed medical personnel are not Medicaid reimbursable.

Licensed Practical Nurse

An LPN must adhere to the following when providing Nursing Services:

1. An LPN must be supervised at all times by a RN. The RN may either be physically present or accessible by phone or pager (Exceptions to on-site supervision are allowable in accordance with SC Code of Law, Title 40-33-770).
2. The LPN can provide any service allowable under state licensure and regulations.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Licensed Practical Nurse (Cont'd.)

3. The LPN must follow the policies, procedures, and guidelines for the employing entity.
4. The RN supervisor will provide the initial assessment of the child's condition as appropriate and establish a plan of care based on the child's medical condition in accordance with state licensure and regulation. If the LPN receives additional information regarding the child's health condition after the initial assessment, the LPN will consult with the RN in accordance with Advisory Opinion #23 of the South Carolina Board of Nursing.
5. Supervision by the RN of the LPN must be performed at a minimum of every 60 days. This can be done through direct observation or a review of clinical service notes.

Physician Oversight

Medicaid recognizes Nursing Services as those that fall within the scope of practice of an RN or LPN as authorized by the South Carolina State Board of Nursing. Nursing Services may be billed to Medicaid provided all services rendered are allowed under state law. Administering prescription medications and conducting medical acts must be under the direction of a physician, dentist, or other authorized personnel or included in a written protocol. If a nurse is practicing in an "Extended Role" according to the Nurse Practice Act (§ 40-33-270 of the 1976 code), a written physician preceptor agreement and a written protocol must be agreed upon by the physician and nurse, signed and dated by both parties, and reviewed annually. The preceptor agreement and written protocols must be readily available for review by SCDHHS upon request.

All requirements stated in the Nurse Practice Act (§40-33-270 of the 1976 code) and the Medical Practice Act (§40-47-10) must be met and followed. Additionally, specific requirements for written protocols may be found in these statutes. If a physician preceptor agreement and written protocols are in place, the physician must be readily available and be able to be contacted in person or by telecommunications or other electronic means to provide consultation and advice when needed.

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Service Description

Services that are part of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination are not reimbursable under this program. However, services rendered subsequent to and as a result of an anomaly discovered during an EPSDT exam are reimbursable. EPSDT provides a comprehensive and preventive, well child screening program in South Carolina. EPSDT provides comprehensive and preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. If you would like additional information about the EPSDT program, contact the Division of Physician Services at (803) 898-2660. Mass screenings are not reimbursable under this program; however, vision and hearing assessments are reimbursable if they are performed in conjunction with a nursing assessment for IEP services.

Reimbursement is available for services that conform to accepted methods of diagnosis and treatment for appropriate personnel. Reimbursement is not available for time spent documenting services, time spent traveling to or from services, or for cancelled visits and missed appointments. Medicaid will only pay for nursing direct service provision. Observation is included in the direct services payment as long as the nurse (RN or LPN) is attending to one individual during a face-to-face encounter. If the child needs monitoring after a specific service provision, then his or her Plan of Care documentation must reflect the ongoing need for monitoring. Although the nurse may be accountable for the time the child is in the Health Room, it may not be Medicaid-billable time.

Reimbursable nursing services under this program will include any service that an RN or LPN is allowed to provide under state licensure and regulation. Nursing Services can include, but are not limited to, the following: nursing care assessments, nursing procedures, emergency care, or individual/group health counseling.

Nursing Assessment

- Nursing assessment of applicants registering for early child development programs
- Nursing assessment of children referred for special education eligibility evaluation

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Nursing Assessment (Cont'd.)

- Nursing assessment related to the IEP, IFSP, or ITP
- Nursing assessment of new or previously identified medical/health problems based on child initiated or teacher/staff referral to nurse, including substance use assessment, child abuse assessment, pregnancy confirmation, etc.
- Home visits for comprehensive health, developmental, and/or environmental assessment

Nursing referrals for any reasons are Medicaid reimbursable only when they occur as a part of a Nursing Assessment.

Nursing Care Procedures

- Administration of immunizations to children in accordance with state immunization law
- Medication assessment, monitoring, and/or administration
- Interventions related to the IEP, IFSP, or ITP
- Nursing procedures required for specialized health care including, but not limited to, feeding, catheterization, respiratory care, ostomies, medical support systems, collecting and/or performance of test, other nursing procedures, and development of health care and emergency protocols (See chart on following page)

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

| NURSING PROCEDURES REIMBURSED BY MEDICAID | |
|---|---|
| Feeding | <ul style="list-style-type: none"> • Nutritional assessment • Naso-gastric feeding • Gastrostomy feeding • Jejunostomy tube feeding • Parenteral feeding (IV) • Naso-gastric tube insertion or removal • Gastrostomy tube reinsertion |
| Catheterization | <ul style="list-style-type: none"> • Clean intermittent catheterization • Sterile catheterization |
| Respiratory Care | <ul style="list-style-type: none"> • Postural drainage • Percussion • Pharyngeal suctioning • Tracheostomy tube replacement • Tracheostomy care |
| Ostomies | <ul style="list-style-type: none"> • Ostomy care • Ostomy irrigation |
| Medical Support Systems | <ul style="list-style-type: none"> • Ventricular peritoneal shunt monitoring • Mechanical ventilator monitoring and emergency care • Oxygen administration • Nursing care associated with Hickman/Broviac/IVAC/IMED • Nursing care associated with peritoneal dialysis • Apnea monitoring • Medications: Administration of medications-oral, injection, inhalation, rectal, bladder, instillation, eye/ear drops, topical, intravenous |
| Collecting and/or Performance of Test | <ul style="list-style-type: none"> • Blood glucose • Urine glucose • Pregnancy testing |
| Other Nursing Procedures | <ul style="list-style-type: none"> • Sterile dressing • Soaks |
| Development of Health Care and Emergency Protocols | <ul style="list-style-type: none"> • Health care procedures • Emergency Protocols • Health for Individual Education Plan (IEP), Individual Family Services Plan (IFSP), or Individualized Treatment Plan |

SECTION 2 POLICIES AND PROCEDURES

OTHER MEDICAID-COVERED SCHOOL-BASED SERVICES

Emergency Care

Emergency Care is the assessment, planning, and intervention for emergency management of a child with a chronic or debilitating health impairment.

The provision of emergency care may include the following:

- Nursing assessment and emergency response treatment (*e.g.*, CPR, oxygen administration, seizure care, administration of emergency medication, and triage).
- Post-emergency assessment and development of preventive action plan

Individual/Group Health Counseling

Individual/Group Health Counseling is the nursing assessment, health counseling, and anticipatory guidance for a child's identified health problem or developmental concern. There is no reimbursement for Health Education.

Documentation

See Documentation Requirements under General Information earlier in this section.

SECTION 2 POLICIES AND PROCEDURES

SOUTH CAROLINA MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING

Some of the activities routinely performed by school districts are activities that could be eligible for Medicaid reimbursement under the School District Administrative Claiming (SDAC) Program. The South Carolina Medicaid School-Based Administrative Claiming Guide is intended to provide information for schools, State Medicaid Agencies, Centers for Medicare & Medicaid Services staff, and other interested parties on the existing requirements for claiming Federal Financial Participation (FFP). To obtain a copy of the guide, contact your Medicaid program manager.

SECTION 2 POLICIES AND PROCEDURES

SOUTH CAROLINA MEDICAID SCHOOL-BASED ADMINISTRATIVE CLAIMING

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SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Requirements for Participation in Community-Based Services

Community-Based Children's Behavioral Health Services are designed to provide necessary treatment services and support to children and their families within the context of each child's current home and community. Intervening while the child is still in his or her home can help prevent more restrictive interventions.

Potential providers of Therapeutic Behavioral Services and Psychosocial Rehabilitation Services must complete the following steps in order to become enrolled Medicaid providers.

Step 1: The potential provider is to submit a detailed proposal describing the services to be rendered and the structure of the organization. Proposal pages must be numbered. The proposal must be submitted to the SCDHHS for review to determine compliance with minimum Medicaid Standards for the service. Incomplete proposals will be returned.

Please submit three copies of the proposal to:

Department of Health and Human Services
Behavioral Health Services
Post Office Box 8206
Columbia, SC 29202-8206

The proposal needs to address, at a minimum, the following components:

1. A detailed program description outlining how the service is to be provided, including the following:
 - a) Mission statement
 - b) Organizational chart (if the enrolling entity currently provides any Medicaid-reimbursable services, this must be delineated on the chart)
 - c) Program structure, days and hours of operation
 - d) Treatment philosophy and model(s)

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Requirements for Participation in Community-Based Services (Cont'd.)

- e) Population to be served, including age, diagnosis, and problem profile of children eligible for program services
 - f) Program policies
 - g) History and background of the provider
 - h) Assurance of financial viability. If an independent audit of the organization has been conducted within the past two years, enclose a copy of the Independent Auditor's Report Statement.
 - i) Copies of all provider-proposed personnel and program forms
2. A copy of the program's Standard Operating Policy and Procedures, to include crisis procedures, emergency safety procedures, and a copy of the Personnel Manual
 3. Staff training plan, including completion of all pre-enrollment training
 4. Provider's policy for ensuring staff meet appropriate qualifications
 5. For PRS, a completed budget that outlines reasonable, anticipated costs and specifies the number of children to be served by the program. **No "start-up" funds can be provided.** (Contact Behavioral Health Services program staff.)
 6. Information regarding licensing authority and a written description of corporate structure of the entity/organization
 7. Letters of support from the referring agencies and any applicable Memoranda of Agreement with collaborative agencies

All providers of Therapeutic Behavioral Services and Psychosocial Rehabilitation Services will be subject to applicable state licensure regulations. If not part of a school district program, a Therapeutic Behavioral Services provider must be licensed as a Daycare Center by the Department of Social Services. A provider must be a public or private entity that is governed by a Board of Directors and/or is part of an established entity/corporation

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Requirements for Participation in Community-Based Services (Cont'd.)

that provides administrative oversight. Providers who are part of the Department of Mental Health (DMH) or the Department of Alcohol and Other Drug Abuse Services (DAODAS) or LEA network are referred to their own agencies' provider manuals for more specific enrollment requirements.

Potential providers should contact the Department of Behavioral Health Services for additional information.

Step 2: Upon receiving a completed proposal, BHS will initiate the review and approval process. During this process, providers may be contacted for additional information. Once enrolled, providers are required to submit an **annual cost report** within 90 days following the end of their fiscal year for each Medicaid service they are enrolled to provide. The annual cost report should be sent to:

SCDHHS
Division of Ancillary Reimbursements
Post Office Box 8206
Columbia, SC 29202

Program Expansion

Providers of Therapeutic Behavioral Services and Psychosocial Rehabilitation Services wishing to expand the scope of their services, thus increasing the number of children served, must obtain approval from the appropriate BHS program representative prior to expansion. Providers will be required to submit, at a minimum, an updated program description and any changes in policies and procedures since initial approval, and may be required to submit a new budget.

Unit of Service

Community-Based Children's Behavioral Health Services must be billed in units as defined in the service standard. For the purpose of Therapeutic Behavioral Services programs, a billable unit is defined as a 15-minute block of time **during which** the child receives Medicaid-reimbursable treatment services from a treatment provider. Medicaid may be billed for a unit of service only if the child received some treatment services during that time period. Therapeutic Behavioral Services programs may be reimbursed for home visits.

For the purpose of **Psychosocial Rehabilitation Services (PRS)**, a billable unit is defined as a day on which the child

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Unit of Service (Cont'd.)

receives Medicaid-reimbursable treatment services from a treatment provider.

Providers must maintain adequate documentation to support the number of units billed. For Psychosocial Rehabilitation Services, the LCS should place a "P" in the appropriate blocks on the Progress Summary Note for each day the child received treatment. An "A" should be used for each absent day. The date of discharge should be annotated with a "D." Psychosocial Rehabilitation Services "Transition" days should be documented with a "T." Treatment services are billable from the date of admission.

Training Requirements

All community-based service providers must ensure that staff members working directly with clients successfully complete a course from a certified trainer in the prevention and management of aggressive behavior with an emphasis on de-escalation skills. In addition, annual refresher courses must be provided. For more information, refer to the subsection on Emergency Safety Interventions.

PSYCHOSOCIAL REHABILITATION SERVICES (FORMERLY CLINICAL DAY PROGRAMMING)

Definition

Psychosocial Rehabilitation Services (PRS) (formerly Clinical Day Programming) is a comprehensive system of individual, family, and group treatment services dedicated to the mitigation of the effects of serious emotional and/or behavioral disturbances on children and adolescents. Children referred to Psychosocial Rehabilitation Services are typically needing a structured educational/social setting in which their maladaptive behaviors may be therapeutically remediated with the ultimate goal of producing sufficient change so that the children can function successfully in a less restrictive setting.

Psychosocial Rehabilitation Services must be provided in coordination with the local school district for children ages 6 to 21. Treatment is provided within a psychosocial context involving programming that integrates therapeutic interventions in an educational setting crafted to provide a more effective response to the individual needs of children

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Definition (Cont'd.)

and their families.

At the level of the individual child, interventions designed to enhance social problem solving skills, positive interaction skills, and anger control will be delivered in accordance with a formal treatment curriculum that includes group and individualized programming as well as classroom goal-setting exercises. Aversive parent-child interaction, inconsistent discipline, and disruptions in the parent-child affective bond (e.g., parental rejection) are associated with serious behavior problems in children. Research has demonstrated that the failure to address these issues is associated with the failure of treatment to produce behavior changes in children. Therefore it is essential that parenting interventions be conducted within the context of PRS.

For the purposes of this program, family may be defined as any of the following:

- Biological parent(s)
- Step-parent(s)
- Relative(s) who have legal guardianship
- Adoptive parent(s)
- Permanent caregiver

When a child is in an out-of-home placement, and the plan is for the child to return home, the family must be an integral part of the implementation of the child's treatment plan.

When a child is in an out-of-home placement, and the child is not expected to return home, the primary significant other (case manager, residential services staff, etc.) must be an integral part of the implementation of the child's treatment plan.

Expected outcomes of this service are to prevent more costly and restrictive treatment options and to aid children in functioning successfully within their home and school environments.

Treatment goals shall be developed that will enable the student to:

1. Show a significant reduction in behaviors that could constitute a risk to the safety of self or others,

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Definition (Cont'd.)

and/or demonstrate manageable behaviors in any and all environments

2. Develop adaptive interaction styles, as well as adaptive problem solving and coping strategies
3. Demonstrate an enhanced ability to learn as evidenced by increased attention span, increased ability to engage in developmentally and socially appropriate activities, and increased capability to interact appropriately with adults and peers across various situations
4. Successfully transition to a less restrictive educational placement

Treatment goals shall be developed that will enable the family to:

1. Learn effective strategies for managing problem behaviors and interacting with their child
2. Identify and develop a collaborative and supportive relationship with school personnel aimed at optimizing the child's academic and social functioning

Although an intensive service, Psychosocial Rehabilitation Services should be provided in a setting with a level of restrictiveness commensurate with the client's needs. This service is intended to be community-based and may be provided by public and private providers in both traditional and non-traditional educational settings. Such programming is to be regarded as a treatment service rather than a place, so that flexibility and individualization are a natural consequence. For continuity of care, services should be rendered five days per week.

All providers of PRS must adhere to all of the standards outlined under Emergency Safety Interventions (see ESI under Program Requirements).

Medical Necessity and Prior Authorization

Services shall be recommended by a physician or other Licensed Practitioner of the Healing Arts for a child who fulfills one or more of the following descriptions:

1. The child currently displays behavior problems serious enough to jeopardize current school and/or

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

home placement and/or that make the child a risk to the safety of self or others.

2. The child is emotionally disturbed or mentally ill to the extent that a diagnosis using the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is applicable. This includes the use of appropriate V-codes for diagnostic purposes.
3. The child is returning home or to a family-like setting following a psychiatric hospitalization or a residential placement, and Psychosocial Rehabilitation Services is considered the most appropriate setting prior to the child returning to a less restrictive school placement.

The physician or other Licensed Practitioner of the Healing Arts will complete a Medical Necessity Statement (see the Forms section) authorizing the service delivery. The Medical Necessity Statement must substantiate the need for the Psychosocial Rehabilitation Services as evidenced by the above criteria. The Medical Necessity Statement must be received from the referring state agency/entity at the time of admission to the program (a faxed copy is acceptable) and placed in the client's record with the initial treatment plan. The original Medical Necessity Statement must be received from the referring state agency/entity within 10 days of admission to the program and placed in the client's record. If the child is readmitted to this service following a discharge, a new Medical Necessity Statement must be completed.

If applicable, services must be pre-authorized by a designated agent. This is accomplished through completion of the Referral Form/Authorization for Services (DHHS Form 254) (See the Forms section), which is presented to the provider by the referring agent at time of admission. The Referral Form is required when state agencies refer to private treatment providers.

Program Staff

Program Director

Qualifications

Psychosocial Rehabilitation Services supervision and treatment services shall be under the direction of a

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Director (Cont'd.)

Program Director who may also be the Supervising Lead Clinical Staff (LCS). Individuals holding a professional license must be licensed to practice in the state in which they are employed. The Program Director shall be a professional who must meet one of the following qualifications:

- A **Psychiatrist** is an M.D. who has completed residency in psychiatry.
- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners.
- A **Licensed Psychologist** holds a doctoral degree in psychology from an accredited university or college and is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling areas.
- A **Mental Health Counselor** holds a master's or doctoral degree from a program that is primarily psychological in nature (e.g., counseling, guidance, social science equivalent) from an accredited university or college.
- A **Mental Health Professional Master's Equivalent** holds a master's degree in a field that is closely related to the bio-psycho-social sciences or treatment of the mentally ill, or holds a master's degree in a reasonably related field that is augmented by graduate courses and experience in a closely related field. Also, appropriate Ph.D. candidates who have bypassed the master's degree but have more than enough hours to satisfy a master's requirement, as well as professionals who are credentialed as Licensed Professional Counselors or Marriage and Family Therapists, can be considered Mental Health Professional Master's Equivalents.
- A **Social Worker** holds a master's degree from an accredited college or university and is licensed by the appropriate State Board of Social Work Examiners.
- A **Clinical Chaplain** holds a Master of Divinity degree from an accredited theological seminary and

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Director (Cont'd.)

has two years of pastoral experience and one year of Clinical Pastoral Education that includes provision of supervised clinical services.

- A **Psychiatric Nurse** is a registered nurse with a master's degree in psychiatric nursing.

Responsibilities

The Director shall provide program oversight and be available for consultation regarding treatment issues and special client needs.

Lead Clinical Staff

Qualifications

Psychosocial Rehabilitation Services shall be supervised and rendered by a Lead Clinical Staff (LCS) who must meet the professional standards as defined by SCDHHS. For the purposes of Psychosocial Rehabilitation Services, the following professionals may serve as Lead Clinical Staff in addition to those listed in the section **Clinical Staff** under Staff Requirements earlier in this section:

- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners and has a minimum of one year of experience working with the population to be served.
- A **Psychiatrist** is a licensed M.D. who has completed residency in psychiatry and has a minimum of one year of experience working with the population to be served.
- An **Early Childhood Specialist** holds a master's degree in early childhood education or child development and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse** is licensed to practice as a registered nurse with advanced practice certification in the state in which he or she is rendering services, is practicing under a physician preceptor according to a mutually agreed-upon protocol, and has a minimum of one year of experience working with the population to be served.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (Cont'd.)

- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse Specializing in Psychiatric Nursing** is licensed to practice as a registered nurse with advanced practice certification and is practicing under a physician preceptor according to a mutually agreed-upon protocol. Additionally, this advanced practice nurse has completed advanced study and clinical practice, as in a master's program in psychiatric nursing, has gained expert knowledge in the care and prevention of mental disorders, and has a minimum of one year of experience working with the population to be served.

Prior to rendering the PRS, all Lead Clinical Staff (LCS) must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.

The LCS must attend a minimum of 20 documented contact hours of training annually.

Responsibilities

The Lead Clinical Staff (LCS) will specify program content to be addressed based on client needs. The LCS shall be responsible for the following:

- The LCS must ensure that all treatment staff receive the minimum equivalent of 20 training hours annually, with additional in-service training provided as needed. All training activities shall be documented and maintained on file at the program site. Case supervision and consultation do not supplant training requirements.
- The LCS must provide case supervision and consultation a minimum of two hours per week. Supervision hours may be incrementally distributed throughout the week as the LCS deems appropriate. The LCS must maintain supervision records.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (Cont'd.)

- The LCS must assure that services are provided to children in a safe, efficient manner in accordance with accepted standards of clinical practice.
- The LCS must be involved in each child's assessment and treatment, including participation in the planning and implementation of the child's individual treatment plan, 90-day treatment plan reviews, and the development of the weekly Progress Summary Notes.

Non-Lead Clinical Staff

Qualifications

Non-Lead Clinical Staff (Non-LCS) must meet the following qualifications in order to render the Psychosocial Rehabilitation Services:

- The Non-LCS must either possess a bachelor's degree from an accredited university or college or be a non-degreed paraprofessional who demonstrates the theoretical and/or practical knowledge of treatment of emotional and behavioral child and adolescent disturbances.
- Prior to rendering the PRS, all Non-LCS must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.
- The Non-LCS must be privileged by the program to render PRS under supervision of the LCS.
- The Non-LCS must have a minimum of 20 documented contact hours of training per year.

All Non-LCS shall receive a minimum of two hours of case supervision per week, provided by the LCS staff.

Responsibilities

The Non-LCS will conduct observations and treatment interventions as specified in the child's Individual Treatment Plan and as directed by the Supervising LCS.

Staff-to-Client Ratio

All of the following apply:

- There shall be a minimum of one treatment staff to each eight clients.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Staff-to-Client Ratio (Cont'd.)

- Each Psychosocial Rehabilitation Services program will have a minimum of two treatment staff. There shall be a minimum of two treatment staff at each PRS site. One of the treatment staff must be the LCS.
- Treatment staff shall have direct contact with children during program hours

Program Content

Each PRS program will provide specific treatment activities within a structured environment that supports the development of appropriate behaviors, skills, emotional growth and satisfactory family and peer relationships. Each child's participation in the activities provided will be summarized in a weekly Progress Summary Note. Activities that are purely educational are necessary components of Psychosocial Rehabilitation Services but are not Medicaid-reimbursable services. Educational services are rendered in addition to and in collaboration with the Psychosocial Rehabilitation Services.

The services listed below are the components of PRS.

Assessment and Evaluation

Behavioral, emotional, and environmental assessment and evaluation services provide a determination of the nature of the child's and/or family's problems, factors contributing to the problems, and the strengths and resources of the client and family. Psychosocial Rehabilitation Services provide a safe environment in which to evaluate the client's functioning level and respond with structured interventions.

Group Interventions

Psychosocial Rehabilitation Services include face-to-face process interactions between staff and clients. These interactions are directed to focus on the development of age-appropriate emotional, intellectual, behavioral, and interpersonal role functioning within groups. Settings for group interventions may vary from group discussion to "play therapy" or other group modalities facilitating problem identification, processing, and resolution. Client outcomes of these interventions should be directly related to the child's ITP and may include, but are not limited to: enhanced self-esteem; improved problem solving skills and

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Content (Cont'd.)

task completion abilities; demonstrated self control; improved peer, teacher, and parent interactions; enhanced communication skills; improved direction-following capabilities; enhanced self-understanding; and appropriate use of leisure time. Group Interventions shall be delivered **by the LCS** a minimum of one time per week. Group Interventions shall be at least one hour in duration.

Individual Interventions

Client-staff interactions designed to direct the child toward acceptable, adaptive behavior are included as part of the program's treatment. Staff will provide face-to-face therapeutic interactions with individual children on an "as needed" basis. The purpose of such interventions is to facilitate individualized opportunities for children and staff to identify problems, examine impediments to achieving desired results, and to reframe problems in ways that formulate solutions. Individual Interventions shall be delivered **by the LCS** a minimum of one time per week.

Rehabilitative Psychosocial Therapy

Included are therapeutic activities designed to improve or preserve the child's level of functioning. This component is designed to facilitate therapeutic interaction between staff, children, and community, as well as to provide children with reality orientation, minimize self-involvement, improve interpersonal skills, and improve concentration when participating in these goal-directed activities.

Coordination and Linkage

Psychosocial Rehabilitation Services include the provision of coordination and linkage with needed community services and resources. This involves coordinating services with the educational, social, criminal justice, and health/mental health systems. **These efforts should not duplicate or replace efforts of the child's designated case manager.** Regular communication and collaboration with any or all disciplines involved in serving the child and his or her family should be incorporated within the structure of Psychosocial Rehabilitation Services. Treatment planning meetings and progress assessment staffings should encourage participation from all disciplines relative to the needs of the child.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Content (Cont'd.)

Crisis Management

Crisis Management is an intense component provided immediately to the identified child following abrupt or substantial changes in the child's functioning. Crisis Management can be employed to reduce the immediate personal distress, to assess the precipitant(s) that resulted in the crisis, and/or to reduce the chance of future crisis situations through the implementation of preventive strategies.

Family Involvement

Psychosocial Rehabilitation Services include planned interactions between staff, the child, and the child's family and/or significant others. Staff must be culturally competent and work with parents as partners in every way possible. The purpose of family involvement should be to identify and address any family-related barriers to the success of PRS and to mobilize family resources to support the treatment goals of PRS. Monthly family involvement is strongly encouraged. One home visit (*e.g.*, to the child's current living arrangement) is required per school year. If extenuating circumstances prevent the program staff from completing the home visit, the reasons preventing the visit shall be documented in the child's clinical record.

Transitioning

The overriding goal of Psychosocial Rehabilitation Services is for the child to make sufficient progress so that he or she may be returned to a less restrictive school setting. When a child changes from a treatment setting that is highly structured, predictable, and interpersonally supportive to a less restrictive school setting that provides less support and guidance, it is very difficult for the child to transfer the skills gained in the treatment settings. In order to increase the likelihood of a successful transition, a clear plan for transition activities should be part of the child's treatment plan. The program should develop a schedule for the implementation of the child's transition, indicating when Transition Days are to be used.

Transition activities include client visits to the proposed receiving site and return visits, as needed, to PRS services. When applicable, return visits to the program are reimbursable as long as the services are rendered within

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Content (Cont'd.)

the dates provided on the Referral Form (DHHS Form 254). Return visits must be documented on the weekly Progress Summary Note and the client's treatment plan must be current and reflect the goals of these visits.

Programs may bill Medicaid for a maximum of 20 Transition Days per client program admission. The program should annotate Transition Days with a "T" in the attendance documentation section of the weekly Progress Summary Note. Clinical documentation of Transition Days shall include but is not limited to the following:

- The length and nature of the visit to the proposed receiving school
- Staff interventions and support on behalf of the client
- The client's progress on treatment goals and interventions
- Any collaborative activity with personnel at the receiving school that is in support of the treatment goals and interventions

Length and Frequency of Service

The PRS program shall meet the following operational guidelines:

- The Psychosocial Rehabilitation Services day must last a minimum of four hours.
- A therapeutic schedule must be in place authenticating the activities that constitute the length of the program day.
- Treatment should be offered a minimum of five days per week.
- Treatment services delivered on the child's last day in the program are billable.
- The PRS program must be operational a minimum of 180 days during the year. This does not preclude the program offering PRS services during the summer.
- Wraparound Services **may not** be billed concurrently with PRS; i.e., during PRS program hours.
- The PRS program must include a strong educational component reflecting coordination with

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Length and Frequency of Service (Cont'd.)

the local school district.

- In order to prevent disruption of PRS therapeutically scheduled activities, services rendered by other providers during the PRS day must be coordinated by both entities. Documentation of coordination efforts must be reflected in the clinical service notes.

Documentation

Medicaid reimbursement is directly related to the delivery of services. Each clinical record must contain adequate documentation to support the services rendered and billed. Documentation of the treatment services provided to the child, the child's responsiveness to the treatment, and the interaction and involvement of the staff with the child and family should justify and support the services billed to Medicaid.

The record contains, at a minimum, the essential elements outlined under **Clinical Records**.

Individual Treatment Plan

Initial Treatment Plan

An individual treatment plan must be developed for every child by or before the 30th day of admission in the program. If a treatment plan is not developed within 30 days, services rendered from the 31st day until the date of completion of the treatment plan are **not Medicaid reimbursable**. The treatment plan shall be based on an assessment of the strengths and needs of the child and family, and shall address the following:

- Specific problems or behaviors requiring treatment
- Treatment goals and interventions
- Methods and frequency of interventions
- Target dates for completion

Treatment plans must be completed, signed, and dated on each page by the LCS on or before the 30th day present in the program. The child and the family must review and sign the treatment plan on or before the child's 30th day in the program. If the client does not sign the treatment plan or if it is not considered appropriate for the client to sign the treatment plan, the reason the client did not sign must be documented in the clinical record.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Individual Treatment Plan (Cont'd.)

Treatment Plan Review

Treatment plan reviews must be conducted quarterly, 90 days from the date the treatment plan is signed, to assure services and treatment goals continue to be appropriate to the child's needs and to assess the child's progress and continued need for services. The review of the treatment plan is a clinical opportunity to revise goals and interventions or note the completion of others. New goals and interventions may be added during this review. The LCS must sign/title and date each page of the treatment plan at each review. The treatment plan is a working document and should be continuously refined and revised as progress is made and/or new therapeutic issues arise. Modifications should be signed/titled and dated by the LCS.

Treatment Plan Reformulation

The treatment plan must be reformulated annually; i.e., at the beginning of each new school year.

Progress Summary Notes

The Progress Summary Note summarizing program participation, psychosocial/behavioral status and functioning, and progress on treatment goals and interventions must be completed every week. The weekly note must be placed in the client's record within one week following the last service rendered. In order to provide a pertinent clinical description, the documentation must address the following:

- A general observation of the child's condition
- The child and child's family activity and participation in the treatment program
- The child's progress on treatment goals and response to treatment
- Activities of the treatment staff. The involvement of the staff in service provision is required and shall be documented.
- Future plans for working with the child

Lead Clinical Staff must **sign/title and date** the Progress Summary Note as the person responsible for the provision of service. The LCS's signature verifies that the services were provided in accordance with these standards.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Evaluation

To the extent measurable, programs will be evaluated on their effectiveness in the prevention of more costly and restrictive treatment options and in assisting children to function successfully within their home and school environments. Programs shall submit an annual report to the SCDHHS BHS program representative describing their progress in meeting the outcome criteria 90 days after the close of the state fiscal year. Programs will be expected to meet the following outcome criteria targets.

OC1: After planned discharge, at a minimum 90% of the children that were enrolled in Psychosocial Rehabilitation Services will have achieved at least 75% of the goals on their individual treatment plans.

OC2: At a minimum, 75% of children who have been successfully discharged are residing with a consistent, stable caregiver/family for at least three months following discharge. (See the definition of "family" at beginning of Psychosocial Rehabilitation Services.)

OC3: At a minimum, 75% of children and families indicate satisfaction with the PRS.

OC4: The child's attendance in the PRS program is improved over the child's attendance in his or her previous school placement. The child's unexcused absences shall decrease by at a minimum 50%.

OC5: For those children returning to a less restrictive school environment following discharge, at a minimum 80% will experience at least 50% fewer suspensions/disciplinary actions than before their enrollment in PRS.

OC6: For those children not returning to the public school system because of age, at a minimum 50% will be engaged in at least one of the following:

- Completion of their GED
- Vocational training
- Gainful employment

OC7: For those children successfully discharged from PRS program, at a minimum 80% will not return to PRS or a higher level of care within six months from the date of discharge.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

THERAPEUTIC BEHAVIORAL SERVICES (FORMERLY THERAPEUTIC CHILD TREATMENT)

Definition

Therapeutic Behavioral Services (TBS) is a psychosocial and developmental system of services for young children birth through age six. The goal of this service is to cultivate the psychological and emotional well-being of children and to promote their developing competencies.

The child will show significant problem indicators in any one or more of the following developmental areas: behavioral, emotional, social, cognitive, bonding, self-help, receptive and/or expressive language, and physical.

Service delivery is facilitated through direct treatment services to the child and intervention with the family. An integrated complement of services provided by staff includes a well-structured treatment environment; monitoring and changing interactions of the child and family; individual, group, and family therapy; and in-home observation and intervention modalities.

Expected outcomes of this service are the prevention of child maltreatment, the relief of the effects of abuse and neglect, and the empowerment of families to meet the therapeutic needs of their children.

Medical Necessity and Prior Authorization

Therapeutic Behavioral Services (TBS) must be recommended by a physician or other Licensed Practitioner of the Healing Arts, within the scope of his or her practice under state law. The following list indicates the professional designations of those considered Licensed Practitioners of the Healing Arts:

- Physician
- Licensed Psychologist
- Registered Nurse with a Master's Degree in Psychiatric Nursing
- Advanced Practice Registered Nurse with Certification in Psychiatric Nursing
- Advanced Practice Registered Nurse

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Physician's Assistant
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

Determination of medical necessity shall include a developmental and emotional screening tool that is clinically sound and age appropriate such as the Denver Developmental Screening Test II used in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings.

Medicaid-eligible children may be referred for Therapeutic Behavioral Services when one of the following issues is documented:

- The child is unable to succeed in regular child care due to substantiated developmental or behavioral problems.
- The child exhibits developmental or behavioral problems as a result of substantiated case(s) of abuse and/or neglect.
- The child is in imminent danger of being removed from the home due to substantiated developmental or behavioral problems.

The medical necessity for a child's placement in a TBS program must be substantiated with a diagnosis using the most current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This includes the use of V-codes.

The Medical Necessity Statement authorizes the placement of the child in TBS. The Medical Necessity Statement must be signed by a physician or other Licensed Practitioner of the Healing Arts and accompanied by the developmental and emotional screening tool. The Medical Necessity Statement and the developmental and emotional screening tool shall be placed in the child's clinical record on or by the 15th day of service. (See Section 5 for a copy of the Medical Necessity Statement for Therapeutic Behavioral Services.)

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

The SCDHHS Referral Form/Authorization for Services (Form 254) **is required** when state agencies refer to private treatment providers. When applicable, this form must also be maintained in the child's clinical record. (See the Forms section for a copy of Form 254.)

If the child is re-entering this service, a new Medical Necessity Statement and an updated developmental and emotional screening tool must be completed using the medical necessity criteria listed above.

Program Staff

Supervising Lead Clinical Staff (LCS)

Qualifications

The Supervising LCS must meet the qualifications and professional standards outlined by the Department of Health and Human Services. Each program site must designate one LCS as the Supervising LCS with the following qualifications.

- The Supervising LCS shall complete a minimum of 20 contact hours of training per year.
- Prior to rendering TBS, all Supervising LCS must show documentation of 40 contact hours of training in child development and/or early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.

Responsibilities

The Supervising LCS shall be responsible for all decision-making in evaluating, assessing, and treating children who are receiving TBS.

The Supervising LCS is responsible for providing supervision to all treatment staff. Every staff person must receive a minimum of two hours of supervision per week. Supervision may take place in either a group or individual setting. Periods of supervision can be scheduled incrementally, as deemed appropriate by the Supervising LCS. Supervision must include opportunities for discussion of treatment plans and client progress. The Supervising LCS shall maintain a log documenting all staff supervision. This log will also include weekly case consultation with staff. Case supervision and consultation

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Supervising Lead Clinical Staff (LCS) (Cont'd.)

do not supplant training requirements.

The Supervising LCS in each TBS program will be responsible for maintaining a written program description that includes the following:

- A developmentally appropriate curriculum with goals and expected outcomes
- A treatment protocol outlining the program methodology for enhancing/stimulating appropriate behaviors
- An outline of the procedures and instruments in place to provide the assessment services
- A description of treatment services for the child's family

Lead Clinical Staff (LCS)

Qualifications

The LCS must meet the professional standards outlined by SCDHHS. Individuals wishing to be designated in one of the categories requiring a professional license must be licensed to practice in the state in which they are employed and function within the scope of their practice under state law. The following professionals qualify as LCS:

- A **Psychologist** holds a doctoral degree in psychology from an accredited university or college and is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling areas. A minimum of one year of experience working with the population to be served is required.
- A **Registered Nurse** is a licensed RN who has a bachelor's degree from an accredited university or college and has a minimum of three years of experience working with the population to be served.
- A **Mental Health Counselor** holds a doctoral or master's degree from an accredited university or college in a program that is primarily psychological in nature (*e.g.*, psychology, counseling, guidance, or social science equivalent) and has a minimum of one year of experience working with the population to be served.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (LCS)
(Cont'd.)

- A **Social Worker** holds a master's degree from an accredited university or college, is licensed by the State Board of Social Work Examiners, and has a minimum of one year of experience working with the population to be served.
- A **Mental Health Professional Master's Equivalent** holds a master's degree in a closely related field that is applicable to the bio-psych-social sciences or to treatment of the mentally ill; or is a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirement; or is a professional who is credentialed as a Licensed Professional Counselor and has a minimum of one year of experience working with the population to be served.
- A **Clinical Chaplain** holds a Master of Divinity degree from an accredited theological seminary and has one year of Clinical Pastoral Education which includes provision of supervised clinical services. A minimum of one year of experience working with the population to be served is required.
- A **Child Service Professional** holds a bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development, or a related field including but not limited to criminal justice, rehabilitative counseling, elementary or secondary education; or holds a bachelor's degree in another field and has additional training (a minimum of 45 documented hours of training that could include undergraduate or graduate courses, workshops, seminars, or conferences in issues related to child development, children's mental health issues, and treatment) in one or more of the above disciplines. A minimum of three years of experience working with the population to be served is required for the child service professional.
- A **Licensed Baccalaureate Social Worker** holds a bachelor's degree from an accredited university or college, has been licensed by the State Board of Social Work Examiners, and has a minimum of three years of experience working with the

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (LCS) (Cont'd.)

population to be served.

- A **Certified Addictions Counselor** holds a bachelor's degree from an accredited university or college and has been credentialed by the Certification Commission of the South Carolina Association of Alcoholism and Drug Abuse Counselors, the NAADAC – The Association for Addictions Professionals, or an International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse approved certification board. A minimum of three years of experience working with the population to be served is required.

For the purposes of Therapeutic Behavioral Services, the following professionals may also serve as Lead Clinical Staff (LCS):

- A **Physician** is a doctor of medicine who is currently licensed by the appropriate State Board of Medical Examiners and has a minimum of one year of experience working with the population to be served.
- An **Early Childhood Specialist** holds a master's degree in early childhood education and/or child development and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse** is licensed to practice as a registered nurse with advanced practice certification and is practicing under a physician preceptor according to a mutually agreed-upon protocol. A minimum of one year of experience working with the population to be served is required.
- A **Licensed Marriage and Family Therapist** is licensed by the appropriate State Board of Examiners as a Marriage and Family Therapist and has a minimum of one year of experience working with the population to be served.
- An **Advanced Practice Registered Nurse Specializing in Psychiatric Nursing** is licensed to practice as a registered nurse with advanced practice certification and is practicing under a

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Lead Clinical Staff (LCS) (Cont'd.)

physician preceptor according to a mutually agreed-upon protocol. Additionally, this advanced practice nurse has completed advanced study and clinical practice, as in a master's program in psychiatric nursing, has gained expert knowledge in the care and prevention of mental disorders, and has a minimum of one year of experience working with the population to be served.

Training Requirements

- Prior to rendering TBS, all LCS must show documentation of 40 contact hours of training in child development and/or early childhood education, children's mental health issues, and/or the identification and treatment of children's mental health problems.
- The LCS shall complete a minimum of 20 contact hours of training per year.

Responsibilities

- At least one LCS shall be on call during all program hours.
- The LCS must assure that services are provided to children in a safe, efficient manner in accordance with accepted standards of clinical practice.
- The LCS's involvement in each child's assessment and treatment shall include, but not be limited to, participation in the planning and implementation of the child's Individual Treatment Plan (ITP), treatment plan reviews, annual treatment plan reformulation, and the development of the Weekly Progress Summary Notes.
- The LCS shall be involved in the active treatment for each child including group and individual therapies as appropriate.

Non-Lead Clinical Staff (Non-LCS)

Qualifications

Non-LCS treatment staff must be directly supervised by an LCS in order to assure that services are being rendered in accordance with accepted clinical practice. Non-LCS staff must be 21 years of age or older and meet one of the following standards:

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Non-Lead Clinical Staff (Non-LCS) (Cont'd.)

- Possess a bachelor's degree from an accredited university or college and have a minimum of one year of experience in working with young children.
- Possess an associate's degree or technical college diploma in early childhood education and/or child development or the equivalent and have a minimum of one year of experience in working with young children.
- Have a high school diploma or GED and a Child Development Associate (CDA) credential and one year of experience in working with young children.
- Have a high school diploma or GED; demonstrate theoretical and practical knowledge of the treatment of abused/neglected children; have at least three years of experience in working with young children; and either obtain a Child Development Associate (CDA) credential (or other nationally recognized credential) or have a plan for completing 60 hours of training approved by the SCDHHS within two years of the employee beginning the Non-LCS position. For any staff to meet this standard, a written plan must be in place that demonstrates the individual is actively working toward achieving this credential/training.
- Prior to rendering TBS, all Non-LCS must show documentation of 40 contact hours of training in child development/early childhood education, children's mental health issues, and the identification and/or treatment of children's mental health problems.
- The Non-LCS shall complete a minimum of 20 contact hours of training per year.

Responsibilities

The Non-LCS will conduct observations and treatment interventions as specified in the child's individual treatment plan and directed by the Supervising LCS.

Staff Assistant (SA)

Qualifications

A staff assistant (SA) must be 18 years of age or older with a high school diploma or a GED. Under the supervision of

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Staff Assistant (SA) (Cont'd.)

a LCS, an SA assists in carrying out program activities. An SA must receive the equivalent of 25 hours of training annually.

Responsibilities

An SA will assist the Supervising LCS, other LCS, and Non-LCS staff as needed.

Program Content

Each Therapeutic Behavioral Services program will provide specific treatment activities within a nurturing, structured environment that supports the development of appropriate behaviors, skills, emotional growth, and family relationships. The services listed below are the components of TBS.

Assessment

Assessment is the professional determination of the child's and family's functioning. At a minimum, an assessment shall include an age-appropriate evaluation of the child's developmental as well as emotional and/or behavioral domains, a description of the nature of the child/family's identified problem(s) and the factors contributing to those problems, a family history and assessment of strengths and needs, and a home environmental assessment. Results of observations of the child, caregiver, and caregiver-child interactions must be documented. Ongoing assessments should be conducted as needed.

Treatment

A general treatment milieu will consist of direct interventions with the child and with the caregiver, provided by the Supervising LCS, other LCS, and Non-LCS staff, with support as needed from staff assistants.

Skill Development

Children will participate based on need as defined in the initial assessment. Interventions with the child shall include activities aimed at promoting fine motor, gross motor, personal-social, communication, and cognitive skills. These activities, provided by treatment staff, will be represented on the child's individual treatment plan and modifications will be made as the child progresses.

Emotional-Behavioral Interventions

Interventions at this level will be accomplished through therapeutic activities based on the results of the assessment and shall be indicated on the child's Individual Treatment

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Treatment (Cont'd.)

Plan (ITP). These therapies shall include interactions with treatment staff one-on-one, in child groups, and with child and family. Individualized techniques for enhancing/stimulating age-appropriate behaviors and emotional and developmental progression must be part of the milieu.

Rehabilitative Psychosocial Therapy

These activities are designed to improve the child's level of functioning and facilitate therapeutic interaction between treatment staff, child, family, and community. These activity therapies provide children with opportunities for reality orientation, minimizing self-involvement, and developing improved interpersonal skills as well as improved concentration abilities.

Group Therapy

Programs are encouraged to offer group therapy to families. Group sessions should be designed to be family friendly and culturally sensitive with specific efforts made to work with parents as partners as much as possible. **Appropriate TBS therapies may include Living Skills classes, but these classes are not Medicaid-reimbursable services.** Group therapy sessions shall focus on treatment collaboration between staff and caregivers in the sharing of information, teaching of familial interventions, and exploring of child development theory and behavior management techniques. These sessions should be directed toward empowering families to be active participants in the treatment process.

Family Therapy

Family therapy is part of the treatment milieu provided by the treatment staff. These modalities are employed both in the center and in the child's home. The treatment staff assists the family in the development of skills to manage child behaviors that put undue stress on the parent and counsel with the family on resolving issues contributing to difficulties in successfully parenting the child. Family therapy presents the opportunity to monitor parent/caregiver-child interactions and provide situational counseling as appropriate.

Home Visit

A home visit is defined as a face-to-face encounter with the TBS child and/or primary caregivers. The objective of the

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Treatment (Cont'd.)

home visit is to conduct assessments of the child's family unit environment. Treatment staff should initiate interventions within the family's home or setting where the child and family reside, thereby enabling the primary caregiver(s) the ability to address the child's behavior problem and/or developmental delay. Treatment staff in collaboration with the child's caregiver(s) should use this time to share information, teach familial interventions, and explore child development and behavior management techniques. Interventions should include continued access to appropriate and available services.

In order for the TBS home visit to be reimbursed by Medicaid, the following must apply:

- The home visit must be conducted by a Supervising LCS or LCS.
- The home visit must be conducted in the home or other appropriate setting. During the visit, caregiver(s)/child interactions can be monitored and appropriate interventions implemented in accordance with the child's ITP.

In situations where it is not deemed clinically appropriate to conduct the visit in the child's home, the provider must document this in the clinical record and indicate where the visit(s) will be conducted.

Mainstreaming

The child may be mainstreamed in a classroom or regular daycare setting where appropriate. In accordance with the child's ITP, TBS staff will work in collaboration with the child's caregivers and other care staff to:

- Maintain current TBS skills
- Monitor behavior
- Initiate interventions

Mainstreaming activities must be documented in the Weekly Progress Summary Note.

Coordination and Linkage

Therapeutic Behavioral Service providers should incorporate into their service delivery coordination and linkage with other disciplines involved or potentially involved in serving the child and his or her family. Providers should work in collaboration with case managers

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Coordination and Linkage (Cont'd.)

to arrange needed services for the child/family who are jointly served.

Staff-to-Client Ratio for Center-Based Services

An LCS or Non-LCS treatment staff member must always be a part of staff-to-client ratio. When staff assistants are included in the ratio, an LCS or Non-LCS must also be a part of that ratio. For example, if there is a group consisting of eight children, 5 and 6 years of age, the ratio may be accomplished with either an LCS or a Non-LCS treatment staff and a staff assistant.

Staffing patterns shall provide for the adult supervision of children at all times and the immediate availability of additional adult(s) for assistance whenever needed. The following minimum staff-to-client ratios shall apply at all times:

- Birth through age two, one staff member to every three children
- Age three through age six, one staff member to every five children
- Mixed age group, one staff member to every three children

Length and Frequencies of Services

Center-Based

- A therapeutic schedule must be in place authenticating the activities that constitute the length of program day.
- Treatment should be offered a minimum of five days per week (school districts shall operate programs based on the district calendar).
- The TBS program must be operational a minimum of 180 days during the year.
- Each unit of service is 15 minutes during which the LCS or Non-LCS is either monitoring the child or engaging the child in interventions.
- The maximum number of billable units each day is 16.
- Time spent in regular (non-mainstreamed) day care services may not be included in the TBS unit of service.

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Length and Frequencies of Services (Cont'd.)

- **Mainstreaming** — Units for interventions rendered in this setting are reimbursable when TBS program staff are in the mainstreamed classroom with the TBS child, monitoring or engaging the child in TBS interventions as they relate to the classroom activities.

Home Visit

Each child's family unit is required to receive two face-to-face home visits every calendar month when the program is in session. The maximum billable frequency of this service shall be once a week. TBS rendered while the caregiver and child are housed in a residential service facility are billable as home visits.

All home visits shall be documented in the Weekly Progress Summary Note. (See Weekly Progress Summary Notes later in this section.)

Service Duration

In most cases, it is anticipated that the TBS goals will be met within 18 months of initiation of the services. Services may be extended for an additional six months if clinically warranted and with the approval and authorization of the referring state agency. The clinical determination for the extension must be documented in the clinical record.

If a client is discharged from a TBS program but subsequently re-enters the service, this is counted as a separate episode of service.

If a client reaches the age of 6 years old while in the TBS program, the provider may continue to serve the child but must discharge him or her prior to the child's 7th birthday.

Assessment

The assessment must be completed prior to the development of the child's ITP. Assessments should address the following:

- A description of the strengths of the child, family, and other systems in the ecology
- A list of impacted participants in the child's treatment. (*e.g.*, primary caregiver, secondary caregiver, other family, TBS child, school/day care, neighborhood/community)

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Assessment (Cont'd.)

- Initial goals and desired outcomes for each participant in the TBS child's treatment
- Strengths and barriers for each participant in the TBS child's treatment
- The presenting problem and the impacting issues

Additionally, the following information must be obtained during the assessment and placed in the clinical record:

- Name, date of birth, sex, and educational level of the child; current address and family's addresses, if different; and telephone number
- Names, relationships, addresses, and telephone numbers of other members of child's primary family/social network who are or may be engaged in services on behalf of the child
- Names, addresses and phone numbers of key professionals engaged in service to the identified child (*e.g.*, teacher, school counselor, attorney, and state agency personnel)
- Directions to the child's home

The assessment must be developed, signed with title, and dated by the LCS or the Supervising LCS. The Supervising LCS must sign with title and date the assessment form as the person responsible for the provision of service.

Individual Treatment Plan (ITP)

Initial Treatment Plan

An Individual Treatment Plan (ITP) is a comprehensive plan of care developed by a multidisciplinary treatment team (may include but is not limited to child's parent/caregivers, school personnel, case manager, representatives of other agencies involved in the case, and the child, when deemed appropriate) following review of the initial assessment and other pertinent clinical information. An ITP must be developed for every child by or before the 30th day of acceptance into the program and must be signed/titled and dated by the LCS. The signature/title and date of the Supervising Lead Clinical Staff are also required. The signature/title and date demonstrate that the ITP has been developed within the timelines set forth in this standard, and that the strategies outlined in the plan are sufficient to meet child/family

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Individual Treatment Plan (ITP) (Cont'd.)

treatment needs. The Supervising LCS is responsible for seeing that this plan is implemented in a manner in accordance with the Medicaid standard for TBS. The child's family or caregiver should review and sign the ITP. If a child's family/caregiver's signature is not obtained, a reason should be documented in the clinical record.

If a treatment plan is not developed within 30 days, services rendered from the 31st day until the date of completion of the treatment plan are **not Medicaid reimbursable**.

The treatment plan shall be based on an assessment of the strengths and needs of the child and family, and shall address the following:

- Specific problems or behaviors requiring treatment
- Treatment goals and interventions
- Methods and frequencies of interventions
- Target dates for completion

Treatment Plan Review

Treatment plan reviews shall be conducted at least quarterly (every 90 days) to assure that services and treatment goals continue to be appropriate to the child. The review should assess the child's progress and continued need for services. The LCS and the Supervising LCS must both sign, title, and date the reviewed plan. The Supervising LCS signature verifies that the ITP is designed for the child in accordance with the Medicaid standard for TBS. The ITP is a working document and may be modified at any time. Modifications must be signed/titled and dated by the LCS and the Supervising LCS. The child's primary caregiver should sign all treatment plan reviews. If a child's family/caregiver signature is not obtained, a reason should be documented on the treatment plan review form.

Treatment Plan Reformulation

A reformulated treatment plan must be developed every 12 months and signed/titled and dated by the LCS, the Supervising LCS, and the child's primary caregiver.

In the event a child should re-enter this service, a new treatment plan must be developed, signed/titled, and dated by the LCS and the Supervising LCS. The child's primary caregiver should sign all treatment plan reformulations. If a

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Individual Treatment Plan (ITP) (Cont'd.)

child's family/caregiver signature is not obtained, a reason should be documented on the treatment plan review form.

Individual Treatment Planning (ITP) Documentation

At a minimum, the ITP shall include the following elements:

- A description of the child and family's presenting problems including the long-term goals of the treatment plan
- Outcome-based goals for remediation of the presenting problems, and targeted completion dates

When the goal is reached, the actual completion date shall also be documented.

When a TBS child is mainstreamed (placed in the least restrictive environment/setting), documentation in the child's treatment plan must show:

- The expected benefits the TBS child receives by being mainstreamed with non-TBS children
- The continued need for TBS
- The level of intensity of service (*e.g.*, two hours per day)

Discharge Planning

Discharge planning shall be documented on the ITP prior to discharge and shall include, at a minimum:

- The reason for discharge
- A follow-up plan to maintain skills TBS developed
- If applicable, a brief description of presenting problems that are unresolved
- Coordination and linkage established to provide ongoing resources to address remaining barriers and deter the resurgence of the initial presenting problems

Clinical Documentation

Medicaid reimbursement is directly related to the delivery of treatment services. All documentation must justify and support the Medicaid billing. Each child's record must contain adequate documentation to support the treatment service rendered. Each TBS clinical record, at a minimum, shall contain the following information:

- Medical Necessity Statement

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Clinical Documentation (Cont'd.)

- Referral Form/Authorization for Services (DHHS Form 254), if appropriate
- A developmental and emotional screening tool that is clinically sound and age appropriate such as the Denver Developmental Screening Test II used in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings
- Signed/titled and dated assessment forms
- Signed/titled and dated Individual Treatment Plan(s)
- Signed/titled and dated Weekly Progress Summary Notes

Weekly Progress Summary Notes

The Weekly Progress Summary Notes summarize program participation of the child and family and **must be documented weekly**. Days present and absent in the program are included in the notes. The summary should be placed in the child's record within one week following the service rendered. The documentation addresses the following areas in order to provide a pertinent clinical description and to assure that the service conforms to the service description:

- A general observation of the child's condition. This should include, but is not limited to, affect, attitude, health, and/or appearance.
- The child's and/or family's activity and participation in the treatment program
- The child's progress on treatment goals and response to treatment
- The involvement of the treatment staff in service provision
- When provided, documentation of group therapy that addresses attendance and reasons for lack of attendance
- Future plans for working with the child
- All home visits should be documented in the Weekly Progress Summary Notes. The home visit documentation shall include the following:

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Clinical Documentation (Cont'd.)

- o The date, time, and place of the last visit and the next visit
- o Physical and emotional status of the caregiver and/or child
- o Environmental (health and safety) factors

The Supervising LCS shall sign/title and date the Weekly Progress Summary Note as the person responsible for the provision of service. The Supervising LCS's signature verifies that the services were provided in accordance with the Medicaid standard for Therapeutic Behavioral Services.

If a Non-LCS is compiling information for the Weekly Progress Summary Notes under the direction of the LCS/Supervising LCS, the signature/title of the Non-LCS and date is required on the Weekly Progress Summary Notes.

Program Evaluation

To the extent measurable, programs will be evaluated on their effectiveness in prevention of child maltreatment, evidence of diminished effects of abuse and neglect, evidence that the indicators prompting the referral have been reduced, and the displayed knowledge of the family's enhanced ability to meet the therapeutic needs of the child. (See the Forms section for a sample Consumer Satisfaction Survey.) Programs shall submit an annual report to the SCDHHS BHS program representative describing their progress in meeting the outcome criteria 90 days after the close of the state fiscal year. Programs will be expected to meet the following outcome criteria targets.

OC1: After planned discharge, at a minimum 80% of the children who were enrolled in Therapeutic Behavioral Services are still residing with a consistent, stable caregiver. A consistent, stable caregiver is defined as a person in the child's natural ecology who provides appropriate developmental stimulation, nurturing, and safety for a one-year period.

OC2: For those children enrolled in a regular day care or school program following the successful completion of TBS, at a minimum 80% of the children will remain in the regular setting for one

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Evaluation (Cont'd.)

year. For those children not enrolled in a regular day care or school program following the successful completion of TBS, at a minimum 80% of the children will not return to TBS or a higher level of care within a one-year period.

OC3: At a minimum, 90% of caregivers indicate satisfaction with Therapeutic Behavioral Services.

OC4: At the time of planned discharge, at a minimum 90% of children will have achieved at least 75% of the goals on their individual treatment plans.

PSYCHOLOGICAL SERVICES

Program Description

Psychological Services involve the evaluation of the intellectual, emotional, and behavioral status of a child for the purpose of developing and/or reviewing therapeutic interventions designed to alleviate dysfunction or distress.

Program Staff

Psychological Services are provided by a school Psychologist. Providers of Psychological Evaluation and Testing Services include:

Psychologist is an individual that holds a doctoral degree in psychology from an accredited college or university, and has a valid and current state license as a PhD or Psy.D. with a specialty in Clinical, Counseling, or School Psychology as approved by the SC State Board of Examiners in Psychology.

School Psychologist I is an individual that is currently certified by the State Department of Education and holds a master's degree from a regionally or nationally accredited college/university with an advanced program for the preparation of school psychologists and qualifying score on the SC State Board of Education required examination.

School Psychologist II is an individual that is currently certified by the State Department of Education and holds a specialist degree from a regionally or nationally accredited college/university with an advanced program for the preparation of school psychologists, and qualifying score on the SC State Board of Education required examination.

School Psychologist III is an individual that is currently

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CHILDREN'S BEHAVIORAL HEALTH SERVICES

Program Staff (Cont'd.)

certified by the State Department of Education and holds a doctoral degree from a regionally or nationally accredited college/university with an advanced program for the preparation of school psychologists, qualifying score on the State Board of Education required examination, and completion of an advanced program approved for the training of school psychologists.

Psycho-educational Specialist is an individual that holds a (60 hour) master's degree plus 30 hours or a doctoral degree in school psychology from a regionally accredited institution approved by NASP or APA or its equivalent, certification by the South Carolina Department of Education as a school psychologist level II or III, two years experience as a certified school psychologist (at least one year of which is under the supervision of a licensed psycho-education specialist) and satisfactory score on the PRAXIS Series II exam. The SC Board of Examiners licenses this individual.

Psychological testing and evaluation provided by a School Psychologist I must be supervised by a School Psychologist II or III or a Licensed Psycho-educational Specialist, and each evaluation report completed by a School Psychologist I must be signed by the supervising school Psychologist.

Note: Annual/Transfer Review (90885) is no longer a Medicaid-covered service.

Service Description

Psychological Testing/Evaluation

96101: Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report

Psychological Evaluation and Testing Services: In accordance with 42 CFR 440.130, Psychological Testing and Evaluation recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, includes evaluation of the intellectual, emotional, and behavioral status and any

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Psychological Testing/Evaluation (Cont'd.)

resulting distress and/or dysfunction. Service components include screening, diagnostic interview, testing and/or assessment.

Testing involves measures of intellectual and cognitive abilities, neuro-psychological status, attitudes, emotions, motivations, personality characteristics, and utilization of other non-experimental methods of evaluation as appropriate. Evaluation consists of review of available medical history records, diagnostic testing and assessment, and a written evaluation report with recommendations. Evaluation should include an observation and interview when appropriate.

A Psychological Services Log Form must be completed for each Medicaid-reimbursable testing/evaluation service provided. The ICD-9-CM diagnosis code and the time spent on each service component must be documented on a Log form. If more than one school Psychologist is involved in providing services, each must sign the Log form and initial the service components/tasks that they provided.

A re-evaluation of a child is considered as a separate evaluation on its own and all components/tasks involved are billable to Medicaid.

Documentation

See Documentation Requirements under General Information earlier in this section.

EMERGENCY SAFETY INTERVENTIONS (SECLUSION AND RESTRAINT)

Pertaining to the below Emergency Safety Interventions section:

- This policy includes providers that have policies prohibiting the use of such interventions but who may have an emergency situation requiring staff intervention.
- All school- and community-based providers are responsible for adhering to all of the requirements in this section if they intend to employ the use of restraint and/or seclusion in their program.

For the purpose of this manual, "restraint" is defined as any type of physical intervention (including mechanical restraints and therapeutic holds) that reduces or restricts an individual's freedom of movement and is administered without the individual's permission.

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CHILDREN'S BEHAVIORAL HEALTH SERVICES

EMERGENCY SAFETY INTERVENTIONS (SECLUSION AND RESTRAINT) (CONT'D.)

Restraint and seclusion shall be used only to ensure the immediate safety of the individual or others when no less restrictive intervention has been or is likely to be effective in averting danger. Restraint and seclusion shall never be used for coercion, retaliation, humiliation, as a threat or form of punishment, in lieu of adequate staffing, as a replacement for active treatment, for staff convenience, or for property damage not involving imminent danger.

All providers must ensure that all staff involved in the direct care of a child successfully complete a course from a certified trainer in the use of restraints and seclusion. Training should be aimed at minimizing the use of such measures, as well as ensuring client safety. For more information on selecting training models, see Section 7 of the Project Rest *Manual of Recommended Practice*, available at <http://www.frcdsn.org/rest.html>.

Staff must successfully complete all requiring training in Emergency Safety Interventions prior to ordering or participating in any form of restraint. All staff involved in the use of seclusion and restraint must use the necessary and appropriate skills, knowledge and expertise to judiciously apply interventions in a safe manner. Providers must adhere to all state licensing laws and regulations regarding the use of seclusion and restraint.

Ordering and Initiation

Each program will develop and implement a comprehensive written policy that governs the circumstances in which these practices are used. The policy shall identify the following:

- The threshold for initiating restraint and seclusion, such that the use of restraint or seclusion will be permitted only after other less-restrictive methods to prevent immediate and substantially bodily injury to the individual or others have been attempted and have failed. An exception may be warranted in the event of an emergency situation where there is a threat of harm to staff or clients. (Please see the documentation section for further information.)
- Forms of restraint identified for use
- Specific criteria for the use of restraint and seclusion

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CHILDREN'S BEHAVIORAL HEALTH SERVICES

Ordering and Initiation (Cont'd.)

- Staff members for the use of restraint and seclusion
- Staff members authorized to approve the use of restraint and seclusion
- Staff members authorized and qualified to administer or apply restraint and seclusion
- Approved procedures for application of each form of restraint and seclusion
- Staff members authorized and qualified to administer or apply restraint and seclusion
- Approved procedures for application for each form of restraint and seclusion
- Procedures for monitoring any individuals placed in restraint and seclusion
- Limitations on the use of restraint and seclusion, including any applicable time limitations
- Procedures for immediate and continuous review of restraint and seclusion incidents to include reducing the likelihood of reoccurrence
- Procedures for comprehensive recordkeeping concerning all incidents of restraint and seclusion
- Procedures for reporting critical incidents resulting from the use of seclusion and restraint

Notification of Rights, Policies and Procedures at Admission

Each program must have written policies regarding notification of rights, policies and procedures at admission. At admission, the facility will inform the incoming individual and, in the case of a minor, the parents or legal guardians of the policy regarding use of restraint and seclusion during emergency safety situations that may occur while the individual is in the program. The explanation will include the program's behavioral expectations and requirements. It will also include:

- Who can implement an emergency safety intervention
- The actions staff members must first take to defuse the situation and avoid an emergency safety intervention
- The situations in which an emergency safety

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CHILDREN'S BEHAVIORAL HEALTH SERVICES

Notification of Rights, Policies and Procedures at Admission (Cont'd.)

intervention may be used

- A description of the emergency safety intervention procedures used
- When the use of emergency safety intervention will end
- What action the individual must exhibit to be released from the emergency safety intervention
- The grievance procedure to report an inappropriate restraint and seclusion
- The opportunity to view time-out and quiet and seclusion rooms or areas

Communication shall take place in a language the individual and his or her parents or legal guardians understand; when necessary, the program must provide interpreters or translators. The program will obtain an acknowledgement in writing from the individual and his or her parents or legal guardians that they have been informed of the program's policy regarding the use of restraint and seclusion. The program will also obtain written consent from the individual's parents or guardians (unless otherwise ordered by the court) regarding permission to use restraint and seclusion in the event of an emergency crisis situation. A staff member must file the acknowledgement and consent forms in the individual's record and will provide copies to both the individual and his or her parents or legal guardian and the referring agency.

Documentation

Each program must document all emergency safety interventions. Documentation includes:

- A description of what happened
- The date and beginning and ending times of the incident
- Any precipitating incidents
- The age, height, weight, and gender of the client
- The exact methods of intervention used, the reasons for their use, and the duration of the intervention
- The names of all clients involved
- The names and titles of staff or others involved, and

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Documentation (Cont'd.)

their relationship to the client

- Names of witnesses to the precipitating incident and subsequent restraint
- The name of the person making the report
- A detailed description of an injury to the client including a body chart or photo
- The action taken by the provider as a result of the injury
- Preventative actions to be taken in the future
- A description of debriefing activities
- The follow-up required
- Documentation of supervisory and administrative reviews
- Description of notification efforts, including who was contacted, how and when they were contacted, and verification that contact was made

Staff must document the intervention in the client's record. For residential providers the documentation must be completed by the end of the shift in which the intervention occurs.

Monitoring/Termination

All providers must have a written log of each seclusion and/or restraint episode.

When available, a staff member should provide visual monitoring of the individual in seclusion or restraint and make a written annotation in the log at least once every fifteen minutes. The entry will describe the individual's behavior at that time and whether he or she needs continued seclusion or restraint. The program will have written procedures that outline the criteria for terminating a seclusion or restraint.

Programs must ensure that, when restraints or seclusion have been employed, the staff conducts regular internal oversight reviews.

Training Requirements

This remaining section on ESI pertains to all school- and community-based providers.

All school- and community-based providers must ensure that all staff involved in the direct care of clients

SECTION 2 POLICIES AND PROCEDURES

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Training Requirements (Cont'd.)

successfully complete a course in the prevention and management of aggressive behaviors. Annual refresher courses must also be provided.

All staff members will be made aware of the program's written philosophy, rules, policies, procedures, intervention modalities, and the expectations for everyone who is working with clients. Each facility will describe in writing the program's plan for staff orientation, which must include but not be limited to:

- The characteristics of individuals served
- Symptoms and behavioral signs of emotional disturbance
- Symptoms of drug overdose, alcohol intoxication, and possible medical emergency
- The program's emergency and evacuation procedures
- Procedures for reporting suspected incidents of child abuse and neglect
- Orientation in first aid and CPR
- Training in universal precautions and infection control procedures
- The program's policies regarding medication, runaway individuals, and behavior support and intervention

No new staff member will be solely responsible for children in care until he or she has received the minimum orientation described above.

The facility must provide ongoing staff training programs appropriate to the size and nature of the program and staff involved. Each program will have a written plan for staff training, including the curriculum for behavior support and intervention training and refresher training as required by the program model.

SECTION 2 POLICIES AND PROCEDURES

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) shall be provided in accordance with South Carolina Medicaid guidelines set forth in SCDHHS' Medicaid Enhanced Services Provider Manual and appropriate Medicaid bulletins, which are hereby incorporated for reference

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MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

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SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

The Special Needs Transportation Program is designed to provide transportation to Medicaid-eligible school students with special needs requiring transportation to medically necessary services in school-based settings provided directly by the Local Education Agency (LEA). This population includes but is not limited to children under the age of 21 who have sensory impairments, physical disabilities, mental retardation, and/or developmental disabilities or delays. Each LEA recognized by the State Department of Education (SDE) is responsible for the arrangement and coordination of Special Needs Transportation services.

REQUIREMENTS FOR PARTICIPATION IN SPECIAL NEEDS TRANSPORTATION

In order to participate in the Special Needs Transportation Program, the LEA must meet all participatory requirements set forth in the program's contractual agreement with the SDE. The term "Local Education Agency" refers to any of the local entities that are recognized by SDE as school districts. Information concerning participation in the Medicaid Transportation Program may be obtained from the Division of Family Services, Department of Transportation Services at (803) 898-2565 or Post Office Box 8206, Columbia, SC 29202-8206.

Special Needs Transportation providers (LEAs) shall provide required transportation services to meet the needs of Medicaid-eligible school students with special needs in a vehicle adapted to serve the needs of the disabled. This shall include a specially adapted school bus used for transporting beneficiaries to and from reimbursable Medicaid services that are provided at a school or other facility when identified in the Individualized Education Plan (IEP).

COVERED SERVICES

Special Needs Transportation reimbursement is available for transportation provided to the following rehabilitative therapy and related health care services:

- Audiological
- Physical Therapy

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

COVERED SERVICES (CONT'D.)

- Occupational Therapy
- Speech and Language Pathology
- Psychological Testing and Evaluation
- Orientation and Mobility (O&M)
- Behavioral Health Services
- Nursing Services for Children Under 21
- Administrative Claiming
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Non-Emergency Transportation

An appropriate Medicaid-reimbursable School-Based Service other than transportation must be rendered on the date of transport to be reimbursable for Special Needs transportation. Medicaid transportation is not reimbursable when the requirement for transportation service is not identified in the IEP.

SPECIAL CIRCUMSTANCES

Beneficiary Escorts

The SDE does not receive an additional reimbursement for an escort to accompany the beneficiary to an authorized medical service. The rate of reimbursement agreed upon in the contract is considered sufficient to cover the cost of an escort, attendant, or other passenger that is required to accompany the Medicaid Special Needs student. The assignment of an escort to a Special Needs bus should be indicated in the student's IEP. If upon arrival at pickup a student requires an escort and one is not present, LEA providers should follow SDE procedures established to respond to such circumstances.

Beneficiary Complaints

Beneficiaries with complaints regarding Special Needs Transportation services should first contact their LEA provider. If the complaint cannot be resolved, a meeting should be scheduled with the LEA, SDE, and the complainant. If the complaint still cannot be resolved, SDE should contact the Special Needs Transportation program representative at SCDHHS at (803) 898-2565. The complainant should contact SCDHHS directly at 1-888-549-0820.

SECTION 2 POLICIES AND PROCEDURES

SPECIAL NEEDS TRANSPORTATION PROGRAM

Vehicle Requirements

For the purpose of establishing the vehicle requirements relating to Special Needs Transportation services, LEAs will utilize a vehicle adapted to serve the needs of the disabled to include a specially adapted school bus and the current policies and procedures as defined by the State Department of Education, Board of Education in accordance with Section 59-67-20, Code of Laws of South Carolina for the Operation of the Public Pupil Transportation Services Reg. No. R 43-80 (as amended).

DOCUMENTATION

Error Correction Procedures

Please reference page 2-9.

Trip and Passenger Pupil Log Form

A Trip and Passenger Pupil Log Form is used daily by the driver to record route information and other ridership data as required by SCDHHS for billing and claims reimbursement for each Medicaid passenger (pupil) accessing transportation each day. This SDE or LEA form will provide basic information for completion of transportation billing and claims generation for reimbursement for each Medicaid passenger (pupil).

These forms are required to be kept in the provider's files as secure documentation. All information on the form is necessary for performance and financial audit purposes. If you choose to format a different version of the SDE-approved form, you are required to submit it to SDE for approval before using it.

District forms shall include:

1. District Name, Address, Phone Number
2. Route Number (as applicable)
3. Driver (Name)
4. Vehicle Number/License Tag Number/District Number
5. Date
6. Passenger Name

Upon completion, drivers are required to sign the log in the space provided.

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SPECIAL NEEDS TRANSPORTATION PROGRAM

PROGRAM COMPLIANCE REVIEW

A program review will be conducted at least once during the contract year to evaluate compliance with program policies and procedures. Contract compliance reviews are conducted to identify areas where programmatic development or improvement is needed and to ensure that Medicaid policy is being met. The completed review will identify service delivery problems and recommend corrective action utilizing quality assurance methodologies approved by SCDHHS. This is also an opportunity to note program strengths and recognize the dedication and commitment the LEA provides to Medicaid beneficiaries.

During a compliance review, the following will be evaluated:

1. Verification of an appropriate Medicaid-reimbursable service other than transportation has been rendered on the date of transport as compared with the Trip Dispatch/Passenger Log
2. Verification of the requirement for transportation service has been identified in the IEP for a Medicaid-eligible Special Needs student
3. Compliance with policy and procedures of the Medicaid Transportation Program to be reimbursable for Special Needs transportation

Non-emergency contractual transportation services may be provided by the LEAs for Medicaid-eligible students requiring transport off-site to and from Medicaid-reimbursable services. Transportation services must be contracted directly through SCDHHS.