SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

MENTAL HEALTH SERVICES NOS (MHS-NOS)

Service Description

Mental Health Services Not Otherwise Specified (MHS-NOS), formerly known as Intensive Family Services, are time-limited, clinical interventions predominantly provided within the home and community environment of an identified child. These services are designed to serve children and adolescents under the age of 21.

MHS-NOS are behavioral, psychological, and psychosocial in orientation. They are multi-faceted and include crisis management, individual and family counseling, skills training, coordination and linkage with other necessary services, resources, and supports to prevent utilization of more restrictive residential services. The services are child centered, have a family focus, and have an ecological, holistic perspective. This would include the child's family, community, educational setting, and peer group. Assessment of needs and treatment planning are strength based and involve a partnership with the child and family.

Services are designed to defuse a crisis that threatens the child's stability within the home environment. The child, family members, and other key individuals in the child's environment learn to evaluate the nature of the crisis, as well as how to anticipate and defuse future crises. Consequently, the likelihood of recurrence is reduced.

Planned interventions assist the family to develop relationships with naturally occurring community networks that support positive adaptation and facilitate the child's adjustment with schools, peers, and community activities.

MHS-NOS are intended to affect the following outcomes for child clients and their families:

- Keep families together by preventing the unnecessary placement of an identified child into the foster care system, juvenile justice system, or an out-of-home therapeutic placement (*e.g.*, psychiatric hospital, therapeutic foster care, and residential treatment facility)

Service Description (Cont'd.)

- Prevent a child who is at risk of coming in contact with or already involved in the juvenile justice system from further penetration into the system
- Prevent disruption of the child's home environment
- Promote reunification of the child back into a family
- Ensure the child client's safety and protection within their home environment

Medical Necessity and Prior Authorization

MHS-NOS must be recommended by a physician or other Licensed Practitioner of the Healing Arts (LPHA) who will certify that the identified child meets at least one of the following medical necessity criteria:

- The identified child will be removed from the home if MHS-NOS is not rendered. The severity of the child's difficulties and the level of family dysfunction are such that out-of-home placement of the child is imminent.
- The identified child's return home is deemed likely to be unsuccessful if MHS-NOS is not rendered. The child and family require this service in order to successfully return the child back into the home environment following an out-of-home placement.
- The identified child and/or the child's home environment is experiencing problems that threaten the child's safety and well-being or family stability.
- The child is at risk of involvement with, or further penetration into, the juvenile justice system.
- An immediate family member of the client meets the criteria for psychoactive substance abuse or dependency according to the most recent edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM*) **and** the client meets one of the four criteria listed above.

The medical necessity for the child's placement in the service must be substantiated with a diagnosis from the most recent edition of the APA's *DSM*. This includes the use of appropriate V Codes for diagnostic purposes. Refer to Section 4 of this manual for a listing of V Codes.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medical Necessity and Prior Authorization (Cont'd.)

The medical necessity is documented by the completion of a Medical Necessity Statement. Refer to "Exhibits" in Section 5 of this manual for an example of the Medical Necessity Statement. The designated referring agent must ensure that a physician or other LPHA evaluates the identified child and recommends that he or she meets the medical necessity criteria for MHS-NOS. The Medical Necessity Statement provides documentation and/or justification of the identified child's problem areas and/or needs which require MHS-NOS. After the medical necessity for services has been determined, the designated referring agent will provide the Medical Necessity Statement, if appropriate, to the service provider, prior to or no later than, 10 days after the time of initial service delivery. The Medical Necessity Statement must be placed in the child's clinical record with the child's initial treatment plan. For further information, refer to "Medical Necessity" under the heading "Program Requirements" in this section.

In order to be Medicaid reimbursable, the service must be authorized by a designated referring agent prior to service delivery. If applicable, authorization for services is accomplished through the completion of a DHHS Referral Form/Authorization for Services Form 254. Refer to "Exhibits" in Section 5 of this manual for an example of DHHS Form 254. DHHS Form 254 is required whenever state agencies refer a client to a private treatment provider. The designated referring agent will provide the treatment provider with the original copy of this form within 10 days of the date of referral.

Staff Qualifications

Services shall be rendered by appropriately trained Lead Clinical Staff (LCS) and/or trained staff who work under the direct supervision of LCS.

Lead Clinical Staff – All LCS shall meet the professional standards defined by DHHS as outlined under the heading "Provider Qualifications" in this section of the manual. Before rendering services, all 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. All LCS must receive 20 contact hours of training annually. Individuals wishing

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Staff Qualifications (Cont'd.)

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.

For the purposes of MHS-NOS, the following professionals may serve as LCS ***in addition*** to those listed in the "Clinical Staff" section of this manual:

- **Physicians** must be doctors of medicine and be licensed by the appropriate State Board of Medical Examiners. They are also required to have a minimum of one year of experience working with the population to be served.
- **Psychiatrists** must be licensed MDs who have completed a residency in psychiatry. They are also required to have a minimum of one year of experience working with the population to be served.
- **Early Childhood Specialists** must possess a master's degree in early childhood education or child development. Further, they must have a minimum of one year of experience working with the population to be served.
- **Advanced Practice Registered Nurses** must be licensed to practice as RNs with AP certification and currently be practicing under a physician preceptor according to a mutually agreed upon protocol. APRNs must also have a minimum of one year of experience working with the population to be served.
- **Licensed Marriage and Family Therapists** must be licensed by the appropriate State Board of Examiners as Marriage and Family Therapists. They must also have a minimum of one year of experience working with the population to be served.
- **Advanced Practice Registered Nurses Specializing in Psychiatric Nursing** must be licensed to practice as an RN with AP certification and be currently practicing under a physician preceptor according to a mutually agreed upon protocol. Additionally, APRNs must have completed advanced study and clinical practice in a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Staff Qualifications (Cont'd.)

master's program in psychiatric nursing and have gained expert knowledge in the care and prevention of mental disorders. They must also have a minimum of one year of experience working with the population to be served.

Non-Lead Clinical Staff – Non-LCS who are supervised by an LCS may provide services. Non-LCS must be at least 21 years of age and be privileged by the program to render the service. Further, they must receive supervision to assure services are rendered in accordance with accepted clinical practice. If the Non-LCS is the primary service provider, the Non-LCS must also sign and date the Progress Summary Note as the service provider.

All Non-LCS must have a bachelor's degree from an accredited university or college and have a minimum of one year of experience in working with children and families. Prior to rendering the services, all Non-LCS must show documentation of 40 contact hours of training in child development or early childhood education, children's mental health issues, and the identification and treatment of children's mental health problems.

All Non-LCS must receive 20 contact hours of training annually.

Supervision

Program Director

Each MHS-NOS program must have a designated Program Director and at least one designated LCS member to function as a supervisor for clinical oversight of the program's LCS and Non-LCS. In some cases, the same individual can perform the two roles.

Supervising Lead Clinical Staff

The individual performing the role of supervising the LCS is responsible for the execution of the following duties:

- Providing direct involvement in evaluating, assessing, and treating children and families
- Developing and signing treatment plans
- Providing and/or supervising service delivery, as well as periodically confirming the medical necessity of continued treatment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Supervision (Cont'd.)

- Assuring that services are provided in accordance with accepted standards of clinical practice in a safe, efficient manner
- Providing supervision to all staff. Supervision must be provided weekly. Periods of supervision may be scheduled incrementally as deemed appropriate. Supervision must include opportunities for discussion of treatment plans and client progress. Documentation of supervision must be maintained. Case supervision and consultation do not supplant training requirements.
- Facilitating regular staffings, once a week at a minimum, in which administrative and client treatment issues and progress are considered. Staffings shall consist of an overview of the services rendered, the identified child and the family's response to services, progress or barriers toward achievement of goals, new problems/needs identified, and any needed changes or modifications to their treatment plan. The staffing must be documented in the Progress Summary Notes.
- Assuring that supervision shall be available to the staff 24 hours per day, seven days per week
- Co-signing all Medicaid documentation of Non-LCS
- Providing and documenting weekly supervision of all LCS and Non-LCS in an individual or group setting. Regular supervision includes the following:
  - Formulation of treatment plans for new clients
  - Review of progress of identified clients toward completion of treatment goals
  - Revision of treatment plans if indicated
  - Individual training as an apprentice to the supervising LCS in the treatment process as needed
  - Individual face-to-face sessions between the supervising LCS and staff

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral and Intake

The MHS-NOS provider shall have a mechanism in place that allows for a 24 hours per day, seven days per week response to initiate screening of a referred child or family.

For children whose physical safety may be at risk and/or children at risk of imminent removal, a prompt response (acceptance or rejection) regarding the appropriateness of the referral should be made within 72 hours.

For children in need of the services, but not at risk of imminent removal, a prompt response (acceptance or rejection) regarding the appropriateness of the referral should be made within one week.

Notification will be sent to the referring agency, *if applicable*, of the acceptance or rejection of the identified child or family for MHS-NOS. If the MHS-NOS are denied, a justification for a decision of rejection should be included.

At least one family member with whom the identified child is living, or will be returning to live with, should be willing to participate in MHS-NOS. The goal is to keep the child in the home, return the child to the home, or strengthen the family unit when abuse and/or neglect is the reason for the referral. When the referral is brought forward due to family conflict, delinquent acts, or chronic runaway behaviors of the identified child, at least one family member, which may include the child, must be willing to participate.

Program Content

MHS-NOS shall be provided for identified children based on assessed needs. These services may be rendered either face-to-face or telephonically. The intent is that this service be provided face-to-face, but it may be provided by telephone under extenuating circumstances. Documentation must support the extenuating circumstances which warrant telephonic provision. The purpose of these services is to reinforce and enhance an individual child’s ability to function within the family and to enhance the total family’s level of functioning through the use of a variety of interventions. Clinical interventions shall be designed to do the following:

- Reinforce and enhance an identified child’s abilities to function within his or her home environment and to enhance the family’s level of functioning

Program Content (Cont'd.)

- Identify and assist an identified child and his or her family in resolving conflicts
- Coordinate efforts between the LCS, a child and family, and the designated referring agent
- Communicate and demonstrate methods of appropriate skills and/or behavior management techniques to help family members effectively manage certain behaviors
- Support or strengthen an identified child's home environment
- Promote the family's relations with a social network that supports positive and pro-social behavior
- Identify and address difficulties in a child's peer relations and school performances
- Encourage family members to promote a child's positive social relations and academic performance

Clinical Interventions

Interventions are provided primarily in the settings that comprise the social environment of an identified child/family and will do the following:

- Reflect an assertive strategy by the LCS in engaging and retaining the identified child, family, and significant others in a therapeutic alliance
- Reflect an assumption of responsibility by the program for coordinating services with the educational, social, criminal justice, and health or mental health systems
- Teach the family to interact with the identified child in ways that increase parental authority and control while conveying acceptance and emotional support
- Address marital and family conflicts that undermine a family's capacity to collaborate with the program in achieving behavior change in the identified child
- Motivate the child to disassociate from deviant peer groups and coach him or her in behaviors that lead to acceptance in pro-social peer groups
- Collaborate with family members and schools in obtaining the identified child's conformance to school rules and improving his or her academic performance

Clinical Interventions (Cont'd.)

- Teach the identified child to increase recognition of the associations between problems he or she is having and his or her behavior, set goals, evaluate the consequences of antisocial responses to conditions that impede the child from realizing goals, and develop and implement pro-social plans in their place
- Make, coordinate, and follow up on referrals for more specialized therapeutic interventions

Duration of Services

Services are available 24 hours a day, seven days a week.

Services will not exceed 24 weeks in a single year (52-week period). The referring or authorizing agency is responsible for determining the number of weeks to be authorized at any one time. The 24 weeks do not have to be consecutive.

Staff-to-Client Ratio

Clinical caseloads shall not exceed one full time staff to five child/family units.

Accessibility and Continuity

Continuity of care must be assured throughout the delivery of the program service.

One staff member other than the primary service provider must be familiar with the dynamics of each case in the event that the primary service provider is unavailable.

A Lead Clinical Staff (LCS) must be available (on call) 24 hours per day, seven days per week to initiate screening of a referred child/family or to respond to an urgent need of enrolled children.

Service Documentation

Client Record

A client record is opened for each identified child referred to the program. The record contains, at a minimum, the essential elements outlined under the heading "Documentation Requirements" in this section of the manual. The MHS-NOS record shall also contain:

- A screening assessment completed by the MHS-NOS program
- A consent to treatment explaining the goal of treatment, the nature of the treatment to be provided, the expected frequency of contact and

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Client Record (Cont'd.)

duration of treatment, financial responsibility, and the rights and responsibilities of the identified child/family in the treatment process

- A standardized fact sheet containing the following:
  - The name, date of birth, sex, race, and educational level of the child
  - A current address and telephone number, and family's addresses and telephone numbers if different
  - Names, relationships, addresses, and telephone numbers of other members of child's primary family or 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 providing service(s) to the identified child (*e.g.*, teacher, school counselor, attorney and state agency personnel)
  - Directions to the client's home
- Ongoing assessments of the strengths and weaknesses or needs of the child, family, school, peers, neighborhood, community, and linkages between the systems
- Assessments should be derived from interactions and interviews with the identified child, family, or key informants conducted in the child's social environment. Assessments should address the following:`
  - Family system
  - Peer relations
  - Home/school behavior
  - Academic achievement and ability
  - Developmental level
  - Cognitive, psychiatric, and substance abuse disorders
  - Exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Individualized Treatment Plan

Initial Treatment Plan – An initial treatment plan must be developed within 10 days of the date of admission to the program. If a treatment plan is not developed within 10 days, services rendered from the 11th day until the date of completion of the treatment plan are **not Medicaid reimbursable**.

The plan must be developed mutually, by the identified child and/or family and the LCS, after a thorough assessment of the child and family's strengths and needs. The referring agency's case manager must also collaborate on the development of the plan.

This plan must be signed and dated by the supervising LCS and the primary LCS. The identified child and/or family members should sign the treatment plan indicating their commitment to the treatment process.

Components of the plan – The treatment plan shall address the following:

- **The specific problems or behaviors that require the provision of MHS-NOS**

  This would include the combination of factors in the family, home, school peer group, neighborhood, and community that contribute to the child's referral problems

- **Intermediary goals to be accomplished**

  The goals should be realistic (*i.e.*, obtainable), measurable, individualized, and should relate to the assessed problems and needs of the identified child. The goals should also be outcome-oriented and based on the child's current level of functioning.

- **Methods and frequencies of intervention**

  This should include the responsibilities of the LCS, the responsibilities of the identified child and/or family members, time frames for goal achievement, and the frequency of services to be delivered.

Treatment Plan Review – The treatment plan for MHS-NOS services must be reviewed, at a minimum, every four weeks. However, when a significant event occurs which affects the course of treatment, a review is required. The purpose of the review(s) is to assess the treatment progress and continued need for services, as well as ensuring

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Individualized Treatment Plan (Cont'd.)

services and treatment goals continue to be appropriate to the identified child's needs. The LCS shall continually make any necessary revisions to the treatment plan. Further, the LCS shall sign and date the plan at each review. For further information on treatment plans, refer to "Individual Treatment Plans" under the heading "Documentation Requirements" in this section of the manual.

Clinical Documentation

All services must be documented in Progress Summary Notes. The Progress Summary Notes must be completed as follows:

- Each time a service is rendered
- Whenever information is obtained that has a bearing on the identified child's treatment
- On dates of plan of care reviews to provide a comprehensive summary of the services provided, the identified child's response to treatment, and the basis for changes to the treatment plan

The LCS must sign and date the form as the person responsible for the provision of services. The LCS' signature verifies that the services were provided in accordance with these standards. If the Non-LCS is the primary service provider, the Non-LCS must also sign and date the Progress Summary Note as the service provider. For further information, refer to "Progress Summaries" under the heading "Documentation Requirements" in this section of the manual.

Discharge Summary

Upon completion of an MHS-NOS program, a discharge summary shall be completed. The summary shall include the problems addressed during the course of treatment, the status of the identified child and family with regard to each treatment intervention taken, and recommendations for continuing treatment if appropriate.

The provider should furnish a copy of the discharge summary to the referring agency, if applicable, within 10 days of discharge.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Program Evaluation and Outcome Criteria

To the extent measurable, programs will be evaluated on their effectiveness in the prevention of costly and restrictive treatment options, as well as their ability to assist children in functioning successfully within their home and school environments. Additionally, programs are required to submit an annual report to the DHHS Program Manager describing their progress in meeting the outcome criteria within 90 days after the close of the state fiscal year.

Programs will be expected to meet the following outcome criteria targets:

OC1 – For a one-year period after planned discharge, 80% of the children reside in the home of family or a consistent stable caregiver.

OC2 – For a one-year period after planned discharge, 80% of the children attend school, job training, or are employed.

OC3 – For a one-year period after planned discharge, 85% of the children are free from abuse and/or neglect.

OC4 – For a one-year period after planned discharge, 80% of the children avoid involvement with the criminal justice system.

OC5 – For a one-year period after planned discharge, 85% of the children do not return to MH-NOS or a more restrictive level of services (*i.e.*, a residential placement).

OC6 – At the time of planned discharge, 90% of children will have achieved 75% of the goals/ objectives on their individual treatment plans.

OC7 – After discharge, 75% of family responses indicate satisfaction with services received.

OC8 – After discharge, 75% of referring agencies indicate satisfaction with services received.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billable Places of Service

MHS-NOS may be provided in the client's home or natural environment, or other approved community mental health facility.

Relationship to Other Services

Only Injectable Medication Administration, PMA, Nursing Services, MH Service Plan Development and MH Assessment by Non-Physician may be billed on the same day as MHS-NOS. MH Assessment by Non-Physician may only be billed on the first day of MHS-NOS.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Lead Clinical Staff (LCS)

Community-Based Wrap Around Services (WRAPS) and/or Mental Health Services Not Otherwise Specified (MHS-NOS) must be rendered by a Lead Clinical Staff (LCS), or by staff under the supervision of the LCS. In addition to provision or supervision of service delivery, the LCS is responsible for continually assessing and evaluating the condition of the children receiving these services. The LCS must spend as much time as is necessary to ensure that children are receiving services according to accepted standards of clinical practice in a safe, efficient manner.

Each provider of WRAPS and/or MHS-NOS shall maintain a credentials file for each LCS member substantiating that they meet the required qualifications. This shall include employer verification of the LCS member's credentials and work experience. The treatment provider must maintain a signature sheet, which identifies all LCS member's names, signatures, and initials. 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.

Individuals wishing to be designated as LCS must be able to document experience working with the population to be served. "Experience working with the population to be served" is defined as direct work experience with the type of children served at the applicable level of care (*i.e.*, children who have been diagnosed as having an emotional or behavioral disorder, children who are victims of child abuse and/or neglect, or children deemed to be "at risk" of developing an emotional or behavioral disorder because of life circumstances). DHHS defines a "year of experience" as paid and/or volunteer experience that is equivalent to 12 months of full-time work experience. Practicum or internship placements as part of a degree program are acceptable as work experience.

The following list describes professionals qualified to serve as an LCS:

- **Physician:** A Doctor of Medicine currently licensed by the appropriate State Board of Medical Examiners who has one year of experience working with the population to be served

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

- **Psychiatrist:** A licensed Medical Doctor who has completed residency in psychiatry and who has a minimum of one year of experience working with the population to be served
- **Psychologist:** A holder of a doctoral degree in psychology from an accredited university or college who is licensed by the appropriate State Board of Examiners in the clinical, school, or counseling area with a minimum of one year of experience working with the population that is to be served
- **Registered Nurse:** A licensed, registered nurse who has a bachelor's degree from an accredited university or college, and a minimum of three years of experience working with the population that is to be served
- **Mental Health Counselor:** A holder of 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) with a minimum of one year of experience working with the population that is to be served
- **Social Worker:** A holder of a master's degree from an accredited university or college and licensed by the State Board of Social Work Examiners who has a minimum of one year of experience working with the population that is to be served
- **Mental Health Professional Master's Equivalent:** A holder of a master's degree in a closely related field that is applicable to the bio/psycho/social sciences or to the treatment of the mentally ill; or a Ph.D. candidate who has bypassed the master's degree but has sufficient hours to satisfy a master's degree requirements; or a professional who is credentialed as a Licensed Professional Counselor with a minimum of one year of experience working with the population that is to be served

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

- **Clinical Chaplain:** A holder of a Master of Divinity degree from an accredited theological seminary with one year of Clinical Pastoral Education that includes provision of supervised clinical services and a minimum of one year of experience working with the population that is to be served
- **Child Service Professional:** A holder of a bachelor's degree from an accredited university or college in psychology, social work, early childhood education, child development, or a related field; which includes, but is not limited to, criminal justice, rehabilitative counseling, and elementary or secondary education; or a bachelor's degree in another field with 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 of the above disciplines

  A minimum of three years of experience working with the population that is to be served is required for the Child Service Professional.
- **Licensed Baccalaureate Social Worker:** A holder of a bachelor's degree from an accredited university or college who is licensed by the State Board of Social Work Examiners and has a minimum of three years of experience working with the population that is to be served
- **Certified Addictions Counselor** A holder of a bachelor's degree from an accredited university or college who is credentialed by the Certification Commission of the South Carolina Association of Alcoholism and Drug Abuse Counselors, the NAADAC – The Association for Addiction Professionals, or an International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse approved certification board and has a minimum of three years of experience working with the population that is to be served

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

Providers shall ensure that all staff, subcontractors, volunteers, interns, or other individuals under the authority of the provider who come into contact with referring agency clients are properly qualified.

All LCS and Non-LCS who are providers of WRAPS and/or MHS-NOS must show documentation of 40 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 before rendering services.

.