South Carolina Department of Disabilities
And
Special Needs

PSYCHOLOGICAL SERVICES STANDARDS

For Medicaid Home
And
Community Based Waiver-funded Services

NEW

Effective February 1, 2013

The mission of DDSN is to assist people with disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals and minimize the occurrence and reduce the severity of disabilities through prevention. Consistent with the agency's mission, the intent of DDSN Waiver Psychological Services is to provide people with an Intellectual Disability or a Related Disability (ID/RD), Autism, Traumatic Brain Injury (TBI), Spinal Cord Injury (SCI), and Similar Disability (SD) the supports needed in order for them to meet their needs, pursue possibilities and achieve their life goals.

I. Definition

A. Services focused upon assessment of needs and counseling/therapy designed to address specific needs in areas such as cognitive and/or affective skills, substance abuse and issues related to seriously inappropriate sexual behavior (e.g., those behaviors which could lead to criminal sexual misconduct). These services include initial assessment for determining need for and appropriateness of psychological services, psychological testing, development of a Treatment Plan and goal-oriented counseling/therapy.

Note: Psychological Services funded by a DDSN-operated Medicaid Home and Community Based Waiver are not intended for behavior modification and should not be provided to reduce incidences of property destruction, elopement, aggression, etc. These problem behaviors should be reduced or eliminated by teaching appropriate replacement behaviors through Behavior Support Services.

II. Providers and Referrals

A. Psychological Services funded by a DDSN-operated Medicaid Home and Community Based Waiver will only be performed by qualified providers who have met and continue to meet specified criteria, including continuing education requirements, as indicated by approval and enrollment with the South Carolina Department of Health and Human Services (DHHS) as a provider of Psychological Services.

B. Services will only be provided to waiver participants authorized by a Service Coordinator to receive the service. The participant record must include a reason for referral and documentation of an initial assessment to determine the appropriateness of services for the person referred.

C. The provider must have a complete and timely authorization issued by the Service Coordinator or reimbursement will not be allowed.

III. Treatment Plan

A. The Treatment Plan must include:

- results of the initial individual needs assessment,

- the participant’s strengths and skills,
- primary problems to be addressed,
- the goal of treatment (desired outcome linked to the referral)
- objectives of treatment (components/steps, linked to the initial interview, that will lead to achieving the goal); and
- recommendations for the type and frequency of services.

B. The Treatment Plan is developed with input/participation from the participant and, as appropriate, his/her family members, friends or service providers.

C. Primary problems to be addressed in the Treatment Plan must be documented in observable, measurable terms.

D. The goal and objectives in the Treatment Plan must be stated in observable, measurable terms and include the expected timeframe for achieving the objectives.

E. The Treatment Plan must include specific criteria for termination of services.

F. The Treatment Plan must be implemented as written or amended.

IV. <u>Provider Progress Notes</u>

A. A progress note must be completed for every session and must include:

- the participant’s name,
- date, time and duration of each session,
- the type of intervention; and
- the signature of the provider with appropriate professional title.

B. Progress notes must be clearly stated and include clinically relevant information. They must specify:

- which Treatment Plan objectives are being treated;
- the content of the session, which must be consistent with primary problem, goal and objectives noted on the Treatment Plan;
- the provider’s clinical observations;
- any relevant activity/issues outside the sessions (homework assignments, behaviors generalized from the sessions, interventions utilizing collaterals, outside interactions or situations that interfere or help with progress, etc.);
- any problems or setbacks that have occurred; and
- follow-up.

C. At least quarterly, the provider must specifically review the treatment goal and objectives to determine progress. These notes must be sent to the authorizing Service Coordinator quarterly.

D. Progress notes reflect that revisions to the Treatment Plan are made when progress toward the achievement of the treatment goal/objective is not made.

E. All documents (progress notes, treatment plans, etc.) must be readily available for review upon request by the Service Coordinator, SCDDSN, SCDHHS or a sub-contracted Quality Improvement Organization (QIO).