

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
June 22, 2010

Phys
OMP
MHRC

MEDICAID BULLETIN

**TO: Physicians, Psychologists, and Licensed Independent Practitioners
of Behavioral Health**

**SUBJECT: I. On-Line Pre-Enrollment Orientation & Medicaid Enrollment
II. Prior Authorization requirements for Licensed Independent
Practitioners**

I. On-Line Enrollment Orientation & Medicaid Enrollment

This information is a follow-up to the Medicaid Bulletin dated April 20, 2010. The South Carolina Department of Health and Human Services (SCDHHS), Division of Family Services, is responsible for the administration of optional State Medicaid Rehabilitative Behavioral Health Services (RBHS) for children and adults. Effective with dates of service on or after July 1, 2010, Medicaid enrollment is open to practitioners who are qualified to practice independently under South Carolina State Law as follows: Licensed Psychologists, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Independent Social Workers - Clinical Practice (CP) (with one year of documented experience). Psychologists currently participating in the Medicaid Program for Psychological Services for children under 21 will not need to re-enroll in the Medicaid program.

Licensed practitioners must have a National Provider Identifier (NPI) number to access the On-line Pre-enrollment Orientation. This training is limited to Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, and Licensed Independent Social Workers-CP. All Licensed Independent Practitioners (LIPs) may register for the on-line orientation at <http://training.scdhhs.gov/academy>. The orientation is available on-line twenty-four (24) hours a day, seven days a week. The orientation is intended to provide education about policy and procedure for rendering Medicaid RBHS and how to avoid potential recoupment of Medicaid payments.

Upon completion of the orientation, the LIP should be able to identify provider qualifications, Medicaid beneficiary eligibility requirements, covered services under RBHS, and basic documentation required for reimbursement.

LIPs must complete all fields of the on-line registration. All contact information submitted must be accurate. A Medicaid application and enrollment forms will be mailed to the LIP upon the successful completion of the orientation. Once the enrollment packet is returned to the address provided, the application and forms will be reviewed for all requested items/documentation. If a portion of the application/enrollment forms is not complete, the LIP will be contacted for additional information. The provider will be notified upon final approval of enrollment in the Medicaid Program.

If a LIP has been billing under a physician's NPI and has clients currently in treatment, he/she must directly enroll as a Medicaid provider and bill, for dates of service on or after July 1, 2010, directly for his/her services. In order to assure continuity of care for beneficiaries currently being seen through this arrangement, the LIP should complete the on-line orientation and enrollment process as quickly as possible.

II. Authorization of Services

All services provided through the LIP program must be medically necessary. In order to document medical necessity, a physician or, in the cases of a state agency referral, a Licensed Practitioner of the Healing Arts must complete a Medical Necessity Statement (MNS) PRIOR to the provision of any services. Failure to have medical necessity established PRIOR to the provision of services will result in the recoupment of payment.

If a physician, rather than a state agency, is referring the beneficiary for treatment, the MNS must be faxed to SCDHHS at (803) 255-8204, as well as be provided to the LIP for the beneficiary's record. For adult beneficiaries, the physician must also submit a completed SCDHHS LIP Authorization Form and a standardized behavioral health screening tool that validates the medical necessity. For beneficiaries under 21, the physician's completion of the MNS is adequate for the initial twelve (12) visits. It is expected that physicians will only refer beneficiaries who are active on their caseloads.

If the initial number of visits authorized is deemed by the provider as inadequate to address the identified goals, reauthorization of services will be required for both adults and children. Reauthorization requests must be sent in two weeks PRIOR to expiration of authorized visits. Failure to obtain reauthorization PRIOR to provision of services will result in denial or recoupment of payment. To request reauthorization of services for both adults and children, the physician must submit an updated, completed MNS, and an updated, completed SCDHHS LIP Authorization Form, and an updated standardized behavioral health screening tool that validates the medical necessity.

Medicaid Bulletin

Page 3

The SCDHHS MNS and SCDHHS LIP Authorization Forms are attached to this bulletin and should be submitted via fax to (803) 255-8204, attention LIP Program. Please ensure all sections are completed and signed by the referring physician. Failure to complete and submit all required documentation will result in delay/denial of reauthorization.

If you have any questions regarding this bulletin, please contact a Program Manager in the Division of Family Services at (803) 898-2565. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/S/
Emma Forkner
Director

EF/mwcj

Attachments

NOTE: Note: To receive Medicaid bulletins by email, please register at <http://bulletin.scdhhs.gov/>.
To sign up for Electronic Funds Transfer of your Medicaid payment, please go to <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select "Electronic Funds Transfer" (EFT) for instructions.

FILL OUT COMPLETELY TO AVOID DELAYS/DENIALS

Client name: _____ Address _____ DOB _____

Medicaid ID # _____ Service Address Location: _____

Licensed Independent Practitioner (LIP) referred to: _____ Ind. NPI #: _____

Current clinical Information: Make a selection below by circling the appropriate choice on the scale. 0=None 1=Mild 2=Moderate 3=Severe 4=Extreme

	0	1	2	3	4		0	1	2	3	4						
Aggression	0	1	2	3	4	Depression	0	1	2	3	4	Relationship Problems	0	1	2	3	4
Abuse (PTSD)	0	1	2	3	4	Harm to self	0	1	2	3	4	Medical Illness	0	1	2	3	4
Anxiety Panic	0	1	2	3	4	Harm to others	0	1	2	3	4	Memory deficit	0	1	2	3	4
Appetite Disturbance	0	1	2	3	4	Hallucinations	0	1	2	3	4	Sleep disturbance	0	1	2	3	4
Attention/Concentration	0	1	2	3	4	Impulsivity	0	1	2	3	4	Substance Abuse	0	1	2	3	4
Deficits in ADLs	0	1	2	3	4	Job/School Problems	0	1	2	3	4	Other (note below)	0	1	2	3	4
Delusions	0	1	2	3	4	Mania	0	1	2	3	4	Current Stressors	0	1	2	3	4

If harm self or others, is there a plan: Yes or No (provide supporting documentation)

If other or current stressor listed as a 3 or 4 please list: _____

Psychiatric Hospitalization: Yes No If Yes indicate dates:

Treatment/Discharge Planning Goals:

(examples of treatments can include Behavior modification, client centered, CBT, Family Therapy, Interpersonal, Medication Management or Other. If other, please be specific and provide explanation below.)

DSM IV TR: Diagnosis (es)	Goals:	Type of Treatment/ Interventions (see above)	Outcomes or Progress/Anticipated Discharge
Axis I	1.	1.	1.
Axis II	2.	2.	2.
Axis III	3.	3.	3.
	4.	4.	4.



MEDICAL NECESSITY STATEMENT FOR REHABILITATIVE SERVICES

Beneficiary's Name: _____ Social Security Number: _____

Date of Birth: _____ Medicaid Number: _____

Diagnosis code(s): _____

[Diagnosis codes must be based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or the ICD.

Indicate the specific Rehabilitative Service(s) being recommended on each line below.

- Rehabilitative Service(s): _____, _____, _____

Identify the Beneficiary's problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards

(Signature of Physician or other Licensed Practitioner of the Healing Arts) (Professional Title)

(Please print name signed above) (Phone Number)

Signature Date: _____ (Services must be initiated within 45 calendar days.)
Must be handwritten

Note: The Referral/Authorization for Rehabilitative Services form (DHHS Form 254) and the MNS must be sent to the provider prior to the provision of services, or at the time the services are rendered.