SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Rehabilitative Behavioral Health Services (RBHS) Training for Providers in a School Setting

Division of Behavioral Health

2022

Disclaimer

- Materials presented today are not comprehensive. This training does not take the place of reading the provider policy and procedure manual. For any ongoing treatment, all beneficiaries must meet criteria for medical necessity for that service. All information in this presentation pertains to South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Medicaid beneficiaries.

Purpose of the Training

- To act as a guide for Rehabilitative Behavioral Health Services (RBHS) providers who are learning about SC Medicaid policy and procedures prior to rendering RBHS in a school setting.

  While this presentation is designed to enhance understanding of the Medicaid standards regarding the LEA Policy Manual, all aspects and policies are not covered in this presentation. Please review the LEA Manual and the Administrative and Billing Manual.

- To help providers avoid potential Medicaid recoupment.

Clinical Standards

Consent for Treatment/ Release of Information

- The Consent for Treatment form must be dated and signed by the beneficiary, parent, legal guardian, primary caregiver (in cases of a minor) or legal representative and must be obtained at the onset of treatment from all beneficiaries and placed in the beneficiary's file from each treatment provider.
- If the beneficiary, parent, legal guardian or legal representative cannot sign the consent form due to a crisis and is accompanied by a next of kin or responsible party, that individual may sign the consent form.
- If the beneficiary is alone and unable to sign, a statement such as "beneficiary unable to sign and requires emergency treatment" must be noted on the consent form and must be signed by the Licensed Practitioner of the Healing Arts (LPHA) and one other staff member.
- The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit.
- A new consent form should be signed and dated each time a beneficiary is readmitted to the system after discharge.
- A Release of Information form must be signed by the beneficiary's parent or guardian authorizing the release of any medical information necessary to process Medicaid claims. This may be incorporated into a Consent for Treatment form.

Diagnostic Assessment Services

- The purpose of the face-to-face diagnostic assessment (DA) is to determine the need for RBHS and establish medical necessity, to confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and needs and/or to assess progress in treatment and confirm the need for continued treatment.
- The assessment is also used to determine the beneficiary's mental status, social functioning and to identify any physical or medical conditions.
- All assessments require one LPHA/ LMSW/ or MHP for each beneficiary.

Documenting Medical Necessity

- Medical necessity must be documented on a DA administered by a qualified Licensed Practitioner of the Healing Arts (LPHA). The LPHA's name, professional title, signature and date must be listed on the document to confirm medical necessity. **If the LPHA is a Licensed Master Social Worker (LMSW), a co-signature by an independently licensed LPHA is required. Also, if a DA is completed by an MHP, a co-signature by an independently licensed LHPA is required.**
- The DA must be completed prior to any RBHS services being rendered, with the exception of the Crisis Management (CM) service. Two CM services are allowed prior to a DA being required. After the second CM service, an assessment to determine medical necessity will be needed prior to any other services being rendered.
- The DA must document the presence of a serious behavioral health disorder from the current edition of the DSM or the ICD, excluding intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM or ICD criteria.
- The DA must clearly state recommendations for treatment, including services and the frequency for each service recommended.

Documenting Medical Necessity (Cont.)

- Medical Necessity must be confirmed within 365 calendar days, if the beneficiary needs continuing rehabilitative services.
- If the beneficiary has not received services for 45 consecutive calendar days, medical necessity must be re-established by completing a follow-up assessment. This is important to remember if services are paused or delayed due to summer break.
- The DA must be maintained in the Medicaid beneficiary's clinical record.
- If SCDHHS or its designee determines that services were reimbursed when evidence of medical necessity, as outlined in this manual, was not documented and maintained in the beneficiary's record, payments to the provider shall be subject to recoupment.

Who Can Establish Medical Necessity

- LPHAs must certify that the beneficiary meets the medical necessity criteria for each service. The LPHA must be enrolled in, or be an employee of a School District that is enrolled in, the South Carolina Medicaid program. The following professionals are considered to be licensed at the independent level in South Carolina and can establish and/or confirm medical necessity:
  - Licensed Physician
  - Licensed Psychiatrist
  - Licensed Psychologists
  - Licensed Psycho-Educational Specialist (LPES)
  - Licensed APRN
  - Licensed Independent Social Worker —Clinical Practice (LISW-CP)
  - Licensed PA
  - Licensed Professional Counselor (LPC)
  - Licensed Marriage & Family Therapist (LMFT)

Diagnostic Assessment (DA) Requirements

- DAs must include the following:
  - An evaluation of the beneficiary for the presence of a mental illness and/or substance use disorder (SUD).
  - This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical and educational records.
  - Clinical interviews with the beneficiary, family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths, medical and educational records and history, including past psychological assessment report and records. Initial assessments must include a clinical summary that identifies recommendations for and the prioritization of mental health and/or other needed services.
- In addition to the assessment itself, the DA service must be documented on a clinical service note (CSN) with a start time and end time. Additionally, the documentation must meet all SCDHHS requirements for CSNs.

Components of the Diagnostic Assessment

The following components must be included in the Diagnostic Assessment:

- Beneficiary's name and Medicaid ID number
- Date of the assessment
- Beneficiary's demographic information:
    - Age
    - Date of birth
    - Phone number
    - Address
    - Preferred language
- Beneficiary's cultural identification, including gender expression, sexual orientation, culture and practices, spiritual beliefs, etc.
- Presenting complaint, source of distress, areas of need, including urgent needs (e.g., suicide risk, personal safety, and/or risk to others)
- Risk factors and protective factors, including steps taken to address identified current risks (e.g., detailed safety plan)
- Mental/behavioral health history of beneficiary, including previous diagnoses, treatment (including medication) and hospitalizations

Components of the Diagnostic Assessment (Cont.)

- Psychological history including previous psychological assessment/testing measures, reports, etc.
- Substance use history including previous diagnoses, treatment (including medication) and hospitalizations
- Exposure to physical abuse, sexual assault, antisocial behavior or other traumatic events
- Physical health history, including current health needs and potential high-risk conditions
- Medical history and medications, including history of past and current medications
- Family history, including relationships with family members, and involvement of individuals in treatment and services, family psychiatric and substance use history
- Mental status nn

Components of the Diagnostic Assessment (Cont.)

- Functional assessment(s) (with age-appropriate expectations)
- Education and employment history
- Housing/living situation (e.g., with whom the beneficiary lives with)
- Diagnosis(es) of a serious behavioral health disorder (description and code must be identified for each) from the current edition of the DSM or the ICD, excluding irreversible dementias, intellectual disabilities or related disabilities and developmental disorders, unless they co-occur with a serious mental disorder that meets the current edition DSM criteria
  - The use of Z-codes is allowed but this is considered a temporary diagnosis for ages 7 and older.
  - The use of Z-codes is not time limited for children ages 0 to 6 of age.
  - Z-codes can be used in any diagnosis field on the claim form.
- Planned service type and frequency of each recommended rehabilitative service
- Referrals for external services, support or treatment

Assessment Billing

- The initial DA (90791) and follow-up assessments (H0031) are billed as an encounter.
- The initial assessment may be rendered once every six months.
- The follow-up assessment may be rendered up to 12 times in a year.

Service Plan Development

- The purpose of this service is to allow the LPHA, LMSW, or MHP to work closely with the beneficiary and/ or family members, and any other supports the beneficiary has, to develop or revise the Individualized Plan of Care (IPOC).
- This service will establish the beneficiary's goals and identify appropriate treatment or services needed to meet those goals.
- The beneficiary and/ or family members must be involved in the planning, developing, and choosing of the needed services.
- Staff-to-Beneficiary ratio for this service is 1:1.

Individual Psychotherapy (IP)

- The purpose of this face-to-face intervention is to assist the beneficiary in improving his or her emotional and behavioral functioning.
- IP is an interpersonal intervention directed towards increasing one's sense of well-being, identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning how to utilize those adaptive behaviors and cognitions.
- IP involves planned therapeutic interventions to address the beneficiary's goals.
- Treatment should be designed to maximize the beneficiary's strengths.
- Staff-to-Beneficiary ratio is 1:1.
- Service Limitations: Only one service can be done per day, and only 6 per month.

Group Psychotherapy (GP)

- GP is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician.
- The focus of GP is to assist beneficiaries with solving emotional difficulties and to encourage the personal development of the group members.
- The group process allows members to offer each other support, share common experiences, identify strategies that have been successful, and to challenge each other's behaviors and cognitions.
- The goals of GP must match the overall treatment plan for the individual beneficiary.
- GP requires a relationship and interaction among group members and a stated common goal.
- Staff-to-Beneficiary ratio is 1:8.
- Service Limitations: Only one session per day and 8 per month.

Family Psychotherapy (FP)

- The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his or her family unit.
- The therapist assists family members in developing a greater understanding of the beneficiary's psychiatric and/ or behavioral disorder and the appropriate treatment for the disorder.
- FP may be rendered with or without the beneficiary as long as the identified beneficiary is the focus of the session. Only issues pertinent to the identified beneficiary may be addressed under this service.
- FP tends to be a short-term treatment with a focus on resolving specific problems.
- One session of FP must be 50 minutes to be reimbursable.
- Staff-to-Beneficiary ratio is one staff to one beneficiary and their family unit per session.
- Service Limitations: One session per day, per beneficiary and four per month.

Crisis Management (CM)

- 2 CM services can be rendered prior to the DA.
- The service can be done face-to-face or telephonic.
- The purpose of this short-term service is to assist a beneficiary who is experiencing urgent or emergent marked deterioration of functioning.
- The clinician must assist the beneficiary in identifying the precipitating event, identifying personal and/ or community resources that he or she can rely on to cope with this crisis, and in identifying specific strategies to be used to mitigate the crisis and prevent similar incidents.
- A crisis can be defined as an event that places a beneficiary in a situation that was not planned or expected.
- A CM is not a scheduled service.

Crisis Management (CM) cont.

- CM should therefore be defined as immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information/ referral.
- Face-to-face interventions require immediate response by a clinical professional and include:
  - A preliminary evaluation of the beneficiary's crisis
  - Intervention and stabilization of the beneficiary
  - Reduction of the immediate personal distress
  - Development of an action plan that reduces the chance of future crises
  - Referrals to appropriate resources
  - Follow up with the beneficiary within 24 hours. If follow up is not possible due to incarceration or hospitalization, documentation should be made to reflect this.

Crisis Management (CM) cont.

- Telephonic interventions are provided either to the beneficiary or on behalf of the beneficiary to collect an adequate amount of information to provide appropriate and safe services, stabilize the beneficiary, and prevent a negative outcome.
- Individuals in crisis may be using substances, so substance use should be recognized and addressed in an integrated fashion.
- Staff-to-Beneficiary ratio is 1:1.

Individualized Plan of Care (IPOC) Overview

- The Individualized Plan of Care (IPOC) is an individualized comprehensive plan of care to improve the beneficiary's condition.
- The IPOC is developed in collaboration with the beneficiary, which may include an interdisciplinary team of the following: significant other(s), parent, guardian, primary caregiver, other state agencies and staff, or service providers.
- Providers must ensure that services are tailored to the beneficiary's individual needs and the service delivery reflects knowledge of the particular treatment issues involved.
- The IPOC utilizes information gathered during the evaluation, screening and assessment process.
- The IPOC must be written to provide a person-centered and/or family-centered plan.

IPOC Overview (Cont.)

- The beneficiary must be given the opportunity to determine the direction of his or her IPOC.
- If family reunification or avoiding removal of the child from the home is a goal for the beneficiary, the family, legal guardian, legal representative, or primary caregiver must be encouraged to participate in the treatment planning process.
- Documentation of compliance with this requirement must be located in the beneficiary's record.
- If the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the beneficiary's clinical record.

IPOC Documentation

- Each provider is responsible for developing the IPOC.
- The beneficiary and guardian must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC.
- It is important for overall health care and wellness issues to be addressed.

IPOC Core Treatment - Duration

- The initial IPOC must be completed, signed, titled, and signature dated by the Licensed Practitioner of the Healing Arts (LPHA) within 30 calendar days of the DA.
- When the initial IPOC is completed by a LMSW or a Mental Health Professional, it must be co-signed by the supervising LPHA prior to any further service delivery.
- Core treatment services may be rendered prior to the completion of the IPOC, provided the services are determined medically necessary by an LPHA.
  - Individual Psychotherapy (IP)
  - Group Psychotherapy (GP)
  - Family Psychotherapy (FP)
  - Service Plan Development (SPD)
  - Crisis Management (CM)
- If the IPOC is not completed and signed within 30 days, services rendered are not Medicaid reimbursable.

IPOC Core Treatment - Addendum

- When services are added or frequencies of services are changed in an existing IPOC, the addendum must include the signature and title of the clinician who formulated the addendum and the date it was formulated. All service changes must meet medical necessity criteria for each discrete service to be added.
- When the IPOC Addendum is developed, the clinician must review the IPOC with the beneficiary and/ or family member or legal representation.
- The IPOC Addendum must be signed and dated by the reviewing LPHA to confirm changes.
- When space is unavailable on the current IPOC, a separate sheet must be added and labeled as “Addendum IPOC” and the addendum must accompany the existing IPOC.
- If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary and other involved parties within 10 business days.

IPOC Core Treatment - Reformulation

- The maximum duration of the IPOC is 365 calendar days from the date of the signature of the LPHA.
- Prior to termination or expiration of the treatment period, the clinician must review the IPOC with the beneficiary and evaluate the beneficiary's progress with respect to each of the beneficiary's treatment goals and objectives.
- The signature of the LPHA, LMSW, or master's level clinical professional responsible for the treatment is required.
- The IPOC must include the date of reformulation, the signature and title of the LPHA or master's level qualified professional authorizing services and the signature date.
- There should be evidence in the clinical record regarding the involvement of the beneficiary and the beneficiary's family, if applicable, in the reformulation of the IPOC.
- Copies of the reformulated IPOC must be distributed to all involved beneficiaries within 10 business days.

Components of the IPOC

IPOC documentation must meet all SCDHHS requirements and include the following components listed below:

- Beneficiary Identification
- Presenting Problem(s)
- Psychiatric Diagnosis(es)
- Goals and Objectives (these should be individualized and measurable)
- Specific Interventions (ex. Motivational Interviewing, CBT)
- Specific Services (list only the services needed for this beneficiary)
- Frequency of Services
- Target Dates
- Contact Information (emergency contacts, etc)
- Discharge Plan (include criteria for achievement)
- Beneficiary and Guardian Signature
- Authorized LPHA Signature(s)

IPOC Utilization

- All services utilized in treatment which are required to be listed on the IPOC must be listed on the IPOC with their appropriate frequencies. Services that must be on the IPOC include the Individual, Group, and Family Psychotherapy.
  - While the DA, follow-up Assessment, CM, and SPD do not have to be on the IPOC in order to provide the service, it's always good practice to include these services at a PRN frequency to ensure the beneficiary and/ or families understand these services may be done.
- Services identified on the IPOC and provided must be based on the recommendation(s) of the diagnostic assessment (DA).
- Services and their frequencies must be appropriate based on diagnosis, needs, and strengths.
- IPOC should be reviewed every 90 days and any recommended changes, or recommendations for continuation, should be documented in the Progress Summary.

Progress Summary

- The 90-day progress summary is a periodic evaluation and review of a beneficiary's progress toward the achievement of goals and objectives, overall response to treatment services, the appropriateness of services rendered, and the need for the beneficiary's continued participation in the treatment.
- The progress summary shall be completed at least every 90 calendar days from the signature date on the initial Individualized Plan of Care (IPOC), and every 90 days thereafter.
- The progress summary must be completed and signed by the Licensed Practitioner of the Healing Arts (LPHA), LMSW, or MHP.
- The progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.
- The treatment plan must be updated to address current needs.

Progress Summary Components

The LPHA, LMSW, or MHP will review and document the following components in the progress summary:

- The beneficiary's name and Medicaid ID number.
- The beneficiary's progress toward treatment goals and objectives.
- The appropriateness and frequency of the services provided.
- The need for continued treatment.
- Recommendations for continued services or discharge of services as outlined in the success criteria for each objective.

Clinical Service Notes (CSNs)

- The purpose of the CSNs is to record the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions, and any changes in medical, behavioral or psychiatric status.
- A CSN is required for each contact or service, for each date of service, for each beneficiary (if service was rendered in a group setting) and must be written and signed by the qualified staff who provided the service.
- Each CSN must support both the type of service billed and the number of units billed.
- Every CSN must be individualized to reflect treatment/service and interventions with a specific beneficiary, for each date of service, for each service rendered to the beneficiary and/or family.
- The content of CSNs shall not be duplicated among the records of beneficiaries served by the provider and/or among dates of service for any one beneficiary served by the provider.
- If CSNs are not completed and maintained in accordance with the requirements in this manual, payments to the provider shall be subject to recoupment.

Availability of Clinical Documentation

- CSNs and other service documentation should be completed, signed (and co-signed if necessary) and placed in the clinical record immediately following the delivery of a service, but no later than five business days from the date of service.
- CSN signatures should also include the date the CSN was written (time stamped preferred) as this may differ from the date of service delivery.
- Any documentation completed and placed in the clinical records for any billed activity after this deadline will be subject to recoupment.

Components of Clinical Service Notes

The CSN must include the following information:

- The beneficiary's name and Medicaid ID number.
- The date of service.
- The name of the rehabilitative service (or its approved abbreviation) and the corresponding procedure code.
- The number of units of service rendered.
- The date of service in a month, day and year format.
- Document the start time and end time for each service delivered. This must be exact times (ex: 1:03pm) and not a rounded time (ex: 1:00pm).
- Location where the service was rendered. Place of Service for school based services will be 03.

Components of Clinical Service Notes (Cont.)

The CSN must include the following information:

- Be typed and/or handwritten — documentation must be legible.
- Be kept in chronological order.
- Abbreviations must be decipherable — if abbreviations are used, the provider must maintain a list of abbreviations and their meanings and the list must be made available to SCDHHS upon request.
- Reference individuals by full name, title and agency or provider affiliation at least once in each note, as applicable.
- Identification of other beneficiaries by name shall not be included.
- Be signed, credentialed or titled, and signature dated (month/date/year) by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with these standards.
- Billing modifiers must match the credentials of the individual rendering the service. See the LEA fee schedule for the approved modifiers.
- Be completed and placed in the beneficiary's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service.

CSNs Clinical Description (FIRPP – focus, intervention, response, progress, plan)

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative service conforms to the service description and authenticates the charges:

- The focus and/or reason for the session or interventions which should be related to treatment objective(s) and/or goal(s) on the Individualized Plan of Care (IPOC), unless there is an unexpected event that needs to be addressed.
- The detailed summary of the interventions (e.g., action steps, tools used, techniques utilized, etc.) and involvement of qualified staff with the beneficiary and/or family during each contact or session/meeting (only time spent rendering the intervention or treatment can be billed)
- The individualized response of the beneficiary and/or beneficiary's family, as applicable, to the interventions and/or treatment rendered at each contact or session/meeting.

CSNs Clinical Description (Cont.) (FIRPP – focus, intervention, response, progress, plan)

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative service conforms to the service description and authenticates the charges:

- The general progress of the beneficiary to include observations of their conditions/mental status. Progress should reflect detailed individualized information about the beneficiary over the course of treatment and shall not reflect general categories of progress or general statements of progress in treatment (e.g., phrases such as “moderate” or “not making progress”, without providing detailed information to support the identification of these will not meet this standard).
- The future plan for working with the beneficiary and the beneficiary’s family, as applicable. This should reflect the plan of action for the next and foreseeable future sessions/meetings with the beneficiary (e.g., statements such as “will continue to meet with person as per IPOC” will not meet this standard).

Utilization Review

- Services must be provided within the maximum frequency authorized on the Individualized Plan of Care (IPOC).
- Services that require a prior authorization must be provided within the maximum frequency authorized by the Managed Care Organization (MCO).
- RBHS Prior Authorization form can be found on the SCDE webpage: https://ed.sc.gov/districts-schools/Medicaid/Medicaid-program-quality-assurance/

Prior Authorizations

MCO	PA Guidelines for Core Services- Individual/Group/Family Psychotherapy (90832, 90834, 90837, 90853, 90846, 90847) *This also includes Multi Family Group Therapy (90849) which is only available for RBHS providers enrolled prior to 7/1/22.	PA Guidelines for Community Support Services- PRS, Behavior Modification, Family Support (H2014, H2017, S9482) *These services are only available to RHBS providers enrolled prior to 7/1/22
Absolute Total Care	• No PA is required.	PA required before any of these services can be delivered.
Healthy Blue	• PA is required for Individual Psychotherapy after 24 visits* (any combination of 90832, 90834, and 90837). ***The 24-visit count begins on 7/1 and runs through 6/30.***	PA required before any of these services can be delivered.
Humana	• No PA is required, but there is a 72-visit annual limit	PA required before any of these services can be delivered.
Molina	• PA is required for Individual & Family Psychotherapy after 24 visits* (any combination of 90832, 90834, 90837, 90846, and 90847). • PA is also required for Group Psychotherapy after 24 visits. • Individual/family therapy visits **<u>are not</u>** counted towards the group therapy visits. ***The 24-visit count begins on 7/1 and runs through 6/30.***	PA required before any of these services can be delivered.
Select Health	• PA is required for Individual Therapy after 24 visits* (any combination of 90832, 90834, and 90837). • The instructions for submitting the PA requests is located on the Behavioral Health page on the website at: https://www.selecthealthofsc.com/pdf/provider/resources/submitting-prior-auth-requests-navinet.pdf. ***The 24-visit count begins on 1/1 and runs through 12/31 and excludes DMH.***	PA required before any of these services can be delivered.

Discharge Criteria

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

- The beneficiary's level of functioning has significantly improved.
- The beneficiary has made limited or no progress with respect to the goals outlined in the Individualized Plan of Care (IPOC).
- Achieved the goals as outlined in the IPOC or reached maximum benefit.
- Developed the skills and resources needed to transition to a lower level of care.
- The beneficiary requested to be discharge from treatment (and is not an imminent danger to self or others).
- The beneficiary requires a higher level of care (e.g., more intensive outpatient treatment, Psychiatric Residential Treatment Facility [PRTF], or inpatient treatment).
- The beneficiary displays the inability to actively participate in the program or no longer is working or participating toward their goals.

Discharge Summary Components

Discharge summary must include:

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

Billable Place of Service

- Services must be administered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.
- Excluded settings include acute care hospitals, inpatient psychiatric hospitals, psychiatric residential treatment facilities (PRTF), institutions of more than 16 beds and recreational settings (a place primarily used for play and leisure activities, such as parks and community recreation centers).
- When done in the school, the Place of Service on the claim should be 03.
- If a private provider also works outside of the school, the school mental health modifiers can not be utilized in those private settings.

Billing Modifiers

- Billing modifiers must match the credentials of the individual rendering the service.
- Modifiers for school based mental health services include:
  - H1- Licensed Clinician
    - Licensed Clinician refers to licensed or certified professionals allowed to practice at the independent level. This includes: LPC, LMFT, LISW, LPES, Certified School Psychologist II, and Certified School Psychologist III
  - H2- Unlicensed Clinician
    - Unlicensed Clinician refers to those professionals who require supervision and co-signature on their Diagnostic Assessment (which is used to confirm medical necessity). This includes: LMSW, MHP, and Certified School Psychologist I

Electronic Signatures

- Providers using alternative signature methods like electronic signatures need to be aware of the potential for misuse.
- The system needs to have software products that are protected against modification and that apply adequate administrative procedures that correspond to recognized standards and laws.
- The individual whose name is on the alternate signature method and the provider are responsible for the authenticity of the information.

Acceptable Electronic Signatures

- Acceptable Electronic Signature Examples (Note: these examples are from Palmetto GBA: Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices https://www.palmettogba.com/Palmetto/Providers.Nsf/vMasterDID/8EEM4Q2610:
- Chart 'Accepted By' with provider's name
- 'Electronically signed by' with provider's name
- 'Verified by' with provider's name
- 'Reviewed by' with provider's name
- 'Released by' with provider's name
- 'Signed by' with provider's name
- 'Signed before import by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- Digitized signature: Handwritten and scanned into the computer

Acceptable Electronic Signatures cont'd

- 'This is an electronically verified report by John Smith, M.D.'
- 'Authenticated by John Smith, M.D'
- 'Authorized by: John Smith, M.D'
- 'Digital Signature: John Smith, M.D'
- 'Confirmed by' with provider's name
- 'Closed by' with provider's name
- 'Finalized by' with provider's name
- 'Electronically approved by' with provider's name
- 'Signature Derived from Controlled Access Password'

Signature Dates

- The signature should be dated (time stamped preferred if done electronically) as required by specific provider type.
- Documentation must contain enough information to determine the date when the service was performed or ordered.

Staff Supervision Requirements

- Services provided by any LMSW or unlicensed Mental Health Professional must be clinically supervised by a LPHA.
- Supervising licensed professionals must have a log documenting supervision of services by the LMSW or MHP.
- Supervision must occur at a minimum of every 30 days.
- Reminder: The supervising LPHA must co-sign the DA and the initial IPOC done by the LMSW and the unlicensed MHP.

MCO Contact Information

Absolute Total Care

- Provider Resources: Multiple resources are available online (https://www.absolutetotalcare.com/providers/resources.html) to include:
  - Provider Manual/Billing
  - Training
  - Provider Portal
- Contact Information:
  - Provider Services: 1-866-433-6041
  - Provider Relations:
    - ATCNetworkRelations@centene.com
    - Provider Relations Representative: Wendy McCrea (Wendy.McCrea@centene.com)
    - Director: Sabrina Macon (Sabrina.C.Macon@centene.com)
  - Contracting:
    - ATC_Contracting@centene.com
    - Contract Negotiator: Heather Middleton (Hmiddletone@centene.com)
    - Director: Melody "Mel" Martin (Melody.G.Martin@centene.com)
- Claim Submission:
  - Claims may be submitted via the provider portal, EDI, and paper.
  - Timely filing is 365 days from the date of service.

Healthy Blue Provider Resources

- PowerPoint Presentation (healthybluesc.com) Behavioral Health Training
- SC_CAID_0622healthyblue101webinar.pdf (healthybluesc.com) Healthy Blue 101
- Provider Education Training Programs: https://provider.healthybluesc.com/south-Carolina-provider/provivder-education
- Behavioral Health Provider Relations Consultant:
  - Rikkia G. Kohn
  - Email: Rikkia.Kohn@bluechoicesc.com

Humana
Healthy Horizons™ in South Carolina

Healthy Connections

In order to become participating, please email:

SCBHMedicaid@humana.com

You will receive an automated message with instructions advising of the documents needed to process your enrollment.

Following that automated message, you will receive the credentialing and contracting documents.

For your convenience, information is already prepopulated on your forms to help expedite the process.

Once the all completed documents are received, they will be entered into our system for credentialing.

You may **type** *and* **sign** in the documents directly.

WELCOME TO HUMANA!

Once your credentialing has been approved, you will receive a welcome packet including a copy of your executed agreement with your effective date.

****Please note, services provided *prior* to your effective date will require non par prior authorization****

There are many online resources to help familiarize yourself with Humana procedures.

South Carolina Medicaid for Providers – Humana

Claims

Electronic Payer ID 61101

CMS 1500 billing form

Timely filing 365 days

Provider Portal

Availity: EDI Clearinghouse, Revenue Cycle Management, Provider Portal

Provider Service number

866-432-0001

Provider Orientations will be held on Fridays From 10 am-11 am or 2pm-3pm via Zoom.

July 22nd at 10am

August 5th at 10am and 2pm

August 12th at 10 am

August 19th 10am and 2pm

Please email athompson100@humana.com for Zoom invite

Also available to conduct in-person training.

Molina Provider Resources

- **Link to Molina Provider Medicaid Home Page**
  MolinaHealthcare.com/Providers/SC/Medicaid/Home
  - Register to be a user on the Availity Essentials Portal
    - Real-time transactions including claims, eligibility, and benefits
  - Prior Authorization updates and Code LookUp Tool
  - Quick links
  - Online submission options for provider disputes and appeals

- **Provider Services Contact Information**
  - Phone (855) 237-6178
  - SCProvider.Services@MolinaHealthcare.com

- **Clearinghouse–Change Healthcare–Payer ID 46299**

Important Information for Select Health Providers

- **Unenrolled RBHS providers** will need to complete the Healthy Connections Medicaid provider application (located on the SCDHHS website) and a Select Health credentialing application. For a Select Health Credentialing application packet, please contact **Kathy McLaurin at KMcLaurin@selecthealthofsc.com.**
- **Prior authorization: Medical necessity review is required for outpatient psychotherapy visits (codes 90832, 90834, 90837) after 24 visits.**
  - This does **not** apply for children and youth in Foster Care, the Department of Mental Health (DMH), or the Medical University of South Carolina (MUSC).
  - For calendar year 2022, the 24-visit count runs through December 31. The calendar year visit count will start over January 1, 2023. Six visits per month limitation applies.
  - Authorization requests must be submitted via our NaviNet Provider portal: **https://navinet.navimedix.com/**. Follow the step-by-step **instructions for submitting prior authorization requests** available on the Select Health Behavioral Health webpage.
  - Required documentation: Include with your request, the most recent Individual Plan of Care (IPOC), progress notes, and three (3) most recent clinical service notes; upload all in one document.
  - Approval notification and certification number will be provided within minutes of submission.
- **Claims submission**: Submit claims utilizing the CMS-1500 claim form, following SCDHHS and standard CPT filing guidelines. Remember to submit the School District ID in box 19, EDI Loop 2300 segment NTE.
  - Select Health provides a no-cost claims submission portal for our providers. The portal can be accessed through the NaviNet provider portal under ***Workflows for This Plan – Claim Submission*** link, or direct link: https://physician.connectcenter.changehealthcare.com/#/site/home**.** To register to use ConnectCenter, click on the ***SIGN UP*** link in the middle of the screen and complete the online registration.

For more detailed information, visit our School-based Mental Health Initiative webpage on our website. For questions, please contact Kathy McLaurin at the email listed above.

Select Health of South Carolina

Questions?


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