



LICENSED INDEPENDENT PRACTITIONER'S (LIP) REHABILITATIVE SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

Effective July 1, 2010, the State of South Carolina (South Carolina or State) State Medicaid Plan was amended to allow an array of behavioral health services under the Rehabilitative Services Option, Code of Federal Regulations (CFR) 42 CFR 440.130(d). Rehabilitative Services are medical or remedial services that have been recommended by a Physician or other Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under South Carolina State Law and as further defined by the South Carolina Department of Health and Human Services (SCDHHS) for maximum reduction of a physical or mental disability and restoration of a beneficiary to their best possible functional level.

Services in this manual are intended to be delivered in an outpatient and community setting only. In accordance with 42 CFR 435.1009-1011, RBHS are not available for beneficiaries residing in an Institution of Mental Disease. Inpatient Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTFs) receive an all-inclusive, per diem rate for services. RBHS services provided to beneficiaries in these settings are not Medicaid reimbursable.

The SCDHHS encourages the use of “evidence-based” practices, and “emerging best practices” in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis and treatment planning; and fosters improvement in the delivery system of mental health services to children and adults in the most effective and cost-efficient manner. Evidence-based practices are defined as preferential use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. The National Registry of Evidence-based Programs and Practices and other relevant specialty organizations publish lists of evidence-based practices that providers may reference.

Services must be determined medically necessary to be eligible for Medicaid reimbursement and some services must be authorized prior to service delivery. Medical necessity means the need for treatment services is necessary in order to diagnose, treat, cure, or prevent an illness, or which may reasonably be expected to relieve pain, improve and preserve health, or be essential to life.

The requirements for prior authorization are articulated later in this section. Failure to obtain authorization prior to provision of service when required will result in non-payment.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Section 4 - Procedure Codes](#)

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Rehabilitative Services are provided to, or directed exclusively toward the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.

All Medicaid beneficiaries must meet specific medical necessity criteria in order to receive RBHS services.

Eligibility for Services

The determination of eligibility for services should include a comprehensive assessment or evaluation of the beneficiary.

Unless otherwise specified in the specific service description, Medicaid-eligible beneficiaries may receive services when there is a primary psychiatric diagnosis as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or International Statistical Classification of Diseases (ICD) (excluding irreversible dementias, intellectual disabilities or related disabilities, developmental disorders, unless they co-occur with a serious mental disorder that meets current edition DSM criteria), and services are determined medically necessary. Persons with a developmental disability should be carefully assessed to determine if there are co-occurring behavioral problems and if those problems could be addressed with services. A determination should be made if the beneficiary is reasonably expected to improve in adaptive, social, and/or behavioral functioning from the delivery of services.

Medical necessity based on Z-codes is allowed but is considered temporary and may not be used for longer than six-month duration. Z-codes do not replace a psychiatric diagnosis from the current edition of the DSM or ICD. After six months, medical necessity must be established by a psychiatric diagnosis if continuation of services is needed. Z-codes may not be used for ages 7 and up for longer than six-month duration. The use of Z-codes is not time limited for children ages 0 to 6 of age. Clinical documentation justifying the need for continued RBHS must be maintained in the child's clinical record.

Providers are strongly encouraged to verify current eligibility status prior to service delivery via the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool). Please reference the South Carolina Provider Administrative and Billing Manual to identify the process for checking beneficiary's eligibility status.

Managed Care Organizations

Effective April 1, 2012, behavioral health services are covered for beneficiaries enrolled in Medicaid Managed Care Organizations (MCOs). The policy herein does not apply to services covered by an MCO. Providers are not allowed to bill for services rendered to a beneficiary covered by a specific MCO unless the provider is credentialed with that MCO. Providers are encouraged to visit the SCDHHS website at <https://www.scdhhs.gov/providers/health-managed-care-plans> for additional information regarding MCO coverage.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Licensed Independent Practitioner (LIP) providers must fulfill all the requirements for South Carolina licensure and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor, Licensing and Regulation. Licensed professionals must maintain a current license from the appropriate authority to practice in the State and must be operating within their scope of practice.

Professionals with appropriate education and experience who have passed prerequisite examinations as required by the applicable state laws and licensing board and additional requirements as may be further established by SCDHHS may qualify to provide services according to the policy herein.

Except as required by 42 CFR 431.52, LIP providers must be located within the South Carolina Medicaid Service Area (SCMSA) to ensure (i) quality care is delivered based on clinical standards, (ii) the full covered service array is available under the behavioral health benefit, and (iii) each member has access to in-person care whenever necessary.

The following LIPs allowed by South Carolina State Law to practice independently are eligible to enroll directly with the Medicaid program:

- A **Licensed Psychologist** with the following qualifications:
 - Ph.D. or Psy.D. from an accredited college or university.
 - A valid and current professional license with a specialty in Clinical, Counseling, or School Psychology, as approved by the South Carolina Board of Examiners in Psychology (SCBEP).
- A Licensed Psycho-Educational Specialist (LPES) with the following qualifications:
 - Master's, doctorate or specialist degree from a degree program approved by the National Association of School Psychologists, the American Psychological Association or from a degree program that the Board finds to be substantially equivalent based on criteria established by the South Carolina Department of Labor, Licensing and Regulation.

- Certified by the South Carolina Department of Education as a school Psychologist level II or III and served successfully for at least two years as a certified school Psychologist in a school psychology or comparable setting (at least one year of which must have been under the supervision of a LPES) and a satisfactory score on Praxis® Series II exam.
- A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists.
- A Licensed Independent Social Worker - Clinical Practice (LISW-CP) with the following qualifications:
 - Master's degree or doctorate from a board-approved social work program.
 - One year of experience working with the population to be served.
 - A valid and current professional license as approved by the South Carolina Board of Social Work Examiners.
- A Licensed Marriage and Family Therapist (LMFT) with the following qualifications:
 - Master's, doctorate, or specialist degree from a degree program accredited by the Southern Association of Colleges and Schools Commission on Colleges, the Association of Theological Schools in the United States and Canada, a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education, or a regionally-accredited institution of higher learning.
 - A minimum of 48 graduate semester hours or 72 quarter hours in Marriage and Family Therapy.
 - A minimum of three semester hour graduate level courses with a minimum of 45 classroom hours or 4.5 quarter hours for each course. One course cannot be used to satisfy two different categories.
 - A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists.
- A Licensed Professional Counselor (LPC) with the following qualifications:
 - A minimum of a 48-hour master's degree or higher in counseling or in a related discipline.
 - All coursework, including any additional core coursework, must be taken at a college or university accredited by the Commission on Colleges. The Southern Association of Colleges

and Schools Commission on Colleges; or the Association of Theological Schools in the United States and Canada; or a post-degree program accredited by the Commission on Accreditation for Marriage and Family Therapy Education; or a regionally accredited institution of higher learning subsequent to receiving the graduate degree.

- A valid and current professional license by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists.

PROVIDER MEDICAID ENROLLMENT AND LICENSING

Licensed Independent Practitioner Enrollment Guidelines

The Centers for Medicare and Medicaid Services (CMS) strengthened requirements for Medicaid provider screening to prevent fraud, waste, and abuse. CMS requires state Medicaid agencies to screen all provider applications based on a categorical risk level of “limited,” “moderate” or “high.” This categorization helps the agency align with federal requirements and ensures taxpayer funds are appropriately safeguarded.

When a state Medicaid agency designates a provider type as a “high” categorical risk, the agency must require fingerprint-based criminal background checks (FCBC) for providers and any entity with 5% or more direct or indirect ownership interest in the provider. ***LIP providers are included in the “high risk” category and as such are required to comply with the CMS regulations (42 CFR Part 455 subpart E) associated with this category.*** The FCBC must be completed during the enrollment process. Additionally, it is vital that provider owners and managing employees understand that they can be held criminally liable for the actions of the providers’ employees, agents, and representatives.

Requirements for enrollment as a “high risk” provider include the following steps:

- Newly enrolling LIP providers must undergo level 1 and level 2 fingerprint-based criminal history background checks (FCBC) with both the South Carolina Law Enforcement Division and the Federal Bureau of Investigation;
- Must undergo a pre-enrollment site visit;
- May undergo a post-enrollment site visit to verify that the information submitted to SCDHHS is accurate and to determine compliance with federal and state enrollment requirements. (§ 455.432[(a)]);
- Must provide 100% disclosure of ownership to the grandparent level and attest to the disclosure of ownership during the provider enrollment process in accordance with CFR 42 §455.102.

**** The above requirements do not apply to state agency providers, mental health counselors who are school district employees, or entities acting on behalf of a state agency, including child-placing agencies and Developmental Evaluation Centers.***

Newly enrolling LIP providers may learn more about fingerprinting requirements, high-risk provider types, and disqualifying criteria by visiting the list of frequently asked questions (FAQ) on the agency's Provider Enrollment page (<https://www.scdhhs.gov/providers/become-provider>).

Additional resources and complete instructions for the online Medicaid Provider Enrollment application process are also available on the Provider Enrollment webpage at:
<https://www.scdhhs.gov/ProviderRequirements>.

LIP applicants must complete the following additional steps to become enrolled as a Medicaid provider:

1. Obtain a National Provider Identifier (NPI) number. An NPI number is required to enroll directly with the Medicaid program. Information about the NPI number is available on the Centers for Medicare & Medicaid Services website at: <https://nppes.cms.hhs.gov>.
2. Register for the Pre-Enrollment Orientation at:
<https://training.scdhhs.gov/academy/course/view.php?id=5>. The Pre-Enrollment Orientation is available online 24 hours per day, seven days per week. The orientation is designed to provide the LIP with knowledge about policy and procedures, and prevent potential Medicaid recoupment as a result of a post payment review. Following the orientation, the LIP will be prompted to complete a questionnaire.
3. Complete the online Provider Enrollment application. On the application, providers must select "New Enrollment" and the following options depending on whether enrolling an individual or a group:

LIP ENROLLMENT OPTIONS — INDIVIDUAL

Enrollment Type	Individual
Provider Type Description	Other Medical Professionals
Specialty Description (<i>Select only one specialty</i>)	LISW-CP, LPC, LMFT, LPES or Psychologist
Subspecialty Description	No Subspecialty

Note: Individual LIPs must receive a Medicaid Individual Legacy ID number.

LIP ENROLLMENT OPTIONS — GROUP

Enrollment Type	Organization
Provider Type Description	Groups
Specialty Description (<i>Select only one specialty</i>)	LISW-CP, LPC, LMFT, LPES, Psychologist or Multiple Specialty Group

LIP ENROLLMENT OPTIONS — GROUP

Subspecialty Description

No Subspecialty

Note: LIP group practices must enroll and receive a Medicaid Group Legacy ID number. Each LIP wishing to render Medicaid reimbursable services through a group practice must also be enrolled individually with Medicaid and can affiliate themselves during their online application process with a currently enrolled group practice.

Entering the Medicaid Group NPI number on the Medicaid billing form will ensure that payment is made to the group rather than to the individual LIP. While the group may receive Medicaid payments, the enrolled practitioner who renders or oversees the service rendered to a beneficiary is responsible for ensuring the quality and extent of services delivered.

Enrollment in the Medicaid program does not provide a guarantee of referrals or a certain funding level. Failure to comply with all Medicaid policy requirements may result in termination of Medicaid enrollment.

Services Rendered Under Supervision

Licensed Psychologist

Medicaid reimbursement may be sought for services rendered by an unlicensed person providing psychological services under the direct supervision of a Psychologist licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the supervising Psychologist must provide services at the same location as the supervisee and be immediately accessible by phone or other electronic device when the services being billed are provided. In addition, there must be a written protocol in place for addressing crisis situations when they arise. The supervising Psychologist is responsible for all services rendered, fees charged and reimbursement received.

For Medicaid billing purposes, the supervising Psychologist must co-sign all session notes to indicate that he or she accepts responsibility for the service rendered. No more than three full-time supervisees may be in the employ of any one supervising licensed Psychologist.

In addition to the above requirements for Medicaid billing purposes, the SCBEP maintains a set of Guidelines for Employment or Supervision of Unlicensed Persons Providing Psychological Services. The supervising licensed Psychologist must register all information deemed necessary by SCBEP with SCBEP at the time of initiation of supervision, prior to service delivery and at the time of annual license review. There must be evidence that supervision guidelines have been adhered to as set forth by this Board.

To obtain copies of the SCBEP requirements or to ask questions regarding supervision, call the SCBEP at (803) 896-4664 or visit <https://lir.sc.gov/psych/>.

Licensed Professional Counselor Supervisors and Marriage and Family Therapist Supervisors

Medicaid reimbursement may be sought for services rendered by a LPC Associate or LMFT Associate under the direct supervision of a Licensed Professional Counselor Supervisor (LPC/S) or a Licensed Marriage and Family Therapist Supervisor (LMFT/S) licensed to practice in South Carolina. The associate-level provider must be supervised by an independent supervisor with the same license type. For Medicaid billing purposes, direct supervision means that the LPC/S or LMFT/S must provide services at the same location as the supervisee and be immediately accessible by phone or other electronic device when the services being billed are provided. In addition, there must be a written protocol in place for addressing crisis situations when they arise. The LPC/S or LMFT/S is responsible for all services rendered, fees charged and reimbursement received.

For Medicaid billing purposes, the LPC/S or LMFT/S must co-sign all session notes to indicate that he or she accepts responsibility for the service rendered and there must be no more than six full-time supervisees in the employ of any one LPC/S or LMFT/S.

In addition to the above requirements for Medicaid billing purposes, the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists maintains policy and guidelines for Intern supervision.

All of the required supervision documents must be submitted to the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists at the time of initiation of supervision and prior to service delivery. There must be evidence that supervision guidelines have been adhered to as set forth by this Board.

To obtain copies of the Board requirements or to ask questions regarding supervision, please call the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists at: +1 803 896 4658 or visit <https://llr.sc.gov/cou/>.

Licensed Independent Social Worker - Clinical Practice

Medicaid reimbursement may be sought for services rendered by applicants for LISW licensure under the direct supervision of a LISW-CP licensed to practice in South Carolina. For Medicaid billing purposes, direct supervision means that the LISW-CP must provide services at the same location as the supervisee and be immediately accessible by phone or other electronic device when the services being billed are provided. In addition, there must be a written protocol in place for addressing crisis situations when they arise.

The LISW-CP is responsible for all services rendered, fees charged and reimbursement received. For Medicaid billing purposes, the supervising LISW-CP must co-sign all session notes to indicate

that he or she accepts responsibility for the service rendered. There must be no more than six full-time supervisees in the employ of any one supervising LISW-CP.

In addition to the above requirements for Medicaid billing purposes, the South Carolina Board of Social Work Examiners maintains policy and guidelines for LISW Supervision. All of the required documents must be submitted to the South Carolina Board of Social Work Examiners at the time of initiation of supervision and prior to service delivery. There must be evidence that supervision guidelines have been adhered to as set forth by this Board.

To obtain copies of the Board requirements or to ask questions regarding supervision, please call the South Carolina Board of Social Work Examiners at: +1 803 896 4664 or visit

<https://lir.sc.gov/sw/>.

Maintenance of Licensed Independent Practitioner Credentials

Individual LIPs or group providers are responsible for ensuring that all professionals rendering services must maintain current licensure and appropriate standards of conduct.

LIP providers must maintain and make available upon request, appropriate records and documentation of qualifications, trainings and investigations. Provider must ensure that adequate and correct fiscal records shall be kept to disclose the extent of services rendered and ensure that claims for funds are in accordance with all applicable laws, regulations and policies. If these records are kept in another location or a central corporate office, the LIP will be given five business days to retrieve the records for the agency that is requesting them.

All Medicaid-enrolled groups must maintain a file substantiating each practitioner's qualifications and training. This shall include employer verification of the LIP's licensure and work experience. The group must maintain a signature sheet that identifies all professionals providing services by name, signature and initial.

LIP(s) shall also ensure that all interns and other individuals that require supervision are under the authority of the provider who comes in contact with beneficiaries, are properly qualified, trained and supervised.

In addition to documentation of LIP credentials and training, the group must keep the following specific documents on file:

- A completed employment application form.
- Copies of advanced degrees.
- A copy of all applicable licenses.
- Letters or other documentation of verification of previous employment/volunteer work to document experience with the population to be served.

- A copy of the individual's criminal record check form from an appropriate law enforcement agency; the criminal record check must be updated annually.
- Verification must be updated annually from the child abuse registry that there are no findings of abuse or neglect against the individual.
- Verification must be updated annually from the State and national sex offender registries that there are no findings of sexual charges against the individual.

Maintenance of Organizational Policies

Providers must have a policy for definition of confidentiality issues, record security and maintenance, consent for treatment, release of information, beneficiary's rights and responsibilities, retention procedures and code of ethics.

Providers must have a policy in place specific to Emergency Safety Intervention (ESI). ESI policy applies to any community-based provider(s) that has policies prohibiting the use of seclusion and restraint but who may have an emergency situation requiring staff intervention.

Providers must have a written policy and procedure for emergency situations and must ensure that the practitioners are trained and prepared in the event of an emergency situation.

If the provider intends to use restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring beneficiary safety. For more information on selecting training models, see Section 7 of the Project Rest Manual of Recommended Practice, available at: <http://frcdsn.org/wp-content/uploads/2014/04/Manual-of-Recommended-Practice.pdf>.
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion or restraints are being used that adheres to all state licensing laws and regulations (including all reporting requirements).

Failure to have these policies and staff training in place at the time services are rendered will result in termination from the Medicaid program and possible recovery of payments.

Provider Referral Process

There are three ways that a LIP may receive a referral to provide services:

1. A Medicaid-enrolled Physician may refer an eligible beneficiary to the LIP via the SCDHHS Behavioral Health Referral and Feedback Form. To ensure coordination of care, the feedback portion of this form should be completed by the LIP and returned to the referring Physician within 30 calendar days of the assessment date.
2. A State agency can provide a referral. If the State agency is making a referral to a LIP, they may furnish the receiving provider the assessment, Individualized Plan of Care (IPOC), list of services to render, and any other clinical documentation. To ensure coordination of care, the completed clinical service notes (CSN) must be forwarded to the State agency by the referring entity.
3. An eligible Medicaid beneficiary may self-refer for services provided by a LIP.

Note: Referrals (provider-to-provider or self-referred) can be done via phone, email, fax and hard copy mail. Providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

BUSINESS CLOSURES

Business Termination Guidelines

In the event the LIP provider closes his or her practice, the provider will adhere to all of the following applicable State laws, rules and regulations:

- In cases of voluntary termination or closure, the provider shall provide written notification 30 days prior to the closure to SCDHHS and other appropriate agencies.
- Notification shall include the location where beneficiary and administrative records will be stored.
- The responsible party must retain administrative and beneficiary records for five years.
- Prior to closure, the LIP provider will notify all beneficiaries and assist them with locating appropriate service providers.
- When a provider closes, the owner is responsible for releasing records to any beneficiary who requests a copy of his or her records. The owner is also responsible for the transfer of records to the appropriate State agencies, if applicable.
- Even if a provider closes, the provider may be responsible for repayment of any overpayments that occurred during the time the provider rendered treatment to Medicaid beneficiaries.

If a provider does not have any claim activity (fee-for-service or encounter, paid or denied) over the course of an 18-month period, their provider ID will be terminated. This inactivity alone will not qualify as an adverse termination and the provider may re-apply to the South Carolina Healthy Connections Medicaid program should they meet all current requirements.

If the provider is terminated involuntarily by Medicaid, the provider is responsible for all beneficiary and administrative records in the event of a post-payment review.

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COVERED SERVICES AND DEFINITIONS

BEHAVIORAL HEALTH SCREENING

The purpose of Behavioral Health Screening (BHS) is to provide early identification of behavioral health issues and to facilitate appropriate referral for a more focused assessment and/or treatment. BHS is designed to quickly identify behavioral health issues and/or risk of development of behavioral health problems and/or substance abuse.

This face-to-face service requires completion of a brief questionnaire to examine the nature and context of the problem and identify patterns of behavior. Screenings are conducted using a standardized or SCDHHS-approved tool, through interviews or self-report. Some of the common tools used are:

- Global Appraisal of Individual Needs - Short Screener (GAIN)
- Eyberg Child Behavioral Inventory (ECBI)
- Drug Abuse Screening Test (DAST)

Screenings should be scored utilizing the tool's scoring methodology and referrals made based on the interpretation of the results.

Reimbursement for BHS is only available for the interpretation and/or scoring of the screening tool and does not include time spent administering the tool.

Telehealth Overview

The Centers for Medicare and Medicaid Services (CMS) defines telehealth as the use of electronic information and telecommunications technologies to extend care when a provider and a patient are not in the same place at the same time.

Services rendered via telehealth may be rendered synchronously or asynchronously using a telecommunication system (audio/video) that permits interactive communications between a provider and a patient. The telecommunication system must be Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant. DHHS only reimburses for services conducted synchronously, using both audio and video components unless otherwise specified.

Services delivered via telehealth are not an addition to Medicaid-covered services but an option for the delivery of certain covered services. Quality of health care must be maintained regardless of the mode of delivery.

Telehealth Definitions:

Synchronous Telehealth

Synchronous telehealth is real-time, audio-video communication that connects physicians and patients in different locations.

Referring Provider

The referring provider is the provider who has evaluated the beneficiary, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment.

Consulting provider

The consulting provider is the provider who evaluates the beneficiary via telehealth upon the recommendation of the referring provider.

Eligible Providers:

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Medicaid program are eligible to bill for covered Medicaid services via telehealth in accordance with SCDHHS coverage policies and the provider's scope of practice. Both the referring and the consulting providers must be enrolled in the Medicaid program.

Referring Sites

A referring site (also called the patient site) is the location of an eligible Medicaid beneficiary at the time of the telehealth session. Medicaid beneficiaries are eligible for services via telehealth only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters must be knowledgeable of how the equipment works and be able to provide clinical support if needed during a session.

Covered referring sites are:

- The office of a qualified practitioner defined as a physician, Nurse Practitioner, Certified Nurse Midwife Physician Assistant, or Licensed Independent Practitioner
- Hospital (inpatient and outpatient)
- RHCs
- FQHCs
- Public Schools

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- Patient home

Consulting Sites

A consultant site (also called the distant site) is the site at which the provider is located at the time the telehealth service. The provider performing the medical care must be enrolled in the Medicaid program and provide services in accordance with the licensing board and the scope of practice.

Practitioners at the distant site qualified to furnish services via telehealth are:

- Licensed Independent Practitioners (and associates)

Office and outpatient visits that are conducted via telehealth are counted towards the applicable benefit limits for these services.

Medicaid allows the service to be delivered via telehealth when the service meets the following criteria:

- The beneficiary must be present and participating in the telehealth visit, [unless otherwise specified in the procedure code description](#).
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used, permitting encrypted communication between the distant site physician or practitioner and the Medicaid beneficiary. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted.
- The telehealth equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Any staff involved in the telehealth visit must be trained in the use of the telehealth equipment and competent in its operation.
- A trained healthcare professional at the referring site (patient site presenter) is required to present the beneficiary to the provider at the consulting site and remain available as clinically appropriate (this condition is waived when the referring site is the patient home).
- If the beneficiary is a minor (under 18 years old), a parent and/or guardian must present the minor for telehealth service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telehealth session unless attendance is therapeutically appropriate.

- The beneficiary retains the right to withdraw from the telehealth visit at any time.
- All telehealth activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.
- The beneficiary has access to all transmitted medical information, except for live interactive video, as there is often no stored data in such encounters.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.
- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's need.
- The medical care can be safely furnished.
- No equally effective, more conservative or less costly treatment is available Statewide.

Associate-level providers should continue to request reimbursement under supervising clinician's enrollment and follow other billing guidance as articulated in this manual.

Services rendered via telehealth must include a GT modifier.

Service Location

The only excluded settings for BHS services are PRTFs and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Assessments

Comprehensive Assessment — Initial and Follow-Up

The purpose of an Initial Comprehensive Assessment is to determine the need for services by establishing medical necessity, to establish and/or confirm a diagnosis, and to provide the basis for the development of an effective course of treatment. The Initial Comprehensive Assessment may include but is not limited to, psychological assessment/testing to determine accurate diagnosis or to determine differential diagnosis. The diagnostic assessment must be completed within 14 calendar days of the admission to the practice.

Initial assessments must include face-to-face time with the beneficiary and include an evaluation of the beneficiary for the presence of a behavioral health disorder. The initial assessment is used to determine the beneficiary's mental status, social functioning, and to identify any physical or medical conditions.

Initial assessments include a clinical interview with the beneficiary and/or family members or guardians as appropriate, review of the presenting problems, symptoms and functional deficits, strengths and history, including past psychological assessment reports and records. Initial assessments should be completed in one day. If additional time is needed to complete a thorough assessment, billing should occur on another day through the follow-up assessment code.

Follow-up assessments occur at any time after an initial assessment, to re-evaluate the status of the beneficiary, identify any changes in behavior and/or condition and to monitor and ensure appropriateness of treatment. Follow-up assessments are face-to-face and may also be rendered to assess the beneficiary's progress, response to treatment, the need for continued treatment and establish medical necessity.

The LIP should attempt to determine whether another Comprehensive Assessment (initial or follow-up) has been conducted in the last 90 days and efforts should be made to access those records. An assessment should be repeated only if a significant change in behavior or functioning has been noted. Delivery of this service may include contacts with family and/or guardians for the purpose of securing pertinent information necessary to complete an evaluation of the beneficiary.

When an assessment has not been received from the referral source, the LIP must certify and document through a Comprehensive Assessment that the beneficiary meets the medical necessity criteria for services. The following guidelines shall be used to determine medical necessity:

- Medical necessity must be based on information provided by the beneficiary, their family, or others who are familiar with the beneficiary.
- Medical necessity must be based on current clinical information. If the diagnosis has not been reviewed in a 12-month or more period, the diagnosis must be confirmed immediately.
- Medical necessity must be made within SCDHHS's standards for timeliness.

The comprehensive assessment must:

Establish one or more diagnoses, including co-occurring substance use or dependence if present in accordance with the current edition of the ICD

- Determine the appropriateness of treatment services, including the need for integrated treatment of co-occurring disorders
- Upon periodic review, determine progress towards goals and justify continuation of treatment

- Confirm medical and/or psychiatric necessity of treatment

If the beneficiary has not received RBHS for 45 consecutive calendar days, the medical necessity must be re-established by completing a follow-up assessment.

CALOCUS-CASII Assessment — Community Support Services

The Child and Adolescent Level of Care/ Service Intensity Utilization System (CALOCUS-CASII) Assessment is used to establish medical necessity for children and adolescents ages 6-18 who are entering into community support services of Psychosocial Rehabilitation, Behavior Modification and Family Support. The assessment must be a face-to-face assessment with the beneficiary.

CALOCUS-CASII links a clinical assessment with standardized criteria that describes the level of intensity of services needed for a beneficiary. The CALOCUS-CASII rating can be done for any beneficiary in any setting, regardless of the diagnosis or service agency with which the beneficiary is involved.

CALOCUS-CASII must be administered by a LPHA that has successfully completed training on CALOCUS-CASII and passed a competency test with prior written approval from SCDHHS.

The CALOCUS-CASII tool considers four distinct types of potential co-morbid areas: psychiatric, substance use, developmental and medical.

CALOCUS-CASII ranges from Level 1 to Level 6 where the frequency, intensity, location and duration of treatment are correlated to the severity of the child or adolescent's condition.

Treatment and/or services are recommended based on the composite score of the dimensions and the corresponding level of care. Services may be provided by a community mental health system, a private therapist, an interagency community-based system of care, or other providers of mental, psychiatric or behavioral health services. It is always preferable to keep children in their communities. Clinical professionals must determine if enhanced community services could be provided to support the child and his or her family as an alternative to placement.

The levels of care are:

- Level 1 — Recovery Maintenance and Health Management
- Level 2 — Outpatient Services
- Level 3 — Intensive Outpatient Services
- Level 4 — Intensive Integrated Service without 24-Hour Psychiatric Monitoring
- Level 5 — Non-Secure 24-Hour Services with Psychiatric Monitoring

- Level 6 — Secure 24-Hour Services with Psychiatric Management

When CALOCUS-CASII score indicates a Level 4, 5 or 6, PRTF placement is not required. Other community resources at a higher frequency and/or intensity of services, based on the needs of the individual, should be considered.

Staff-to-Beneficiary Ratio

The staff-to-beneficiary ratio for the Comprehensive Assessment (initial and follow-up) requires one LIP for each beneficiary.

Service Location

Excluded settings for assessment services are PRTFs (unless prior approved for retro-eligibility) and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any 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.

Psychological Testing and Evaluation

Psychological Testing and Evaluation services include psychodiagnostics assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorschach, WAIS) and are only to be rendered by a Licensed Psychologist or LPES.

Testing and evaluation must involve face-to-face interaction between a Licensed Psychologist/LPES and the beneficiary for the purpose of evaluating the beneficiary's intellectual, psychiatric and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status and personality characteristics, as well as use of other non-experimental methods of evaluation. Testing includes face-to-face time administering the tests to the beneficiary and time interpreting these test results and preparing the report.

Psychological testing/assessment may be used for the purpose of psychodiagnostics clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning. Psychological testing/assessment can be used to confirm or rule out a diagnosis of Autism Spectrum Disorder.

All psychological assessment by the assessor must include a specific referral question(s) that can be reasonably answered by the proposed psychological assessment/testing tools to be administered. All requests for psychological assessment/testing must clearly establish the benefits of the psychological assessment/testing, including but not limited to, how the psychological evaluation/testing will inform treatment.

When necessary/appropriate, consultation shall only include telephone or face-to-face contact by a Psychologist/LPES to the family, school, or another health care provider to interpret or explain the results of psychological testing and/or evaluations related to the care and treatment of the beneficiary. The Psychologist/LPES must document the recommended course of action.

Staff-to-Beneficiary Ratio

The ratio for Psychological Testing and Evaluation requires one Psychologist/LPES for each beneficiary.

Service Location

The only excluded settings for Psychological Testing and Evaluation services are PRTFs and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Service Plan Development

Service Plan Development (SPD) is a face-to-face or telephonic interaction between the beneficiary and a qualified clinical professional or a team of professionals to develop the IPOC based on the assessed needs, strengths, weaknesses, social history, and support systems of the beneficiary and to establish treatment goals and treatment services to reach those goals.

The planning process should focus on the identification of the beneficiary's/family's needs and desired life outcomes. The beneficiary, multiple agency staff or interdisciplinary team members (if applicable) should identify the skills and abilities of the beneficiary that can help them achieve their goals (e.g., competitive employment, independent living, etc.), identify areas in which the beneficiary needs assistance and support and decide how the team can meet those needs.

For multiple agency staff or interdisciplinary team members, a minimum of three human service agency staff or interdisciplinary team members constitute a team.

Multi-agency meetings may be face-to-face or telephonic and only allowable when the discussion focuses on planning and coordinating service provision for the identified beneficiary.

While attendance of multiple provider representatives may be necessary, only one staff person that is actively involved in the planning process from each provider office may receive reimbursement.

Service Location

SPD may be offered in all settings in the community that allow for privacy and confidentiality.

Core Services

Psychotherapy is the treatment of mental illness and behavioral disturbances in which the LIP, through definitive therapeutic communication, addresses the emotional disturbance, reverses or

changes maladaptive patterns of behavior, and encourages personality growth and development. Psychotherapy times are for face-to-face services with the beneficiary and/or family member.

Psychotherapy services are provided within the context of the goals identified in the beneficiary's Individualized Plan of Care or IPOC. Assessments, plans of care and progress notes in the beneficiary's records must justify, specify and document the initiation, frequency, duration and progress of the therapeutic modality. The nature of the beneficiary's needs and diagnosis including substance abuse, strengths and resources, determine the extent of the issues addressed in treatment, the psychotherapeutic modalities used by the clinical professional and its duration.

Psychotherapy Services may be provided in an individual, group or family setting. All CSN must document how the individual, group, or family Psychotherapy session applied to the identified beneficiary's treatment goals.

Individual Psychotherapy

Individual Psychotherapy is a face-to-face intervention with the beneficiary or beneficiary and family member with the purpose of restoring the beneficiary to his/her best possible functional level. Procedure codes for Psychotherapy with patient and/or family member are used when individual Psychotherapy is being provided. The beneficiary must be present for all or some of the service.

Individual Psychotherapy Staff-to-Beneficiary Ratio

The ratio for individual Psychotherapy is one LIP to one beneficiary and/or family member.

Group Psychotherapy

Group Psychotherapy is a face-to-face intervention with a group of beneficiaries, who are addressing similar issues, with the purpose of restoring the beneficiary to his/her best possible functional level.

Group Psychotherapy is conducted in small groups. The group must be a part of an active treatment plan and the goals of the group therapy must match the overall treatment plan for the individual beneficiary. The focus of the therapy sessions must not be exclusively educational or supportive in nature.

Group Psychotherapy Staff-to-Beneficiary Ratio

The ratio for group Psychotherapy requires one LIP for up to eight beneficiaries.

Family Psychotherapy

Family Psychotherapy a face-to-face intervention with family members of the beneficiary with the purpose of treating the beneficiary's condition and improving the interaction between the beneficiary and family member(s) so that the beneficiary may be restored to their best possible functional level.

Family Psychotherapy may be rendered with or without the beneficiary to family members of the identified beneficiary as long as the identified beneficiary is the focus of the sessions. The identified

beneficiary is the family member with the symptom that has brought the family into treatment. Only issues pertinent to the identified beneficiary may be addressed under this service.

Family Psychotherapy Staff-to-Beneficiary Ratio

The ratio for family Psychotherapy requires one LIP for each family unit. Only one individual beneficiary can be billed for any one session of family Psychotherapy.

Psychotherapy is billed as an encounter code based on the length of the session time. Only one individual beneficiary can be billed for any one session of family Psychotherapy. Please refer to procedure codes information for appropriate coding.

Family Psychotherapy Service Location

The only excluded settings for Psychotherapy services are hospitals, PRTFs and freestanding Inpatient Psychiatric Facilities.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Crisis Management

Crisis Management (CM) is a face-to-face, or telephonic, short-term service is to assist a beneficiary, who is experiencing a marked deterioration of functioning related to a specific precipitant, in restoring his/her level of functioning and/or to stabilize the beneficiary. The goal of this service is to maintain the beneficiary in the least restrictive, clinically appropriate level of care.

The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he/she can rely on to cope with this crisis, and in developing specific strategies to be used to mitigate this crisis and prevent similar incidents.

CM should therefore be immediate methods of intervention that include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual.

CM is for beneficiaries who are experiencing seriously acute psychiatric symptoms or psychological/emotional changes that result in increased personal distress and who would without intervention, be at risk for a higher level of care, such as hospitalization or other out-of-home placement.

Beneficiaries in crisis may be represented by a family member or other individuals who have extensive knowledge of the beneficiary's capabilities and functioning. The beneficiary must be present for all or some of the service.

Face-to-face interventions require immediate response by a clinical professional and include:

- A preliminary evaluation of the beneficiary's specific crisis.
- Intervention and stabilization of the beneficiary.
- Reduction of the immediate personal distress experienced by the beneficiary.
- Development of an action plan that reduces the chance of future crises through the implementation of preventative strategies.
- Referrals to appropriate resources.
- Follow-up with each beneficiary within 24 hours, when appropriate.
- 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.

Crisis Management Staff-to-Beneficiary Ratio

The ratio for CM requires at least one LIP for each beneficiary.

Crisis Management Service Location

CM services may be provided in a beneficiary's home, nursing facility, emergency room, outpatient hospital, clinic setting or other community locations in the beneficiary's natural environment.

Services can be delivered in any setting that is convenient for the both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.

Services may not be provided to beneficiaries residing in a PRTF or freestanding Inpatient Psychiatric Facility.

Services provided to younger beneficiaries (children) must include coordination with family or guardians and other systems of care as appropriate.

While a DA is required prior to rendering core services, crisis management can have two services billed prior to the DA ONLY when provided in a school setting. This would also require the LIP to be under a subcontract with a school district.

Transition/Discharge

The authorizing entity is responsible for determining the duration of treatment based on the individual needs of the beneficiary. Beneficiaries should be considered for discharge from treatment when they meet the following criteria:

- Level of functioning has significantly improved with respect to the goals established in the IPOC.

- Beneficiary requests discharge (and is not imminently dangerous to self or others).
- Beneficiary requires a higher level of care (i.e., inpatient hospitalization or PRTF).

NON-COVERED SERVICES

The following services are not reimbursable by Medicaid:

- Court appearances.
- Supervision/staffing.
- Mileage/driving time.
- Completing/amending a Medicaid billing form.
- Any contact on behalf of a non-referred Medicaid beneficiary.
- Telephone contact related to office procedures or appointment time.
- Consultation for beneficiaries who are not involved in an ongoing assessment or treatment.
- Consultation performed by persons supervised by the Psychologist.
- Report preparation and completion.
- Services provided to Medicaid-eligible beneficiaries who do not fall within the population served by Rehabilitative Services, with the exception of services provided to Medicaid eligible beneficiaries who are also Qualified Medicare Beneficiaries.

Note: For this population, Medicaid will reimburse the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by South Carolina Medicaid. Reimbursement for these services will be consistent with State Plan.

- Services of an experimental, research or unproven nature, or services in excess of those deemed medically necessary.
- Biofeedback
- Hypnotherapy
- Sensitivity Training
- Encounter Groups or Workshops
- Parenting Classes

- Cancelled Appointments or Appointments Not Kept
- Court Testimony

This list may not include all non-covered services. If you have questions regarding the types of services covered under this service array or otherwise covered by Medicaid, please contact the SCDHHS Medicaid Provider Service Center at (888) 289-0709. You may also submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

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UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Quality Improvement Organization — Physician and Self: Referrals Process

Medicaid fee-for-service beneficiaries must receive prior authorization from a Quality Improvement Organization (QIO) and reimbursement from SCDHHS.

The following services do not require prior authorization by the QIO:

- BHS
- Comprehensive Assessment (initial or follow-up)
- SPD
- CM

For SCDHHS contracts with a QIO for utilization review and prior authorization services, the following services may be authorized by the QIO to the enrolled LIP once medical necessity has been established:

- Psychological Testing and Evaluation
- Psychotherapy
- Group Psychotherapy
- Family Psychotherapy

The LIP should use the SCDHHS LIP Prior Authorization Request Form to request prior authorization for the above services.

For initial requests, the Comprehensive Assessment, which documents medical necessity, should be submitted along with the SCDHHS LIP Prior Authorization Request Form. Prior authorization requests for Psychological Testing and Evaluation, must include the reason for testing and the referral source (Physician, school, LPHA, etc.).

If the number of visits authorized is deemed inadequate to address the identified goals, reauthorization of services will be required.

For Continued Treatment Review, the most recent IPOC and summary should be submitted with the SCDHHS LIP Prior Authorization Request Form. Continued treatment requests must be submitted two weeks prior to the expiration of authorized visits. Failure to obtain reauthorization prior to the provision of services will result in recoupment of payment.

To receive reimbursement from Medicaid, all prior authorization requests must be submitted to KEPRO using one of the following methods:

Fax: (855) 300-0082

Web Portal: <http://scdhhs.kepro.com>

If the authorization request is approved by KEPRO, the LIP will be notified via QIO approval letter and prior authorizations will be indicated for a six-month period. If using the web portal, the LIP must download the approval document(s). The approval document(s) must be placed in the beneficiary's clinical record prior to or at the time of the appointment for treatment, a faxed copy is acceptable.

The LIP provider may contact KEPRO using one of the following methods:

Customer Service: (855) 326-5219

Fax: (855) 300-0082

Provider Issues Email: SCproviderissues@kepro.com

LIP providers must ensure that only authorized amounts of services are provided and submitted for reimbursement and that all services are provided in accordance with all SCDHHS policy requirements. If SCDHHS or its designee determines that services were reimbursed when there was not a valid QIO approval letter in the beneficiary's file, the provider payments will be subject to recoupment.

Retroactive Coverage

When a beneficiary receives retroactive Medicaid coverage and services are medically necessary, the QIO approval letter will be provided to the LIP provider within 10 business days from the date of the Medicaid eligibility determination.

For beneficiaries receiving retroactive coverage, documentation requirements must be met in order to receive Medicaid reimbursement for the covered period.

Service Limit Exception for Fee-for-Service Beneficiaries

There may be clinical exceptions to the service limits when the number of units or encounters allowed may not be sufficient to meet the complex and intensive needs of a beneficiary. On these occasions, requests for frequencies beyond the service limits may be submitted directly to the SCDHHS for approval. See below for required documentation that must be submitted to SCDHHS for these requests.

- Most recent Diagnostic Assessment

- Most recent IPOC.
- All CSN for all services rendered to beneficiary during the previous 90-days of request.
- QIO approval letter.
- Fax cover sheet for service limit exceptions (if applicable).
- LIP Exception Request Form.

Requests must be complete and submitted in accordance with the defined sets of documentation requirements noted above. Requests that do not meet all of the requirements will not be processed.

Requests can be submitted to SCDHHS via the following methods:

- Fax to: (803) 255-8204
 - A fax cover sheet must be included with the fax which includes the provider name, date and number of pages submitted.
 - “Attn: LIPs Exceptions”
- Encrypted email to: behavioralhealth004@scdhhs.gov

SCDHHS will either approve, deny or request additional information within 10 business days of receipt of the request. The provider will be notified in writing if additional information or if the request is approved or denied. Additionally, should the request be denied, the denial letter will explain how the provider may appeal the decision.

Managed Care Organizations

If the beneficiary is enrolled in a Medicaid MCO the provider must request prior authorization and claim reimbursement from the MCO directly.

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REPORTING/DOCUMENTATION

CLINICAL RECORDS AND DOCUMENTATION REQUIREMENTS

Each LIP provider shall maintain a clinical record for each Medicaid-eligible beneficiary that fully describes the extent of the treatment services provided. The beneficiary's name and Medicaid number should be on **all** clinical documentation and billing records. The clinical record must contain documentation sufficient to justify Medicaid reimbursement and should allow an individual not familiar with the beneficiary to evaluate the course of treatment.

The absence of appropriate and complete records may result in recoupment of payments by SCDHHS. An Index as to how the clinical record is organized must be maintained and made available to Medicaid reviewers/auditors at the time of request.

Each provider shall have the responsibility of maintaining accurate, complete, and timely records and should always adhere to procedures to ensure confidentiality of clinical data.

The beneficiary's clinical record must include, at a minimum, the following documentation:

- A Comprehensive Diagnostic Assessment, which establishes medical necessity.
- SCDHHS Behavioral Health Referral and Feedback Form, if applicable.
- QIO approval letter.
- Signed/titled and dated IPOC, progress summaries and reformulations.
- Signed releases, consents and confidentiality assurances for treatment.
- Signed/titled and dated CSN.
- Court orders, if applicable.
- Copies of any evaluations and or tests, if applicable.
- Physician's orders, laboratory results, lists of medications and prescriptions (when performed or ordered), if applicable.
- Copies of all written reports, and any other documents relevant to the care and treatment of the beneficiary.

Consent for Treatment

A consent form dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor), or legal representative must be obtained at the onset of treatment from all beneficiaries and placed in the beneficiary's file. If the beneficiary, parent/guardian or legal representative cannot sign the Consent form due to a crisis, and the beneficiary is accompanied by 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" should be noted on the Consent form and must be signed by the LIP. The beneficiary, parent/guardian or legal representative should sign the Consent form as soon as circumstances permit. A new Consent form should be signed each time a new service is added, and dated each time a beneficiary is readmitted to services after discharge.

Consent forms are not necessary to conduct court-ordered examinations. However, a copy of the probate court order must be kept in the clinical record.

Coordination of Care

SCDHHS encourages coordination of care and continued communication between the referring Physician or State agency, other collaterals and the LIP. There should be evidence in the record of coordination between the LIP and the referring entity regarding treatment. Interim progress reports should be provided to the referring entity as warranted supporting the ongoing medical necessity of the services rendered. The LIP may provide the referring entity with clinical service documentation describing the services rendered, outcomes achieved and any recommendation for continued or additional services. These reports are not separately reimbursable but considered part of the beneficiary's overall care.

Abbreviations and Symbols

Abbreviations may be used in the CSN or IPOC. Service providers shall maintain a list of abbreviations and symbols used in the clinical documentation which leaves no doubt as to the meaning of the documentation. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

Error Correction

Medical records are legal documents. Staff should be extremely cautious in making alterations to the records. In the event that errors are made, adhere to the following guidelines:

- Draw one line through the error, and write "error," "ER," "mistaken entry," or "ME" to the side of the error in parenthesis. Enter the correction, sign or initial and date it.
- Errors cannot be totally marked through; the information in error must remain legible.
- No correction fluid may be used.

Late Entries

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times to handle omissions in the documentation.

Late entries should rarely be used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following guidelines:

- Identify the new entry as a "late entry."
- Enter the current date and time.
- Identify or refer to the date and incident for which late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible.
- When using late entries, document as soon as possible.

INDIVIDUALIZED PLAN OF CARE

The IPOC is a comprehensive plan of care outlining the service delivery that will address the specific strengths and needs of the beneficiary. The IPOC must be individualized and specify problems to be addressed. The IPOC must be person/family centered and developed with the full participation of the beneficiary and his or her family.

The beneficiary must be given the opportunity to determine the direction of his or her treatment. The beneficiary 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 does not sign the IPOC or if it is not considered appropriate for the beneficiary to sign the IPOC, the reason the beneficiary did not sign the IPOC must be documented on the IPOC and clinical record.

If reunification or avoidance of removing the beneficiary from the home is a treatment goal, families/legal guardian/representative/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/representative/primary caregiver will not be involved in the treatment planning process, the provider must provide justification. Evidence of this justification must be located in the beneficiary's clinical record. For adults, family/legal representative should be included, as appropriate.

The IPOC must contain the signature and title of the LIP and the date signed.

The IPOC must address the following:

- Goals and objectives of treatment - these should be specific short- and long-term goals, be individualized to the beneficiary and be measurable. Types of interventions, including any evidence-based practices that will be used.
- Planned frequency of service delivery - this must be appropriate to the needs of the beneficiary.
- Criteria for achievement - this should outline how success for each goal and objective will be demonstrated. This must include a desired outcome to the treatment process.
- Estimated duration of treatment - target dates should reflect projected incremental change over the course of a year, and should not uniformly reflect the annual expiration date of the IPOC.
- Long-term or discharge goals - this must include the anticipated date of discharge from services and expected gains to be achieved through participation in treatment and services, and anticipated aftercare needed (if applicable).

Individual Plan of Care Due Date

An IPOC should be developed prior to the delivery of a service.

Services required to be on the IPOC may be provided following the completion of the diagnostic assessment. If the IPOC is not completed and signed within 45 days, services rendered are not Medicaid reimbursable. The LIP's signature is required to confirm the appropriateness of care.

CM, SPD, BHS, Psychological Testing and Evaluation, and Comprehensive Assessment services are not required to be listed on the IPOC and can be provided prior to the development of the IPOC.

The IPOC must be reviewed and updated as needed according to the beneficiary's progress, but at a minimum every 90 days via the progress summary process identified below.

IPOC Reformulation

A new IPOC must be developed every 12 months. If services are discontinued, the LIP must indicate the reason for discontinuing treatment on the IPOC. The IPOC must include the date it was reformulated, the signature, title and signature date of the LIP. When the IPOC is developed at least two months prior to the expiration date, the new plan is effective with the anniversary date. Please refer to the documentation format example located on the provider portal.

IPOC Changes

If the provider determines during treatment that additional services are required, these services should be added to the treatment plan. Services added or frequencies of services changed in an existing IPOC must be signed or initialed and dated by the LIP. The original IPOC signature date stands as the date to be used for all subsequent progress summaries, reviews and reformulations.

Beneficiaries are not required to have face-to-face contact with the LIP for the addition of services or changes in service frequency.

A copy of the updated IPOC must be made available to the beneficiary.

Progress Summary

The 90-day progress summary is a periodic evaluation of a beneficiary's progress toward the treatment objectives, appropriateness of the services being furnished and need for the beneficiary's continued participation in treatment.

The progress summary of the beneficiary's participation in services will be conducted at least every 90 calendar days from the signature date on the IPOC and at a minimum, each 90 days thereafter.

The progress summary must be summarized by the LIP and documented on the IPOC and identified as the progress summary.

The LIP will review the following areas:

- The beneficiary's progress toward treatment objectives and goals. Any barriers to progress should also be identified.
- The appropriateness of the services provided and their frequency. Failure to provide the recommended services and their frequency should also be explained.
- The need for continued treatment.
- Recommendations for continued services.

CLINICAL SERVICE NOTES(CSN)

General Requirements

All services must be documented in CSN upon the delivery of services and filed in the beneficiary's record. Each discrete service should have its own CSN capturing service and bill time. The purpose of the CSN 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. Documentation must justify the amount of reimbursement claimed to Medicaid.

Medicaid requires that the LIP provider attest to the accuracy of the diagnoses, treatment modalities and claims submitted for all Medicaid beneficiaries.

The following requirements must be met in order for a LIP to be in compliance with Medicaid documentation policy for services. All CSN must include:

- The beneficiary's name and Medicaid ID.

- Date of service.
- Name of the service provided (Psychotherapy, Family Psychotherapy, Group Psychotherapy, etc.).
- Place of service.
- Duration of service (start and end time for each service delivered).
- Separate documentation for siblings.
- Documentation must be legible and abbreviations decipherable. If abbreviations are used, the provider must maintain a list of abbreviations and their meanings. This list must be made available to SCDHHS.
- Be typed or handwritten using only black or blue ink.
- Be legible and kept in chronological order.
- Reference individuals by full name, title and agency/provider affiliation at least once in each note.
- Be signed, titled and signature dated (month/date/year) by the LIP responsible for the provision of services. The signature verifies that the services are provided in accordance with these standards.
- Be completed and placed in the clinical record following service delivery but no later than five business days from the date of service.

All documentation must support the number of units billed.

LIP(s) should review each requirement listed above to ensure that services are not left vulnerable to the recoupment of funds in the event of a Medicaid audit. In addition to the general requirements, there is additional documentation requirements for some services. Please refer to the Service Specific Documentation section for additional information.

SERVICE SPECIFIC DOCUMENTATION

Behavioral Health Screening

BHS results should be documented during the screening session with the beneficiary. The completed screening tool and written interpretation of the results must be filed in the beneficiary's record no later than 10 working days from the date of the service.

Documentation must:

- Include the outcome of the screening.

- Identify any referrals resulting from the screening.
- Support the number of units billed.

Comprehensive Assessment — Initial and Follow-Up

Components of an assessment include:

- Beneficiary name
- Date of birth
- Medicaid ID
- Referring state agency or physician (if applicable)
- Date of the assessment.
- Beneficiary demographic information.
- Presenting complaint, source of distress.
- Medical history and medications.
- Family history.
- Psychological and/or psychiatric treatment history including previous psychological assessment/testing reports, etc.
- Substance use history.
- Mental status.
- Current edition DSM or ICD diagnosis.
- Beneficiary and/or family strengths and support system.
- Exposure to physical abuse, sexual abuse, anti-social behavior or other traumatic events.
- Recommendations for additional services, support, or treatment based on medical necessity criteria, including specific Rehabilitative Services.
- LIP's name, professional title/credentials, signature, and date

The initial assessment should be completed in one day. If additional time is needed to complete a thorough assessment, billing should occur on another day utilizing the follow-up assessment code.

CALOCUS-CASII Assessment — Community Support Services

Assessments must be documented in a manner which addresses all of the necessary components and clearly establishes medical necessity. When submitting a claim for the CALOCUS-CASII assessment, documentation of the scoring instrument and supporting clinical documentation is required.

Psychological Testing and Evaluation

Minimum standards require service note documentation in the beneficiary's record that includes the purpose of the session, the results of the Psychological testing and evaluation and/or make reference to the completed test. When the administration and interpretation of psychological tests is required to aid in the determination of diagnoses and level of impairment, a Psychologist/LPES must carry out the diagnostic assessment.

A documentation format example can be found on the provider portal.

Assessments performed by unlicensed supervisees are not separately reimbursable.

Psychological Testing and evaluation is billed as a 60-minute unit with a limit of 10 units within a week and limit of 20 units billed annually.

Service Plan Development

Documentation should include the involvement of the clinical professional and/or team of professionals in the following:

- The development, staffing, review and monitoring of the IPOC.
- Discharge criteria/achievement of goals.
- Confirmation of medical necessity.
- Establishment of one or more diagnoses.
- Recommended treatment.

Psychotherapy Services

The documentation for individual, family and group psychotherapy shall address the following items in order to provide a pertinent clinical description, to ensure that the service conforms to the service description, and to authenticate the charges:

- The specific objective(s) from the IPOC toward which the session is focused.

- The structured activities of the beneficiary in the session.
- The beneficiary's response to the intervention/treatment.
- The specific intervention(s) used.
- The beneficiary's progress or lack of progress made in treatment.
- Recommendation and future plans for working with the beneficiary.
- Service duration — start and end time.

Crisis Management

A CSN must be completed upon contact with the beneficiary and should include the following:

- Start time and duration.
- All participants during the service.
- Summary of the crisis or the symptoms that indicate the beneficiary is in a crisis.
- Content of the session.
- Active participation and intervention of the staff.
- The response of the beneficiary to the treatment.
- Beneficiary's status at the end of the session.
- A plan for what will be worked on with the beneficiary.

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BILLING GUIDANCE

BILLING REQUIREMENTS

LIPs may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Medicaid will generally pay the lower of the established Medicaid reimbursement rate.

USE OF Z-CODES

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.

Billing Information/Location of Service

See the "Service Location" heading for each service in this manual section. The following list provides the codes most commonly used:

- 03 — School
- 11 — Doctor's Office
- 12 — Beneficiary's Home
- 19 — Off-Campus Hospital
- 22 — Outpatient Hospital
- 23 — Emergency Room
- 99 — Other Unlisted

SPECIAL RESTRICTIONS RELATED TO OTHER SERVICES

BHS cannot be billed on the same date of service as 90791 and/or H2000.