SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Licensed Independent Practitioner Policy Update

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Updates Overview

Section	Name	Page	Changes
Cover Page	Title	N/A	Updated to "Licensed Independent Practitioner (LIP) Behavioral Health Services Provider Manual"
1	Program Overview	2	Revised "Contents" listing, which reflects new manual template; updated language to provide an overview of service delivery model.
2	Covered Populations	4	Updated language to define members eligible for services; added information on verification of member eligibility;.
3	Eligible Providers	5	Updated language to provide definition of “provider” as per the SCDHHS/federal regulations; clarification of services provided by non-independently licensed clinicians under board-approved supervision.
4	Covered Services and Definitions	13	Provides guidance on structure of covered services; added a pertinent definition section; expanded existing telehealth policy to provide a broader overview, including definitions, eligible providers, places of service, and telehealth service criteria; added medical necessity chart for ease of reference.
5	Utilization Management	22	Updated language to provide general information about the claims review process; language added to clarify that PA is connected to the individual practitioner.
6	Reporting/Documentation	26	Expanded to include examples and more specific guidance; clarified language around consent and release of information; added further clarification on documenting IPOC goals/objectives, PSs, and discharge summaries; expanded service-specific documentation.
NEW 7	Billing Guidance	44	Reorganization of current policy to provide information on procedure code sets, claim type information, indicators, and modifiers; expanded clarification on use of Z codes; added a new section about reimbursement and charge limits.
NEW 8	Benefit Criteria and Limitations	47	Revised service definitions, modernized language reflecting best practices, revised service categories and reordered service array; added expanded procedure codes section within manual and separate link removed.

Section 1: Program Overview

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New Language

- "The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of behavioral health services delivered to Healthy Connections Medicaid members via the following programs:
  - Fee-for-Service (FFS)
  - Managed Care Organizations (MCO)"
- Refers providers directly to the *Provider Administrative and Billing Manual* to ensure understanding of general rules and guidelines in Medicaid service delivery and submission of claims.
  - Providers are responsible for knowing *both* manuals--the Administrative and Billing Manual and the appropriate Medicaid services provider manual--when rendering Medicaid services.

Section 2: Covered Populations

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New Language

- “The following full-benefit members may receive medically necessary diagnostic and rehabilitative behavioral health services:
  - Children: Members age 0 through 20 years (through the last day of the month of the 21st birthday)
  - Adults: Members age 21 years and older

- Member eligibility must be verified by providers on the date of service to ensure appropriate provider payment."

Section 3: Eligible Providers

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New Language

- Provider Qualifications
  - "An eligible provider is a firm, corporation, association, institution, or an individual practicing as one business entity with a written participation agreement in effect with SCDHHS to provide behavioral health services to members enrolled in the Healthy Connections Medicaid program pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the Social Security Act, as amended.

    As it relates to delivery of behavioral health services specified in this manual, the Medicaid-enrolled provider will be referred to as a "licensed independent practitioner ('LIP provider'). Providers of rehabilitative behavioral health services may be enrolled at an organizational or individual level; **this manual pertains to policy and requirements for individually enrolled licensed practitioners who render rehabilitative behavioral health services.**"

Section 3: Eligible Providers

New Language

- "LIP providers supervising those without independent licensure must conform to their scope of practice and all board-stipulated supervision guidelines (including supervision limitations, such as number of individuals supervised at one time), as indicated by the respective licensing and/or certification board or as stipulated in this manual."
- Reinforces that for Medicaid reimbursement, supervisees must be under the direct supervision of the board-approved supervisor:
  - "For Medicaid billing purposes, direct supervision means that the supervising LIP provider must be housed at the same practice location as the supervisee and be immediately accessible in person, by phone, or other electronic device when billed services are being provided by the supervisee."

Section 3: Eligible Providers

- Linking an Individual Provider to a Group
  - Reinforces that individuals must submit this request in writing; Provider Enrollment will not accept group practice requests going forward after July 1.

  New Requirement

  - Requires ***notarized signature*** of individual LIP provider submitting the written request.
- Updated business requirements for group practices and those operating as a sole proprietor.

Section 4: Covered Services and Definitions

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New Information

- Includes standard definitions:
  - Covered Services
  - Provider
  - EPSDT
  - Medically Reasonable and Necessary
- "Covered Services" defines:
  - Medicaid State Plan Services
    - Organization of behavioral health services within the manual; describes each category of behavioral health services and lists the relevant individual services for each; also provides an overarching category definition capturing the type of services within the category.
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for members age 0-21
  - Telehealth service delivery, standardized for all Medicaid manuals; includes general overview, definitions, eligible providers, places of service, and telehealth service criteria

Section 4: Covered Services and Definitions

New Information

Medicaid State Plan Services

- Organization of behavioral health services includes:
  1. Screening and Assessment Services
     - Behavioral Health Screening (BHS)
     - Diagnostic Assessment (DA) and DA Follow-up
     - CALOCUS-CASII
     - Psychological Testing and Evaluation/Psychological or Neuropsychological Test Administration and Scoring (PTE/PTA)

Section 4: Covered Services and Definitions

New Information

2. Service Plan Development (SPD) of the Individual Plan of Care (IPOC)
   - SPD – Interdisciplinary team with client/family
   - SPD – Interdisciplinary team without client/family

3. Core Treatment Services
   - Individual Psychotherapy (IP)
   - Family Psychotherapy (FP)
   - Group Psychotherapy (GP)

4. Crisis Management Services
   - Crisis Intervention

Further information on services and service definitions is found in Section Eight.

Section 4: Covered Services and Definitions

New Information

- Service-Specific Medical Necessity Criteria
  - *User friendly chart of all LIP services and corresponding medical necessity criteria.*

Section 5: Utilization Management

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New Information

- *"Authorization is allowable only for a specific individual provider, not the group practice with which an individual provider is linked. When a member is transferred to another provider within the same group or to another practice, the new provider must submit this information to the QIO to ensure a new PA number is issued for the new provider. Circumstances (as determined by the QIO) may require the new provider to resubmit the prior authorization."*
- Service Limit Exception Process
  - Further clarification of the PA process and required documentation for service limit exceptions.

Section 6: Reporting/Documentation

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New Language

- Consent to Examinations and Treatment
  - If a member presents for intervention due to a mental health crisis but is a new patient, is alone and unable to sign for consent due to age, and parent/legal guardian/legal representative is not available, the next of kin or other responsible party who brought the member may sign the consent form.
  - A statement such as, “appropriate party is not present to sign for consent; client requires emergency treatment,” must be noted on the consent form and signed by the provider and one other staff member as a witness.
  - The parent/legal guardian/legal representative must sign the consent form as soon as circumstances permit and before any additional services are provided.
  - In all such circumstances, efforts must be made to contact the parent/legal guardian/legal representative to obtain verbal consent; efforts to contact (if unable to reach) and verbal consent must be documented in the clinical record.

Section 6: Reporting/Documentation

New Information/Language

- Service-Specific Documentation Requirements
  - Clarified, reorganized, and updated language for Medicaid requirements with specific examples, when relevant:
    - "Behavioral Health Screening (BHS)
      - BHS results shall be documented during the screening session with the member. The completed screening tool and written interpretation of the results must be filed in the member's clinical record within 10 working days from the date of service. Services must be documented on a CSN with a start time and end time (ex., 10:03 A.M. to 10:56 A.M.).
      - Additionally, the documentation must meet all SCDHHS requirements for CSNs. Documentation must also:
        - Include the outcome of the screening.
        - Identify any referrals resulting from the screening.
        - Support the number of units billed."

Section 6: Reporting/Documentation

New Language

- Diagnostic Assessment
  - Include full mental status exam; expanded view of trauma history; expands clinical interpretive summary to include case conceptualization that leads to diagnosis, the medically necessary services and frequencies recommended, outside referrals to be made, and anticipated treatment start date.
  - ➢ *THIS ALLOWS FOR INITIAL TREATMENT IN INTERIM PRIOR TO IPOC FORMULATION.*
- Psychological Testing and Evaluation
  - "PTE is not intended to be a member's initial behavioral health service and is provided only when medically necessary. If the member has been referred by another provider who, after efforts have been made to assess and diagnose the member, requires the administration and interpretation of psychological tests to aid in the determination of diagnoses and level of impairment, the Psychologist or LPES must complete the Diagnostic Assessment (using the follow-up DA procedure code)."

Section 6: Reporting/Documentation

New Language

- Crisis Intervention
  - Service name changed.
  - Increased focus on suicide prevention, screening for suicide risk, and evidence-based practices.
  - If member is assessed to be safe to return home, documentation now requires completion of Safety Plan and a copy filed in the chart.
  - Provider must include plan for follow-up post-crisis and steps for ongoing monitoring.

Section 6: Reporting/Documentation

New Language

- **Other Specific Documentation Requirements (IPOC, CSNs, Progress Summaries, Discharge Summaries):**

  **Updated guidance in this section assists the provider in addressing common Medicaid documentation errors **

  - IPOC
    - More expansive and descriptive information on goals and objectives, specifies SMART goals, clarifies documenting clinical interventions;
    - Provides clarification for specificity required in service frequency and individualized timeframes for goal achievement;
    - Provides description of criteria for achievement.
    - Clarifies age of consent and when there must be client permission to include parent/guardian in treatment, such as when the member can sign their own treatment plan.

Section 6: Reporting/Documentation

New Language

- CSNs
  - More detailed explanation of required components

    Ex. "A detailed statement of general progress of the member to include observations of their conditions/mental status. Progress must reflect individualized information about the member over the course of treatment and shall not be general categories or generalized statements of progress in treatment (phrases such as "moderate improvement" and/or "not making progress" will not meet this standard unless detailed supporting information is provided)."

Section 6: Reporting/Documentation

New Language

- CSNs
  - More detailed explanation of required components

REQUIRED ELEMENTS OF A CSN	
Element	**Description**
1. Focus and/or reason for the session or interventions	• Related to the treatment objective(s) and/or goal(s) on the IPOC, unless there is an unexpected event that needs to be addressed, in which case it must be identified as the reason for the diversion from the planned course of the session.
2. Detailed summary of the interventions	• Action steps, tools used, techniques utilized, etc., and involvement of qualified staff with the member and/or family during each contact or session (only time spent rendering the intervention or treatment can be billed. See the Covered Services section for additional information).
3. Individualized response of the member and/or member's family, as applicable	• Includes the statements made, information processed, actions taken, etc., by member and/or family to the interventions/treatment rendered in session.
4. Detailed statement of member's general progress	• Includes observations of the member's condition/mental status. Progress must reflect individualized information about the member over the course of treatment and shall not be vague categorizations or generalized statements of progress in treatment (i.e., phrases such as "moderate improvement" and/or "not making progress" will not meet this standard unless more detailed supporting information is provided).
5. Plan for the next session with the member and/or the member's family, as applicable	• This can reflect the plan of action for the next and/or foreseeable future sessions (such as "will continue to practice mindfulness exercises at the end of each session for the next four meetings to reinforce this newly learned skill;" statements such as, "will continue to meet with client as per IPOC," will not meet this standard).

Section 7: Billing Guidance

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New Information/Language

- Guidance added to provide further clarification on charge limits, reimbursements, and prohibited billing practices.

Procedure Code Updates:

- Behavioral Health Screening -- H0002
  - Updated per national CPT code guidelines from 15-minute unit to an encounter; one encounter per day/per member.
- Psychological Testing and Evaluation Codes – 96131 and 96136, 96137
  - PTE codes and service definitions match billing requirements for psychological evaluation.

Section 7: Billing Guidance

New Information/Language

- Z codes
  - Added definition of this allowable diagnostic category to address "factors influencing health status and contact with health services".
  - Clarified requirements for using Z codes as diagnosis.

Section 8: Benefit Criteria and Limitations

Section 8: Benefit Criteria and Limitations

NEW MANUAL SECTION

"The services defined in the Licensed Independent Practitioner Behavioral Health Services Provider Manual are organized in the following categories:

1. **Screening and Assessment Services**
2. **Service Plan Development of the IPOC**
3. **Core Treatment Services**
4. **Crisis Management Services**

This section will provide the service criteria and benefit limitations for each covered service."

Section 8: Benefit Criteria and Limitations

NEW SECTION

- Each LIP service category lists:
  - Specific billable services within that category;
    - Service definition;
    - Frequency and Service Limitations;
    - Special restrictions related to other services.
- ***All information needed to provide the service is included in one manual section.***

Section 8: Benefit Criteria and Limitations

New Information/Language

- **Each service definition is updated:**
  - Modernized/updated language;
  - Updated practices to reflect newer trends in standards of behavioral health care and best practices;
  - Focus on evidence-based techniques and promising practices in standard behavioral health care delivery.

Section 8: Benefit Criteria and Limitations

New Information/Language

1. Screening and Assessment Services

- Behavioral Health Screening (BHS)
  - Updated with current best practice screening measures; includes emphasis on best practice suicide risk and trauma screening.
- Diagnostic Assessment
- Diagnostic Assessment—Follow-Up
- CALOCUS-CASII – *GT modifier allowable*
- Psychological Testing and Evaluation
- Psychological Test Administration

Section 8: Benefit Criteria and Limitations

New Information/Language

2. Service Plan Development of the IPOC

- SPD-Interdisciplinary Team — Conference with Member/Family
- SPD-Interdisciplinary Team — Conference without Member/Family

3. Core Treatment Services

- Individual Psychotherapy
- Group Psychotherapy
  - Expanded information on benefits and use of group therapy
- Family Psychotherapy

Section 8: Benefit Criteria and Limitations

New Information/Language

4. Crisis Management Services

- Crisis Intervention
  - Expanded information on best practice suicide risk screening and assessment.
  - Safety planning
    - Stanley Brown Safety Plans
      - Stanley-Brown-Safety-Plan-05-02-2024.pdf
      - Home - Stanley-Brown Safety Planning Intervention
    - Counseling on Access to Lethal Means
      - CALM: Counseling on Access to Lethal Means – Suicide Prevention Resource Center

Section 8: Benefit Criteria and Limitations

New Information/Language

- **Procedure Codes**
  - Updated procedure codes with more information on service limits.
  - Retooled procedure codes chart.
  - Available within the manual, at the end of Section 8, in a user-friendly format reflecting guidance provided within the section.

Contact

Please submit any questions in the webinar's Q&A box or providers may reach the Office of Behavioral Health at our new email address:

MedicaidStatePlan@scdhhs.gov

THANK YOU FOR ATTENDING!


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