SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Rehabilitative Behavioral Health Services Policy Update

Melanie Hendricks, MSW, MSPH, LISW-CP, ACSW
Director of Behavioral Health
July 8, 2026

Updates Overview

Section	Name	Page	Changes
1	Program Overview	1	• Revised "Contents" listing, which reflects new manual template; updated language to provide an overview of service delivery model; EBPs moved to appendices links on manual webpage.
2	Covered Populations	3	• Updated language to define members eligible for services; added information on verification of member eligibility
3	Eligible Providers	4	• Updated policies and procedures to be maintained and updated during enrollment as a provider • Updated reporting program changes • Clarified staffing requirements: A minimum of four separate distinct staff members; must have no overlapping duties: the clinical director cannot be counted as one of the two required professional or paraprofessional staff • Removed service key • Maintenance of fiscal and medical records is moved to section six • Clarified service-specific staff qualifications for Office of Substance Use Services (OSUS) and rehabilitative behavioral health services (RBHS) providers
4	Covered Services and Definitions	28	• Expanded existing telehealth policy to a telehealth overview policy and telehealth criteria. • Updated definitions of services and their criteria, including State Plan services and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Included other qualified master's or bachelor's level providers as identified in the Eligible Providers Section of this manual, as an RBHS telehealth provider regarding consulting sites
5	Utilization Management	55	• General policies regarding program integrity, utilization management, or fraud, waste and abuse, are now referred to in the Provider Administrative and Billing Manual • Updated authorization policy regarding medical necessity and services
6	Reporting/ Documentation	60	• Updated definitions of service-scope documentation requirements
New 7	Billing Guidance	84	• Reorganization of current policy to provide information on procedure code sets, claim type information, indicators and modifiers; added a new section about reimbursement and charge limits
New 8	Benefit Criteria and Limitations	89	• Added new section within manual that provides clarity of criteria and benefit limitations for each covered service • Updated procedure code table for RBHS
New	Procedure Codes	116	• A new, organized listing of procedure codes with expanded information on service limitations and requirements for billing included within the manual at the end of Section 8; added GT modifier to CALOCUS-CASII

Section One: Program Overview

Section One: Program Overview

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) and
  - Managed Care organizations (MCOs)."
- Removed link to procedure codes; included at end of Section 8.
- 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.

New language

- Updated language throughout manual to reflect new state agency names:
  - South Carolina Department of Behavioral Health and Developmental Disabilities (SCDBHDD)
    - SCBHDD Office of Substance Use Services (OSUS)
    - SCBHDD Office of Mental Health (OMH)

Section Two: Covered Populations

Section Two: Covered Populations

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 provider payment.

Section Three: Eligible Providers

Section Three: Eligible Providers

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 an ‘RBHS organization.’ Providers of RBHS may be enrolled at an organizational or individual level. This manual pertains to policy and requirements for organizations enrolled that render rehabilitative behavioral health services. “

Section Three: Eligible Providers *(cont.)*

Updated language

- Updated information on reporting program changes; must be submitted to the PSC when there are name changes, ownership changes, etc.
- Applicable form remains in the RBHS manual forms section.
- Clarified RBHS service-specific staff qualifications for OSUS-affiliated and RBHS providers.

Section Three: Eligible Providers *(cont.)*

New language

- Staffing requirements clarified:
  - "The organization must include, at a minimum, four separate and distinct staff members, including a chief executive officer (CEO) or chief administrator, a clinical director and two other professional or paraprofessional staff to provide direct services. These positions cannot have overlapping job duties."
- For private RBHS organizations, clinical directors must be a licensed practitioner of the healing arts (LPHA). The clinical director must be licensed at the independent level in the practicing state within the South Carolina Medicaid Service Area (SCMSA).
- Diagnostic assessments (DAs) require completion by an LPHA; however, DAs are allowable if facilitated by a non-independently licensed professional in a private organization when supervised and cosigned by an LPHA.

Section Three: Eligible Providers *(cont.)*

New language

- "When services are provided by an unlicensed or uncertified professional or a paraprofessional, the state agency or private organization must ensure the following:
  - The qualified licensed or master's level clinical professional who monitors the performance of the unlicensed professional or paraprofessional must provide documented consultation, guidance and education with respect to the clinical skills, competencies and treatment provided, at least every 30 days.
  - The supervising licensed or master's level clinical professional must maintain a log documenting supervision of the services provided by the unlicensed or uncertified professional or paraprofessional to each member.
  - Supervision may take place in either a group or individual setting. Supervision must include opportunities for discussion of the plan of care and the individual member's progress. Issues relevant to an individual member will be documented in a service note in the clinical record."

Section Three: Eligible Providers *(cont.)*

New language

- Clarified and updated RBHS provider training requirements:
  - “Providers are responsible for ensuring that all staff are appropriately trained, including subcontractors, volunteers, students/interns and other individuals under the authority of the billing provider. Providers are responsible for the development and provision of training to their staff when alternative training is not available. Individuals who are qualified based on documented professional behavioral health experience, training or certification and/or licensure to conduct such training shall carry out the instruction. "

Section Three: Eligible Providers *(cont.)*

New language

TRAINING	ORIENTATION	CORE SERVICES	COMMUNITY SUPPORT SERVICES
TIMEFRAME TO COMPLETE:	Prior to rendering any services.	Within first 60 days of hire.	Within first 60 days of hire.
MINIMUM # OF HOURS REQUIRED:	20 total hours.	8 total hours.	8 hours minimum plus an additional 3 hours of "Service Specific Training" for each specific service rendered by individual staff for the following: CSS, PRS, B-MOD, FS, PSS, TCC, CIS, TFC, and ST.

Section Three: Eligible Providers *(cont.)*

New language

REQUIRED MATERIAL TO BE COVERED:	• Confidentiality/ • Protected Health Information/Consent to Medical Treatment • Member Rights* • Prohibition of Abuse, Neglect, & Exploitation/Mandated Reporting Procedures* • Overview of Provider's Policy and Procedures • Ethics & Professional Conduct • Overview of Behavioral Health Services • Health & Safety/ Emergency Preparedness* • Workplace Violence • Cultural & Linguistic	• Person-Centered Values, Principles, and Approaches • Trauma-informed Care • Suicide Prevention, Screening, and Intervention* • Diagnostic Assessment and Case Conceptualization • IPOC Development	8 hours minimum, covering the following topics: • Person-Centered Values, Principles, and Approaches • Suicide Prevention, Screening, and Intervention* • IPOC Development • Childhood/Adolescent Development (if serving population) 3 hours minimum for each CSS Service-Specific Training, covering the following topics: • Purpose and Service Description • Medical Necessity Criteria for all Populations Served • Staff Qualifications • Staff-to-Member Ratio

Section Three: Eligible Providers *(cont.)*

New language

	• Cultural & Linguistic Competency/Diversity • Fraud, Waste, & Abuse • Overview of Service Documentation • Expectations & Submission of Medicaid Claims (for Admin. Staff) *See Resources, below		• Staff-to-Member Ratio • Billing Frequency • Billable Places of Service • Non-Billable Medicaid Activities • Documentation Requirements • Service Modalities • Interventions – Staff Training Plan Example: Staff A renders both FS and BMOD to members. Staff A must have 3 hours of FS training *and* 3 hours of BMOD interventions training.

Section Three: Eligible Providers *(cont.)*

New Language

- Updated training resources

Resources:

- Providers are encouraged to utilize these resources in developing identified training topics. Where resources are not listed specific to a training topic, the RBHS organization may develop an appropriate training plan for all provider levels under the direction of the organization's Quality Improvement staff and/or Clinical Leadership.

Confidentiality/Protected Health Information/Consent for Medical Treatment

- Overview of Code of Federal Regulation, Title 45 CFR, Section 164.502 (45 CFR 164.502 - Uses and disclosures of protected health information: General rules) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- South Carolina Code of Laws, Section 63-5-340. *Minor's consent to health services.*
- Legal Aspects of Clinical Care: Minor's Rights to Consent in SC
- Code of Laws - Title 44 - Chapter 22 - Rights Of Mental Health Patients

Member Rights

Overview of the following (but not limited to):

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)
- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)
- Appeal
- Freedom of Choice

Section Three: Eligible Providers *(cont.)*

New language

- Updated training resources

Prohibition of Abuse, Neglect, & Exploitation

Focuses on mandated reporting, the provider's reporting policy, requirements for reporting abuse, neglect, exploitation, and disciplinary actions (internally and lawfully) which may be taken as a result of failure to report or follow policy and procedures.

- SC Mandatory Reporter Law -- South Carolina Code of Laws, Section 63-7-310. *Persons required to report.*

Health & Safety/ Emergency Preparedness

Focuses on procedures detailing actions to be taken in the event or occurrence of a natural disaster (e.g., tornado, hurricane, flood, earthquake, ice storm, snowstorm, and etc.) and/or violent or other threatening situation (e.g., explosion, gas leak, biochemical threats, acts of terrorism, workplace violence, and use of weapons, etc.).

Suicide Screening/Prevention

- C-SSRS Screen Version
- Columbia Suicide Severity Rating Scale (C-SSRS) | SAMHSA The Lighthouse Project - The Columbia Lighthouse Project
- CALM: Counseling on Access to Lethal Means – Suicide Prevention Resource Center

Section Three: Eligible Providers *(cont.)*

New language

- Service-specific staff qualifications
  - Language clarified, examples provided where relevant or beneficial to clarity:
  - "Psychosocial rehabilitation services (PRS)
    - PRS services rendered by paraprofessionals must be under the supervision of qualified clinical professionals. A bachelor's degree or above, or a certified SAS currently affiliated with OSUS, is required to render PRS.
    - PRS can be provided individually, face-to-face with one member at a time. PRS can also be provided in small groups of no more than one staff to eight (1:8) adult members and no more than one staff to eight (1:8) child and adolescent members, regardless of the payer source of the members in the group.
    - Only staff who meet the staff qualification requirements specified in this manual for PRS are considered in the 1:8 ratio.
      - For example: If a group consists of nine children, two staff must be present and actively rendering the service. If two staff are not present and actively rendering the service, the provider cannot be reimbursed for the service as the ratio exceeds 1:8. Members in excess of the allowed ratio shall not be present during the delivery of the service."

Section Three: Eligible Providers *(cont.)*

New language

- Peer support services (PSS)
  - "The certified peer support specialist (CPSS) must possess, at a minimum, a high school diploma or GED, and he or she must have successfully completed and passed a South Carolina certification training program and ongoing required continuing education. ***The provider must be 18 years of age or older.*** Those certified as CPSS Supervisors also meet criteria for delivery of PSS."
  - Clarity provided on member age range covered: PSS is an adult-oriented service, ages 18+ only.

Section Four: Covered Services and Definitions

Section Four: Covered Services and Definitions

New information

- Includes standard definitions:
  1. Covered services
     - Defines:
       - Medicaid State Plan services
       - Describes each category of RBHS and lists the relevant services for each; also provides an overarching category definition capturing the type of services within the category.
  2. Provider
  3. EPSDT
     - EPSDT benefit for members age 0-21
  4. Medically reasonable and necessary
  5. Telehealth service delivery, standardized for all Medicaid manuals:
     - Includes general overview, definitions, eligible providers, places of service and telehealth service criteria.

New information

Medicaid State Plan Services

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

Section Four: 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
   - SPD by Non–physician

3. Core Treatment Services
   - Individual Psychotherapy (IP)
   - Family Psychotherapy (FP)
   - Group Psychotherapy (GP)
   - Multiple Family Group Psychotherapy (MFGP)
   - Medication Management

Section Four: Covered Services and Definitions

New information

4. Community Support Services
   - Psychosocial Rehabilitation Services (PRS)
   - Behavior Modification (BMOD)
   - Family Support (FS)
   - Therapeutic Childcare (TCC)
   - Therapeutic Foster Care (TFC)
   - Community Integration Services (CIS)
   - Peer Support Services (PSS)
5. Crisis Management Services
   - Crisis Intervention

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

Section Four: Covered Services and Definitions *(cont.)*

New information

- Service-specific medical necessity criteria
  - User friendly chart of all services and corresponding medical necessity criteria delineated for each service.

Section Five: Utilization Management

Section Five: Utilization Management

New language

- Refers reader to Provider Administration and Billing Manual for policies regarding program integrity, utilization management (UM), or fraud, waste, and abuse.
- Updated language provides clarification on requirements for prior authorization
  - UM for case transfers and prior authorization:
    - "When previously authorized services are transferred from one RBHS provider to another, the current provider is responsible for contacting the quality improvement organization (or MCO, if member is in an MCO) to update the authorization to reflect the new provider. The new provider must follow the previously authorized set of services. If additional services are added or current services are changed, a new prior authorization may be required."

Section Five: Utilization Management *(cont.)*

New language

- Specifies requirements for efforts to coordinate care when multiple providers are involved in the same member's treatment to avoid program duplication.
- Moved UM criteria for peer support services to this section.
- Provides clarifying language on service limit exception process.
- Descriptive and more detailed list of non-covered services.

Section Six: Reporting/Documentation

Section Six: Reporting/Documentation

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 Six: Reporting/Documentation

New language

- Clarified that clinical documentation must be available in medical record prior to submitting claims for Medicaid services.
- Includes language to assist providers in confirming ongoing medical necessity through progress summaries and CSNs.
- Expanded to include reference to SMART goals, best practice clinical documentation standards.
- Updated required components of behavior modification plan, evidence-based safety planning and assessment of suicide risk.
- Added documentation requirements for discharge summaries

Section Six: Reporting/Documentation (cont.)

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 clinical services note (CSN) with a start time and end time (ex., 10:03 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 and
        - Support the number of units billed."

Section Six: Reporting/Documentation *(cont.)*

New language

- DA
  - 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 being recommended, outside referrals being made, and anticipated treatment start date.
    - ➢ *THIS ALLOWS FOR INITIAL TREATMENT IN INTERIM PRIOR TO IPOC FORMULATION.*
- Psychological testing and evaluation (PTE)
  - "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 licensed psycho-educational specialist must complete the DA (using the follow-up DA procedure code)."

Section 6: Reporting/Documentation *(cont.)*

New language

- Crisis intervention
  - Service name changed
  - Increased focus on suicide prevention, screening for suicide risk and use of evidence-based practices.
  - If member is assessed to be safe to return home, documentation now requires completion of a safety plan with the member and available in the medical record (copy provided to member).
  - Provider must include plan for follow-up post-crisis and steps for ongoing monitoring.

Section 6: Reporting/Documentation *(cont.)*

New language

- Other specific documentation requirements:
  - Individualized plan of care (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 signatures on IPOC and when completed, also whether parent/guardian or member signs
- Updated guidance in this section assists the provider in addressing common Medicaid documentation errors

Section Six: Reporting/Documentation (cont.)

New language

- Other specific documentation requirements
  - CSNs
    - ➢ More detailed explanation of required components
- Updated guidance in this section assists the provider in addressing common Medicaid documentation errors

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 Seven: Billing Guidance

Section Seven: Billing Guidance

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 a 15-minute unit to an encounter; one encounter per day per member.
- Psychological testing and evaluation (PTE) codes -- includes 96131 and 96136, 96137
  - PTE/PTA codes and service definitions match billing requirements for psychological evaluation with the full allowable code set.

Section Seven: Billing Guidance

- 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 Eight: Benefit Criteria and Limitations

Section Eight: Benefit Criteria and Limitations *(cont.)*

New manual section

- Organized by RBHS services category
- Each category lists:
  - The identified billable services within that category; for each billable service, the following is included:
    - Service definition;
    - Frequency and service limitations; and
    - Special restrictions related to other services.
- All information needed to provide the service is included in one main manual section.

Section Eight: Benefit Criteria and Limitations *(cont.)*

New information/language

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

Section Eight: Benefit Criteria and Limitations *(cont.)*

New information/language

- Screening and assessment services
  - BHS
    - Updated with current best practice screening measures; includes emphasis on best practice suicide risk and trauma screening.
  - DA
  - DA—Follow up
  - PMA *(new "short definition"– psychiatric medical assessment)*
  - CALOCUS-CASII
  - PTE/PTA

Section Eight: Benefit Criteria and Limitations *(cont.)*

New information/language

- Service plan development (SPD) of the IPOC
  - SPD Interdisciplinary Team — Conference with member/family
  - SPD Interdisciplinary Team — Conference without member/family
  - SPD-by non-physician *(must use modifiers for provider level)*
- Core treatment services
  - Individual psychotherapy
  - Group psychotherapy
    - Expanded information on benefits and use of group therapy
  - Family psychotherapy

Section Eight: Benefit Criteria and Limitations *(cont.)*

New information/language

- Crisis management services
  - Crisis intervention
    - Expanded information on best practice suicide risk screening and assessment
    - Safety planning
      - Stanley-Brown Safety Plan
        - 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 Eight: Benefit Criteria and Limitations *(cont.)*

New information/language

- Procedure codes
  - Updated procedure codes with more descriptive service limits
  - Retooled procedure codes chart
  - Available within the manual, at the end of Section Eight, in a user-friendly format

Questions

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!


SOUTH CAROLINA
ANIMIS OPIBUSQUE PARATI
DUM SPIRO SPERO
SPES
QUIS SEPARABIT
MELIOREM LAPSA LOCAVIT
1776