



STATE OF SOUTH CAROLINA  
DEPARTMENT OF EDUCATION

**Medicaid Billing and  
Documentation for Psychological  
Testing and Evaluation Services**

**SOUTH CAROLINA  
DEPARTMENT OF  
EDUCATION  
MEDICAID SERVICES**

- *Effective September 1, 2014*

- **Step 1: Identify the suspected problem**-The student is identified with a suspected behavioral health problem or with a behavioral health problem and intellectual disability or related disability or developmental disorder.
- **Step 2: Make a Referral** - A referral is then made (by anyone) to a qualified RBHS staff person (see the staff qualification section in the *Medicaid Policy and Procedure Manual*), to conduct the Diagnostic Assessment (DA).

Sample

**Initial** Referral Form for **RBHS Diagnostic Assessment**

Name of School District \_\_\_\_\_

Name of School:		
Print Name of Person Referring :		Title:
Signature:		Date of Referral:
Beneficiary's Name:	Medicaid ID #:	Date of Birth:

**Reason for the Referral:**

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- **Step 3: RBHS Consent Form** - Obtain a signed Parental RBHS Consent Form. A (DA) is conducted by the qualified RBHS staff and assigned a DSM-5 or V-Code diagnosis code.
- **Step 4: Document the Results of the (DA)**-The results must be documented on a Clinical Service Note (CSN), as outlined in the *Medicaid Policy and Procedures Manual*.

**SAMPLE Rehabilitative Behavioral Health Service (RBHS)  
CONSENT FOR TREATMENT (DIAGNOSTIC ASSESSMENT)**

I give the \_\_\_\_\_ School District my permission to conduct an Initial Diagnostic Assessment to determine the need for Rehabilitative Behavioral Health Services (RBHS) 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.

I understand that the Initial Diagnostic Assessment may include, but is not limited to psychological assessment/testing to determine an accurate diagnosis or to distinguish between diagnoses.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Student's Date of Birth

\_\_\_\_\_  
Student Medicaid #

\_\_\_\_\_  
Signature of Parent/Guardian/Primary or  
Caregiver/Legal Representative  
*(This signature is required in cases of a minor)*

\_\_\_\_\_  
Date

**Check if applicable:** \_\_\_\_\_ Beneficiary is unable to sign and requires emergency treatment.

\_\_\_\_\_  
Signature of Physician / LPHA

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

Sample RBHS Initial Diagnostic Assessment

School District: \_\_\_\_\_

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Medicaid# \_\_\_\_\_ Procedure Code: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

School: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Number Street City Zip code

Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employer: \_\_\_\_\_

Name of other parent or guardian: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Number Street City Zip code

Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employer: \_\_\_\_\_

In case of emergency contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Sample RBHS Initial Diagnostic Assessment

**Student Assessment:**

Siblings and others in household:

Presenting complaint (reason for assessment):

Symptoms:

Medical history and medications:

Pertinent family history:

Psychological and/or psychiatric treatment history for student:

Relevant educational records/tests:

Substance use history for student:

Mental status:

Summary of information from testing:

Functional Assessment (with age appropriate expectations):

Exposure to physical abuse, sexual abuse, antisocial behavior, other traumatic events:

Current edition DSM-5 or ICD diagnosis:

Medical Necessity:

Treatment recommendation, if appropriate:

*(Describe or list the type of services and why the services are medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Provider's medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.)*

CALOCUS results, if administered:



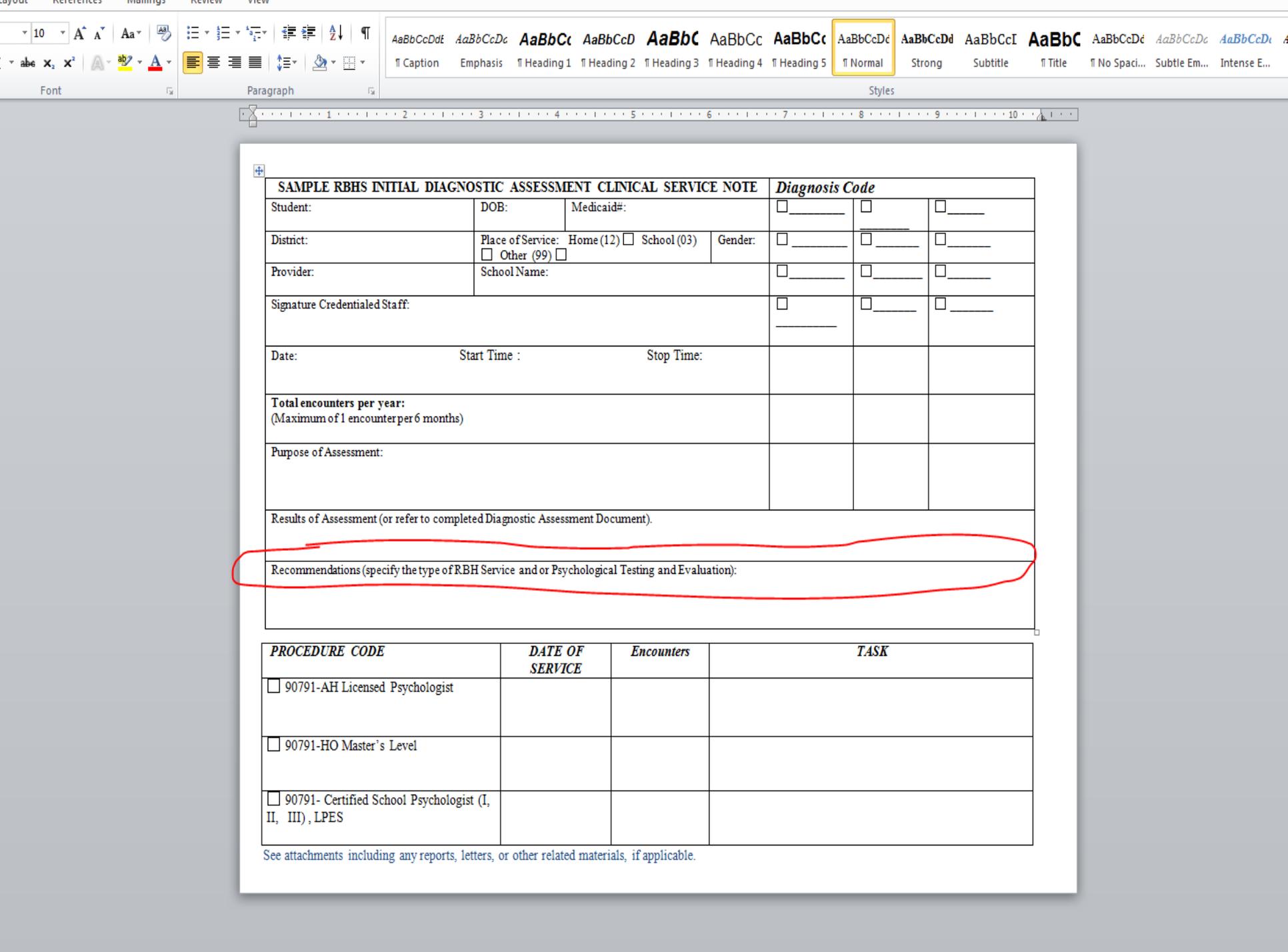


After the DA is conducted, and the LPHA does not suspect a behavioral problem or related disability, under *Medicaid Policy and Procedure*, **the LPHA is not allowed to make a referral for Psychological testing and Evaluation because the referral is not deemed as “Medically Necessary.”**



**STOP HERE, DOCUMENT AND BILL FOR THE DA ONLY!**

**Step 6: Justify the need to conduct a Psychological Test and Evaluation:** A LPHA, for Psychological Services, as listed in the RBHS referral section in the *Medicaid Policy Manual* will **review** the (DA) to determine if a behavioral health or related disability is suspected.....



SAMPLE RBHS INITIAL DIAGNOSTIC ASSESSMENT CLINICAL SERVICE NOTE				Diagnosis Code		
Student:	DOB:	Medicaid#:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
District:	Place of Service: Home (12) <input type="checkbox"/> School (03) <input type="checkbox"/>	Gender:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider:	Other (99) <input type="checkbox"/>	School Name:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signature Credentialed Staff:				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date:	Start Time :	Stop Time:				
Total encounters per year: (Maximum of 1 encounter per 6 months)						
Purpose of Assessment:						
Results of Assessment (or refer to completed Diagnostic Assessment Document).						
Recommendations (specify the type of RBH Service and or Psychological Testing and Evaluation):						

PROCEDURE CODE	DATE OF SERVICE	Encounters	TASK
<input type="checkbox"/> 90791-AH Licensed Psychologist			
<input type="checkbox"/> 90791-HO Master's Level			
<input type="checkbox"/> 90791- Certified School Psychologist (I, II, III), LPES			

See attachments including any reports, letters, or other related materials, if applicable.

# Sample RBHS Initial Diagnostic Assessment

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## **Parental/ Family Assessment:**

Psychological and/or psychiatric treatment history for family:

Substance use history for family:

Justification for Psychological Testing and Evaluation Referral:

## **Other Comments:**

LPHA Name \_\_\_\_\_ Title \_\_\_\_\_

LPHA Signature \_\_\_\_\_ Date \_\_\_\_\_

After a DA is conducted and the LPHA suspects a behavioral or related disability, and is deemed as “Medically Necessary”, **the student is referred by the LPHA for a Psychological Test and Evaluation.**

- ***Definition for Medical Necessity:*** *Medically Necessary describes or lists the type of services and why the services are medically necessary. “Medically necessary” means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Provider’s medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.” (See page 2-48, Eligibility for Rehabilitative services).*

## Referral Form for RBHS Psychological Evaluation and Testing

Name of School District \_\_\_\_\_

Student Name:	Medicaid ID Number:	Date of Birth:
Print LPHA Staff Name (please print):	Title/License:	NPI # if applicable:

DSM-5 Diagnosis \_\_\_\_\_

### Explain Reason for the Referral:

“All psychological assessment/testing 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 assessment/testing will inform treatment.” (*Medicaid Policy Manual, Psychological Services*)

\_\_\_\_\_  
\_\_\_\_\_

- Diagnostic Clarification
- Rule Out Other Diagnosis
- Confirm Secondary Diagnosis
- Other \_\_\_\_\_

### Comments, Observations, (optional)

\_\_\_\_\_  
\_\_\_\_\_

LPHA Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Title/License \_\_\_\_\_

- **Step 7: Conduct Psychological Test:** The Psychological Test and Evaluation will be conducted by the qualified staff listed in the Psychological Services section located under RBHS in the *Medicaid Policy and Procedure Manual*.
- **Step 8: Document the Psychological Test Results** - Once the Psychological Test and Evaluation is conducted and the diagnosis code for the primary and or the secondary disability are classified as behavioral; the results of the *Psychological Test and Evaluation* must be documented on a CSN as described in the documentation section of the *Medicaid Policy and Procedure Manual*. See the Revised RBHS Rate Sheet that is listed in the RBHS Manual.

**Sample RBHS Psychological Services Testing and Evaluation Billing Form/Log**

Student:	DOB:	Medicaid#:	
District:	Place of Service: Home (12) <input type="checkbox"/> School (03) <input type="checkbox"/>	Gender:	
	Other (99) <input type="checkbox"/>		
Provider :	School Name:		
Signature:			
Date:			

<i>PROCEDURE CODE</i>	<i>DATE OF SERVICE</i>	<i>TIME (HOURS)</i>	<i>UNITS</i>	<i>TASK</i>
<input type="checkbox"/> 96101-AH -Licensed Psychologist				
<input type="checkbox"/> 96101- No Modifier Psychologist I, II, III and LPES				
Start Time :                      Stop Time:				<input type="checkbox"/> Interview Beneficiary
Start Time :                      Stop Time:				<input type="checkbox"/> Interview School Staff
Start Time :                      Stop Time:				<input type="checkbox"/> Interview Parents
Start Time :                      Stop Time:				<input type="checkbox"/> Interview Outside Staff
Start Time :                      Stop Time:				<input type="checkbox"/> Administer Test Battery
Start Time :                      Stop Time:				<input type="checkbox"/> Analyzing Test Results
Start Time :                      Stop Time:				<input type="checkbox"/> Write Report
Start Time :                      Stop Time:				<input type="checkbox"/> Other
Start Time :                      Stop Time:				<input type="checkbox"/> Other
	<b>TOTAL UNITS</b>			

**NOTE: Medicaid allows you to bill for 60 minutes at 10 units per day.  
1 unit = 60 minutes**

- **Step 9: Medicaid Billing:** Medicaid will reimburse for the *Psychological Test and Evaluation* if it is deemed as Medically Necessary. If the diagnosis is strictly educational, then Medicaid will not reimburse for the test.

- **Special Notes:**

- Psychological Testing and Evaluation and Diagnostic Assessments can be billed on the same day. Assessments must be billed separately and provide different outcomes.
- An LPHA can perform the following tasks:
  - make the referral,
  - conduct the assessment, and :
  - conduct the Psychological Test and Evaluation.

# **RBHS Psychological Testing and Evaluation**

## **RATE SHEET**

RBHS - LEA RATES						
Service	Procedure Code	Modifier	Staff	Rates	FREQUENCY	DAILY FREQUENCY LIMITS
Psychological Testing and Evaluation (Note: School provides the service)	96101	No modifier	Certified School Psychologist (I, II, III) and Licensed Psycho-educational Specialist	\$90.43	1 unit =60 minutes	10 units per week and 20 units per year
Psychological Testing and Evaluation (Note: referral to a private provider)	96101	AH	Licensed Psychologist	\$90.43	1 unit =60 minutes	10 units per week and 20 units per year
Comprehensive Diagnostic Assessment- <b>Initial</b>	90791	AH	Licensed Psychologist	\$224.63	Encounter	1 per every 6 months
		HO	Master's Level	\$153.94	Encounter	1 per every 6 months
Child and Adolescent Level of Care Utilization System (CALOCUS) Assessment	H2000	AH	Licensed Psychologist	247.32	Encounter	Once a day -2 times per month as needed
Child and Adolescent Level of Care Utilization System (CALOCUS) Assessment	H2000	HO	Master's Level	218.26	Encounter	Once a day-2 times per month as needed
Mental Health Comprehensive Assessment - <b>Follow-up</b>	H0031	AH	Licensed Psychologist	\$112.32	Encounter	12 encounters per year
		HO	Master's Level	\$76.97	Encounter	12 encounters per year

# **Psychological Testing and Evaluation**

## **Audit Checklist**

## SAMPLE Psychological Testing and Evaluation Services

<b>Review Period:</b>	<b>Student:</b> <input style="width: 80%;" type="text"/>
<b>Provider:</b> <input style="width: 80%;" type="text"/>	<b>Medicaid #:</b> <input style="width: 80%;" type="text"/>
<b>Date:</b> <input style="width: 80%;" type="text"/>	<b>Reviewer:</b> <input style="width: 80%;" type="text"/>
<b>School-District:</b> <input style="width: 100%;" type="text"/>	

	REFERRAL	MET	COMMENTS/RECOMMENDATIONS
<a href="#">1.1</a>	Is there an Initial RBHS Initial Diagnostic Assessment (DA) referral in the clinical record? Is the referral signed, dated, and titled?		
<a href="#">1.2</a>	Is the Initial RBHS DA referral <b><u>dated prior to</u></b> the Diagnostic Assessment?		
<a href="#">1.3</a>	Is there an LPHA referral for Psychological Testing and Evaluation services in the clinical record, if applicable? Are the LPHA's name, date and professional title listed on the referral?		
<a href="#">1.4</a>	Is the LPHA referral <b><u>dated prior to</u></b> the RBHS Psychological Test and Evaluation?		
	<b>DIAGNOSTIC ASSESSMENT ( DA )</b>		
<a href="#">2.1</a>	Is there a DA in the clinical record? Is the DA conducted face-to-face with the beneficiary and include an evaluation that indicates the presence of a behavioral health disorder?		
	<b>Does the RBHS DA include the following information:</b>		
	*Beneficiary demographic information		
	*Presenting complaint, source of distress		
	*Medical history and medications		
	*Family history		
	*Psychological and/or psychiatric treatment history	8/5/2015	21

Sample <u>RBHS FOLLOW-UP DIAGNOSTIC ASSESSMENT CSN</u>			<i>Diagnosis Code</i>		
Student:	DOB:	Medicaid#:	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
District:	Place of Service: Home (12) <input type="checkbox"/> School (03) <input type="checkbox"/> Other (99) <input type="checkbox"/>	Gender:	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Provider:	School Name:				
Title:			<b>Purpose of the test:</b>  <b>Results of the test:</b>  <b>Recommendations:</b>		
Signature:					
Date:	Start Time:	Stop Time:			
<b>Total encounters per year:</b> (Max. of 12 encounters per year)					

PROCEDURE CODE	Beneficiary Progress	Response to Treatment	Need for Continued Treatment
<input type="checkbox"/> H0031-AH Licensed Psychologist			
<input type="checkbox"/> H0031-HO Master's Level			
<input type="checkbox"/> H0031 HO Certified School Psychologist (I, II, III), LPES			

# Supervision Links and Contact information

**The Medicaid Policy Manual Link:**

<https://www.scdhhs.gov/provider-type/local-education-agencies-040105-edition-posted-030405>

**Staff Credentials and Supervision Requirements can be located at:**

**SCDHHS Medicaid Policy Manual Link for Supervision:**

<https://www.scdhhs.gov/provider-type/local-education-agencies-040105-edition-posted-030405>

**For More Information Contact:**

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