Basic Rehabilitative Behavioral Health Services (RBHS) Overview

Office of Medicaid Services
2025-2026

SOUTH CAROLINA
DEPARTMENT OF EDUCATION

Purpose of Training

The purpose of this training is to provide a brief overview of the RBHS available to all school districts. Districts are responsible for reviewing the Local Education Agencies (LEA) Provider Manual in its entirety for a comprehensive overview of policy requirements and expectations.

What are RBHS?

- An array of behavioral health services under the Rehabilitative Services Option, 42 CFR 440.130(d) which are allowed via the SC State Medicaid Plan.
- 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 determined by the South Carolina Department of Health and Human Services (SCDHHS).
- For maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level.

Reimbursable RBHS

- Behavioral Health Screen (BHS)
- Diagnostic Assessment (DA)
- Service Plan Development (SPD)
- Crisis Management (CM)
- Individual Psychotherapy (IP)
- Group Psychotherapy (GP)
- Family Psychotherapy (FP)
- Psychological Testing and Evaluation (PTE)*

*PTE was not impacted by the SCDHHS enhanced rate

Who can receive RBHS?

- All Medicaid beneficiaries diagnosed with mental health and/or substance use disorder (SUD), as defined by the current edition of the Diagnostic and Statistical Classification of Diseases and Related Health Problems (ICD) who meet medical necessity criteria.
- The rendering of RBHS shall be:
  - based on the establishment of medical necessity,
  - directly related to the beneficiary's clinical needs, **AND**
  - shall be expected to achieve the specific goals specified in the beneficiary's Individual Plan of Care (IPOC).

Consent

- Consent is the act of providing express permission, in writing, for some particular action to take place.
- Must be obtained at the onset of treatment and placed in the beneficiary's file.
- A Consent for Treatment Form must be dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor), or legal representative.
- If the beneficiary, parent, legal guardian or legal representative cannot sign the consent form due to a crisis the following must occur:
  - If the beneficiary is accompanied by a next of kin or responsible party, that individual may sign the consent form.
  - If the beneficiary is alone and unable to sign, a statement such as "beneficiary unable to sign and requires emergency treatment" must be noted on the consent form and must be signed by the LPHA and one other staff member.
  - The beneficiary, parent, legal guardian, or legal representative should sign the consent form as soon as circumstances permit.
- A RBHS Consent Form template can be found on the Office of Medicaid Services (OMS) webpage. The form can be utilized by school districts.

Release of Information

- A Release of Information Form must be signed by the child's parent or guardian and be present in the clinical record.
- A Release of Information Form authorizes the release of any medical information necessary to process Medicaid claims.
- The request to release information is incorporated into the RBHS Consent Form template available on the OMS webpage. The form can be utilized by school districts.

Medical Necessity

Medical necessity means the need for treatment services is necessary to diagnose, treat, cure, or prevent an illness, or participation in services is reasonably expected to relieve pain, improve and preserve health, or be essential to life.

- All Medicaid beneficiaries must meet specific medical necessity criteria to be eligible for treatment services (see manual).
- The determination of medically necessary treatment must be:
  - documented on a Diagnostic Assessment (DA).
  - based on information provided by the beneficiary, the beneficiary's family, and/or collaterals who are familiar with the beneficiary.
  - based on current clinical information. (If the diagnosis has not been reviewed in 12 or more months, the diagnosis should be confirmed immediately).
  - made by an LPHA enrolled in or employed by a school district that is enrolled in, the South Carolina Medicaid Program.

Medical Necessity Requirements

The results of the assessment must indicate a functioning level that would support the need for services and the behavior must interfere with the ability to function in at **least two** of these areas(for some services):

- daily living,
- personal relationships,
- work setting,
- school, AND
- recreational settings.

Medical Necessity Timeframes

- *Medical necessity must be established **prior to** rendering services.
- Medical Necessity must be confirmed within 365 calendar days of the last assessment, if the beneficiary needs continuing rehabilitative services.
- If the beneficiary has not received services for 45 consecutive calendar days, medical necessity **must be** re-established by completing a follow-up assessment.

*Exception: Two encounters of Crisis Management (CM) can be provided prior to the DA being completed.

Who Can Confirm Medical Necessity?

- LPHAs must certify that the beneficiary meets the medical necessity criteria for each service.
- The following professionals are licensed at the independent level in South Carolina and can establish and/or confirm medical necessity:
  - Licensed Physician
  - Licensed Psychiatrist
  - Licensed Psychologists
  - Licensed Psycho-Education Specialist
  - Licensed Advanced Practice Registered Nurse (APRN)
  - Licensed Independent Social Worker (LISW-CP)
  - Licensed Physician Assistant (PA)
  - Licensed Professional Counselor (LPC)
  - Licensed Marriage and Family Therapist (LMFT)
  - Licensed Addiction Counselors – master's and above
  - Licensed Master's Social Worker – must have the DA cosigned by an independent Licensed Practitioner of the Healing Arts (LPHA)
- The LPHA"s name, professional title, signature and date must be listed on the document to confirm medical necessity.

Diagnostic Assessment (DA)

- The purpose of the face-to-face assessment is to:
  - determine the need for all services rendered and establish medical necessity.
  - to confirm a diagnosis (diagnoses).
  - to assist in the development of an individualized plan of care based upon the beneficiary's strengths and needs and/or
  - to assess progress in treatment and confirm the need for continued treatment.

DA Requirements

- The DA can be administered to all Medicaid eligible beneficiaries who have been identified as having or at-risk of mental health and/or substance use disorder (SUD).
- The DA must document the presence of a serious behavioral health disorder from the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), excluding irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders unless they co-occur with a serious behavioral health problem that meets the current edition DSM or ICD criteria.
- When the DA establishes medical necessity, the assessment must identify the beneficiary's current symptoms or disorder via the current edition of the DSM or the ICD.
- The DA must be maintained in the Medicaid beneficiary's clinical record.

DA Timeframes

- The completed assessment tool and written interpretation of the results must be filed in the beneficiary's clinical record within 10 working days from the date of service.
- The DA must be completed annually (i.e., 365 days) and can be repeated every 6 months (if medically necessary).

DA Documentation Requirements

- Please reference the LEA Provider Manual and SCDHHS **Clinical Assessment Training** to review the requirements and mandatory components of the Diagnostic Assessment.
- In addition to the assessment itself, the DA service must be documented on a clinical service note (CSN) and include all SCDHHS requirements for CSNs.
- The DA must clearly state recommendations for treatment via clinical summary, including services and the frequency for each service recommended.
- If the SCDHHS or its designee determines that services were reimbursed when evidence of medical necessity, as outlined in the LEA manual, was not documented and maintained in the beneficiary's record, payments to the provider shall be subject to recoupment.

Mental Health (MH) Comprehensive Assessment Follow-up

- An MH Comprehensive Assessment Follow-up occurs face-to-face with the beneficiary after an initial assessment to:
  - re-evaluate the status of the beneficiary,
  - identify any significant changes in behavior and/or condition, and
  - to monitor and ensure appropriateness of treatment.
- MH Comprehensive Follow-up assessments may also be rendered to:
  - assess the beneficiary's progress and response to treatment,
  - the need for continued treatment and
  - establish medical necessity for new or additional services to be added to the course of treatment.
- The MH Comprehensive Follow-up assessment should only be utilized when documented behavioral changes have occurred and when the beneficiary needs to be re-assessed.
- Efforts should be made to determine whether another DA has been conducted in the last 90 days and information should be updated as needed. If a DA has been conducted within the last 90 days, efforts should be made to access those records.

Psychological Testing and Evaluation (PTE)

- PTE may be used for the purpose of diagnostic 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.
- PTE services involve the use of formal testing procedures using reliable and valid instruments to measure the areas of intellectual, cognitive, adaptive, emotional and behavioral functioning, along with personality styles, interpersonal skills and psychopathology.

PTE Requirements

- The PTE by the assessor must include the reason or a specific referral question(s) that can be reasonably answered by the proposed psychological assessment/testing tool.
- Prior to administering a battery of tests, the evaluating psychologist should review relevant clinical information from the most recent DA and consider historical clinical information.
- 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.
- Testing and evaluation must involve face-to-face interaction between a licensed/certified psychologist and the beneficiary for the purpose of evaluating the beneficiary's intellectual, emotional, and behavioral status.
- Tests must be standardized, and validated measures recognized by the scientific and professional community as a national standard for professional practice, and may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, motivations, and/or personality characteristics, as well as use of other non-experimental methods of evaluation.
- The results of the standardized tests must be documented in the PTE.
- Please reference the LEA Provider Manual to review the requirements and mandatory components of the PTE.

Individualized Plan of Care (IPOC)

- The Individualized Plan of Care (IPOC) is an individualized comprehensive plan of care to improve the beneficiary's condition.
- The IPOC utilizes information gathered during the evaluation, screening and assessment process.
- The IPOC outlines the service delivery needed to meet the identified needs and improve overall functioning.
- The IPOC must be written to provide a beneficiary-centered and/or family-centered plan.
- Diagnostic Assessment (DA), Crisis Management, and Service Plan Development (SPD) are not required to be listed on the IPOC.

IPOC Development

- The IPOC is developed in collaboration with the beneficiary, which may include an interdisciplinary team of the following:
  - significant other(s)
  - parent/Guardian
  - primary caregiver
  - other state agencies and staff, or
  - service providers
- If the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason **must be** documented in the beneficiary's clinical record.
- The beneficiary **must** sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician **must document** the refusal. If it is considered clinically appropriate for the beneficiary to sign the IPOC, clinical justification **must be** documented on the IPOC. The physician, LPHA master's level qualified clinical professional, or LMSW must sign the final document.

IPOC Requirements

- The IPOC is developed in collaboration with the beneficiary, which may include an interdisciplinary team of the following: significant other(s), parent, guardian, primary caregiver, other state agencies and staff, or service providers.
- If the family, legal guardian, legal representative, or primary caregiver is not involved in the treatment planning process, the reason must be documented in the beneficiary's clinical record.
- The beneficiary must sign the IPOC. If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC. The Physician, LPHA, master's level qualified clinical professional, or LMSW must sign the final document.
- The maximum duration of the IPOC is 365 calendar days from the date of the signature of the LPHA, or master's level qualified clinical professional on the IPOC.
- Prior to termination or expiration of the treatment period the LPHA or master's level qualified clinical professional must review the IPOC with the beneficiary and the beneficiary's family, to evaluate the beneficiary's progress with respect to each of the beneficiary's treatment goals and objectives.
- Please reference the LEA Provider Manual and SCDHHS IPOC Training to review the requirements and mandatory components of the IPOC.

IPOC Timeframes

- The initial IPOC must be completed, signed, titled, and signature dated by the Licensed Practitioner of the Healing Arts (LPHA), master's level qualified clinical professional, or Licensed Master Social Worker (LMSW) within 30 calendar days of the DA.
- If the IPOC is not completed and signed within 30 days, services rendered are not Medicaid reimbursable.
- If changes and updates are made to the original IPOC, an updated copy must be provided to the beneficiary and other involved parties within 10 business days.

Service Plan Development (SPD)

- The purpose of this service is to allow the LPHA, LMSW, or MHP to work closely with the beneficiary and/or family members, and any other supports the beneficiary has, to develop or revise the Individualized Plan of Care (IPOC).
- Multiple staff members of an interdisciplinary team may participate in the process of developing, preparing and/or reviewing the IPOC. While attendance of multiple Provider representatives may be necessary, only one professional that is actively involved in the planning process from each Provider office may receive reimbursement.
- The Service Plan Development must be documented on a CSN.

Psychotherapy Services

- Psychotherapy services are planned face-to-face interventions intended to:
  - help the beneficiary achieve and maintain stability,
  - help the beneficiary improve their physical, mental, and emotional health, and
  - help the beneficiary cope with or gain control over the symptoms of their illness(es) and the effects of their disabilities.

Psychotherapy Service Requirements

- Psychotherapy services are provided within the context of the goals identified in the beneficiary's individualized Plan of care (IPOC).
- Services should be used to assist beneficiaries with problem solving, achieving goals, and managing their lives by treating a variety of behavioral health issues and may be provided in an individual, group or family setting.
- Psychotherapy services do not include educational interventions without therapeutic process interaction, any experimental therapy not generally recognized by the profession nor drug therapy or other physiological treatment methods.

Individual Psychotherapy (IP)

- The purpose of this face-to-face intervention is to assist the beneficiary in improving his or her emotional and behavioral functioning.
- IP is an interpersonal intervention directed towards:
  - increasing one's sense of well-being,
  - identifying maladaptive behaviors and cognitions,
  - identifying more adaptive alternatives, and
  - learning how to utilize those adaptive behaviors and cognitions.
- IP involves planned therapeutic interventions to address the beneficiary's goals.
- Treatment should be designed to maximize the beneficiary's strengths.

Group Psychotherapy (GP)

- GP is a method of treatment in which several beneficiaries with similar problems meet face-to-face in a group with a clinician.
- The group process allows members to:
  - offer each other support,
  - share common experiences,
  - identify strategies that have been successful, and
  - to challenge each other's behaviors and cognitions.
- The focus of GP is to assist beneficiaries with solving emotional difficulties and to encourage the personal development of the group members.

Family Psychotherapy (FP)

- The purpose of this face-to-face intervention is to address the interrelation of the beneficiary's functioning with the functioning of his or her family unit.
- The therapist assists family members in developing a greater understanding of the beneficiary's psychiatric and/or behavioral disorder and the appropriate treatment for the disorder.
- FP may be rendered with or without the beneficiary if the identified beneficiary is the focus of the session. Only issues pertinent to the identified beneficiary may be addressed under this service.

Crisis Management (CM)

- A crisis can be defined as an event that places a beneficiary in a situation that was not planned or expected.
- The purpose of crisis management services is to assist a beneficiary who is experiencing an urgent or emergent marked deterioration of functioning related to a specific precipitant in restoring his or her level of functioning.
- CM should therefore be immediate methods of intervention that can include stabilization of the person in crisis, counseling and advocacy, and information and referral, depending on the assessed needs of the individual.
- The clinician must assist the beneficiary in identifying the precipitating event, identifying personal and/or community resources that he or she can rely on to cope with this crisis, and in identifying specific strategies to be used to mitigate the crisis and prevent similar incidents.
- Clinical professionals should provide an objective frame of reference within which to consider the crisis, discuss possible alternatives, and promote healthy functioning. All activities must occur within the context of a potential or actual psychiatric crisis.

CM Requirements

- The service must be provided face-to-face or telephonic.
- The face-to-face interventions require immediate response by a clinical professional and include:
  - a preliminary evaluation of the beneficiary's crisis,
  - intervention and stabilization of the beneficiary,
  - reduction of the immediate personal distress,
  - development of an action plan that reduces the chance of future crises,
  - referrals to appropriate resources, and
  - follow-up with the beneficiary within 24 hours.
- 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.

Clinical Service Notes (CSNs)

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

90-Day Progress Summary

The 90-Day Progress Summary is a periodic evaluation and review of:

- a beneficiary's progress toward the achievement of goals and objectives,
- overall response to treatment services,
- the appropriateness of services rendered, and
- the need for the beneficiary's continued participation in the treatment.

90-Day Progress Summary Requirements

- The progress summary shall be completed at least every 90 calendar days from the signature date on the initial Individualized Plan of Care (IPOC), and every 90 days thereafter.
- The progress summary must be completed and signed by the Licensed Practitioner of the Healing Arts (LPHA), or another qualified clinical professional.
- The progress summary must be clearly documented on the IPOC or on a separate sheet attached to the IPOC.
- Please reference the LEA Provider Manual and SCDHHS 90-Day Progress Summary Training to review the requirements and mandatory components of the 90-Day Progress Summary.

Electronic Signature Policy

- South Carolina Department of Health and Human Services (SCDHHS) will accept electronic signatures on Medicaid documentation when an electronic health record/system is being utilized.
- The electronic signatures must be created within the electronic health system that is being utilized.
- Please review the SCDHHS Provider Administrative Billing Manual to review/identify the requirements and standards specific to electronic signatures.

RBHS Documentation Sequence

The following documentation sequence must be adhered to when rendering RBHS:

- *Consent to Treat and Release of Information
- *Initial or Follow-up DA that confirms medical necessity
- **IPOC
- CSN
- Progress Summary
- Discharge Summary

*Crisis Management may be rendered prior to obtaining a consent to treat, release of information and prior to the completion of the initial DA.

**Core Treatment Services may be rendered prior to the completion of the IPOC, provided the services are medically necessary. If the IPOC is not completed and signed within 30 days of the DA, services rendered are not Medicaid reimbursable.

Medicaid Reimbursement

- All RBHS Providers shall ensure that:
  - only the authorized units of services are provided and submitted to SCDHHS for reimbursement and
  - all services are provided in accordance with all South Carolina Medicaid Program policy requirements
- Services must be documented in the clinical record and the documentation must justify the amount of reimbursement claimed to Medicaid.
- By submitting claims to SCDHHS for reimbursement, licensed professionals attest that they are in conformance with the relevant practice act(s) and associate regulations. Any services performed by licensed professionals, to include supervisory relationships, that do not comport with the relevant practice act(s) and regulations are subject to recoupment by the Department, and a referral made to the appropriate Board at South Carolina Department of Labor, Licensing and Regulation.

Provider Qualifications

- LEAs may provide RBHS or contract with any qualified provider for school-based services (i.e., SC Department of Mental Health or private RBHS/Licensed Independent Practitioner (LIP) community provider).
- All subcontracts are subject to the terms of the LEA's contracts with SCDHHS, and the LEA's contract must be provided to the subcontractor by attachment to the subcontract.
- The LEA provider is held responsible for the oversight of the performance of the subcontractor.
- Please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us if a copy of the current SCDHHS subcontract format is needed.

Staff Qualified to Render Services

- The following professionals are allowed to provide the *six services in the school setting:
  - Licensed Independent Social Worker – Clinical Practice
  - Licensed Marriage, Family Therapist
  - Licensed Professional Counselor
  - Licensed Psycho-Educational Specialist
  - Licensed Masters Social Worker (Supervision Required)
  - Mental Health Professional (Supervision Required)

- Refer to the Staff Qualifications Chart in the LEA Provider Manual to identify which services each staff can render.

*PTE not included in six services

Staff Supervision & Monitoring

- Licensed clinical professionals have the responsibility of planning and guiding the delivery of services provided by unlicensed or uncertified professionals.
- The licensed professional needs to be licensed at the independent level.
- Supervision may take place in either a group or individual setting.
- When services are provided by an unlicensed or uncertified professional, the State agency or private organization must ensure the following:
  - The supervising LPHA provide documented consultation, guidance, and education with respect to the clinical skills, competencies, and treatment provided of the unlicensed staff, at least every 30 days.
  - The supervising LPHA maintain a log documenting supervision of the services provided by the unlicensed staff.
  - Case supervision and consultation does not supplant training requirements.

Managed Care Organization (MCO)

- All RBHS services are covered under the managed care benefit package.
- If a student's care is managed by an MCO, the district must enroll/contract with the MCO and receive prior approval/authorization for services to receive reimbursement.
- Claims for students whose care is managed by a MCO must be submitted/billed to the MCO, **not SCDHHS**.
- Districts can identify if a child is enrolled in a MCO by utilizing the SC Medicaid Web Portal.

MCO Prior Authorization (PA)

- SCDHHS allows for MCOs to set PA rules and guidance.
- Each MCO has specific requirements for documenting and billing.
- Best practice is to review the MCO's policy and/or contact the MCO for specific billing, PA, contracting, and documentation requirements.
- Please review the following MCO resources:
    - MCO Policy and Procedure manual
    - MCO Contact List
    - MCO Prior Authorization Guidance Sheet

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