South Carolina Coding and Billing Guide for HealthySteps-Related Services

HealthySteps National Office Policy and Finance Team

About this Document

HealthySteps sites can bill Medicaid for some of the services they provide to children and families. The purpose of this document is to support HealthySteps sites in medical coding for HealthySteps-related services.

This document provides a list of open Current Procedural Terminology (CPT) and HealthCare Common Procedure Coding System (HCPCS) codes, with specific applicable Medicaid billing, coding, and documentation guidelines.

There are a variety of requirements and restrictions that can impact your site's ability to bill specific codes, including the provider type, location of service, frequency, and maximum billing units. This document aims to facilitate an understanding of these requirements and restrictions and helps guide your practice in coding and billing for HealthySteps services.

To maximize appropriate reimbursement, we recommend always contacting health insurance companies for verification on billing for services provided.

Disclaimer: This document is not intended to give billing advice or guidance to any specific provider or HealthySteps site and does not consider the fact that payors, providers, and sites may have their own policies and procedures that may affect or prohibit implementation of these recommendations. Additionally, billing guidance is updated often. If there are any updates you recommend, please reach out to HSPolicyandFinance@zerotothree.org.

Contents

South Carolina Medicaid

South Carolina Department of Health and Human Services (SCDHHS) administers Healthy Connections, the state's Medicaid program. Healthy Connections provides health coverage, including behavioral health services to eligible patients.

People who are usually eligible for Healthy Connections Medicaid benefits include:

- Children, including children with developmental delays.
- Parent and caretaker relatives
- Pregnant women
- People with disabilities
- Breast and cervical cancer patients

SCDHHS Contact Information

The HealthySteps National Office Policy and Finance Team is here to support your billing efforts, but for issues and questions regarding South Carolina billing and coding policies and procedures, please use the contacts listed below:

- **SCDHHS – Healthy Connections Contact Numbers**:
    - General Telephone Number: (888) 549-0820
    - Help with Medical Claims: (800) 726-8774
    - Provider Information: (888) 289-0709
    - Office of Eligibility & Member Services: (800) 898-2590

- **SCDHHS – Healthy Connections Website Links:**
    - Healthy Connections Web Portal: https://portal.scmedicaid.com/login

- Healthy Connections List of Medicaid Contacts: https://www.scdhhs.gov/contact
- EPSDT Provider Resources: https://www.scdhhs.gov/resources/programs-and-initiatives/epsdt/providers
- Healthy Connections Provider Fee Schedules: https://www.scdhhs.gov/providers/fee-schedules

- **Provider Manuals**:
  - Physician Services Provider Manual: https://provider.scdhhs.gov/internet/pdf/manuals/Physicians/Manual.pdf
  - Federally Qualified Health Center Behavioral Health Manual:
  - https://provider.scdhhs.gov/internet/pdf/manuals/FQHC/Manual.pdf
  - Rural Health Center Behavioral Health Provider Manual: https://provider.scdhhs.gov/internet/pdf/manuals/RHC/Manual.pdf
  - Licensed Independent Practitioner's (LIP) Rehabilitative Services Provider Manual: https://provider.scdhhs.gov/internet/pdf/manuals/LIPS/Manual.pdf
  - Enhanced Services Provider Manual: https://provider.scdhhs.gov/internet/pdf/manuals/Enhanced/Manual.pdf

Provider Guidelines

Behavioral/mental health providers that are eligible for reimbursement depend upon the clinic type in which the services are being rendered. Below are the provider types, and a crosswalk of clinic types with those providers recognized for reimbursement.

Behavioral/Mental Health Providers:

- Licensed Bachelor Social Worker (LBSW)
- Licensed Independent Social Worker-Clinical Practice (LICSW-CP)
- Licensed Master Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Marriage and Family Therapist Associate (LMFTA)

- Licensed Professional Counselor (LPC)
- Licensed Professional Counselor Associate (LPCA)
- Licensed Psycho-education Specialist (LPES)
- Licensed Psychologist
- Post-Doctorate Psychologist
- Psychiatric Nurse Practitioner (Psychiatric NP)
- Psychiatric Physician Assistant (Psychiatric PA)

Providers Recognized for Reimbursement at Federally Qualified Health Centers (FQHCs):

- Licensed Independent Social Worker-Clinical Practice (LICSW-CP)
- Licensed Master Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Marriage and Family Therapist Associate (LMFTA)
- Licensed Professional Counselor (LPC)
- Licensed Professional Counselor Associate (LPCA)
- Licensed Psychologist
- Post-Doctorate Psychologist

Providers Recognized for Reimbursement at Rural Health Centers (RHCs):

- Licensed Psychologist
- Licensed Independent Social Worker-Clinical Practice (LISW-CP)
- Licensed Master Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)

Guidelines for the Supervision of Associate Behavior/Mental Health Providers

The supervision of all associate behavioral health providers, including post-doctorate psychologists, is required when they are rendering services to patients where the services are to be billed under the supervising provider. Below are the supervision guidelines for each clinic type. There are two types of supervision:

General Supervision - when the supervisor does not have to be located on the premises but must be accessible by phone or other electronic device.

Direct Supervision - when the supervisor must be at the same location as the supervisee and be immediately accessible by phone or electronic device.

There must be a written protocol in place for addressing crisis situations when they arise.

Supervision Guidelines at FQHCs:

- Post-Doctorate Psychologist: Licensed Psychologists must provide direct supervision to a Post-Doctorate Psychologist when they are rendering services.
- LPCA: LPCs must provide general supervision to an LPCA.
- LMFTA: LMFTs must provide general supervision to an LMFTA.
- LMSW: LISW-CPs must provide general supervision to an LMSW.

Supervision Guidelines at RHCs:

- LMSW: LISW-CPs must provide general supervision to an LMSW.

Supervision Guidelines for all Other Clinic Types:

- Post-Doctorate Psychologist: Licensed Psychologists must provide direct supervision to a Post-Doctorate Psychologist when they are rendering services.
- LPCA: LPCs must provide direct supervision to an LPCA.
- LMFTA: LMFTs must provide direct supervision to an LMFTA.
- LBSW and LMSW: LISW-CPs must provide direct supervision to an LBSW and/or LMSW.

Verification at all clinic types must be made regarding if and/or when the supervising licensed practitioner is required to co-sign the notes of the associate behavior/mental health provider.

Use of Billing Modifiers

Billing modifiers, referred to simply as modifiers, are composed of two alpha or numeric characters, that when appended to a billing code, will provide additional information about either the service itself or about the provider rendering the service. Healthy Connections recognizes and requires the following modifiers be appended to billing codes, when coding for behavior/mental health services, and identifying the provider types rendering the services:

Provider Type	Billing Modifier
Psychiatrist	AF
Licensed Psychologist	AH
Doctoral Level Behavioral Health Specialist *(post-doctorate psychologist)*	HP
Psychiatric PA	AM
Psychiatric NP	SA
Registered Nurse	TD
Master's Level Behavioral Health Specialist *(LICSW-CP, LMSW, LMFT, LMFTA, LPC, LPCA)*	HO
Licensed Bachelor Social Worker	HN

Healthy Connections also recognizes and requires the following modifiers to be appended to specific billing codes for specified Enhanced Services in primary care, and identifying either a program or visit type:

Program/Visit Type	Billing Modifier
Child/Adolescent Program	HA
Postpartum Home Visit - Repeat follow-up visit, when either mother or infant was absent for the first visit (reduced services)	52
Enhanced Services follow-up visit	TS
Family Planning	FP

If services are approved to be rendered via interactive audio/video telecommunications, a GT modifier must also be appended.

Medical Necessity Based on Z-Codes for Behavioral/Mental Health Services

The LIP Rehabilitative Services Manual, the FQHC Behavioral Health Provider Services Manual, and the RHC behavioral Health Provider Services Manual all provide identical guidance in the "Covered Population-Eligibility/Special Populations" area.

The guidance advises that a psychiatric diagnosis is required from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD), Clinical Modification (ICD-CM) (excluding irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders, unless they co-occur with a serious mental disorder that meets current edition DSM criteria).

The guidance advises that medical necessity based on Z-codes is allowed for patients who are between the ages of 0-6. There is no time limit on the use of Z-codes within this 0-6 population. Clinical documentation justifying the need for continued services must be maintained in the child's clinical record and is required for the use of a Z-code to support medical necessity for services.

Same Day Billing Exclusion at Federally Qualified Health Centers

Currently the definition of a visit is a face-to-face encounter between a Federally Qualified Health Center (FQHC) patient and a physician, PA, NP, CNM, chiropractor, clinical psychologist, or clinical social worker, during which a Medicaid-covered FQHC core service is furnished.

Only one encounter code is allowed per day at FQHCs, except for the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day. FQHC services are covered when furnished to patients at the center, in a SNF, or at the client's place of residence.

HealthySteps-Related Services

Child Development, Social-Emotional, and Maternal Depression Screenings

Evaluating and promoting optimal child development and well-being includes screenings. Screenings are a significant component of HealthySteps services, and the recommended screening schedule aligns with the American Academy of Pediatrics (AAP) Bright Futures Guidelines. There are many different types of screenings that include child development, social-emotional, and health and behavior. These screenings are usually incorporated into the well-child visit. The table below highlights pertinent billing codes, their descriptions, and guidelines.

CPT Code	Description	ICD-10 Code	Reimbursable Clinicians	Applicable Guidelines
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument. Examples: **ASQ®-3, M-CHAT, PEDS, SWYC**	Z13.42 - Developmental delays Z13.41 - Autism screening	Physician Physician Assistant (PA) Nurse Practitioner (NP)	The ASQ and PEDS utilize the same CPT code. The reporting of more than one unit is applicable when billing for more than one screening code. If an evaluation and management (E/M) service is being reported on the same date of service, Modifier 25 needs to be appended to the E/M code. Reporting of units may be required when entering charges for a claim. For example, the ASQ®-3 and M-CHAT screenings both utilize CPT code 96110 for reporting. If both are rendered on the same day, a quantity of "2" will need to be on the claim. The South Carolina Department of Health and Human Services recommends that health care facilities follow the AAP Bright Futures guidelines for health supervision of infants, children, and adolescents, utilizing their periodicity schedule.
96160	Patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument. Examples: **ACEs-patient focused**	Z13.9 - Report for health risk assessments		
96161	Caregiver-focused health risk assessment instrument with scoring and documentation, per standardized instrument. Examples: **ACEs-caregiver focused, Edinburgh Maternal Depression Screen provided to the mom during a well-child visit, Safe Environment for Every Kid (SEEK)**	Z13.32 - Encounter for screening for maternal depression Z13.9 - Report for health risk assessments		
96127	Social-emotional brief emotional/behavioral assessments. Examples: **ASQ®:SE**	Z13.89 - Screenings for all other		

Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluation includes the assessment of the patient's psycho-social history, current mental status, and reviewing and ordering diagnostic studies followed by appropriate treatment recommendations. Interviews and communication with family members are included in these codes. A psychiatric evaluation is more in-depth than a screening.

Evaluations include the following:

- Description of behaviors present, when they occur, how long they last, and which behaviors occur most frequently, under which conditions,
- how the behaviors impact performance in school and other activities, and relationships with others (e.g., parent/caregiver), and
- description of symptoms (physical and psychiatric), and personal and family mental health history.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90791	Psychiatric diagnostic evaluation	Psychiatric Nurse Practitioner Clinical Psychologist Psychiatrist Licensed Professional Counselor (LPC) Licensed Marriage and Family Therapist (LMFT) Licensed Independent Social Worker Clinical Practice (LISW-CP) Licensed Master Social Worker (LMSW) under the supervision of an LISW-CP	Interviews and communication with family members or other sources are included in the CPT code. Communication factors that complicate the diagnostic evaluation may result in the need for interactive complexity and can be reported in conjunction with the evaluation (see interactive complexity). Since psychotherapy includes continuing psychiatric evaluation, psychotherapy codes are not to be reported with psychiatric diagnostic evaluations. LPCs and LMFTs must have a master's degree or higher to render services (insurance carrier verification is required). Psychiatric diagnostic evaluations are recognized for reimbursement as a behavioral/mental health service at all clinic types except for RHCs. Insurance carrier verification must be made on frequency limitations.
90792	Psychiatric diagnostic evaluation with medical services		

Psychological, Neuropsychological, and Developmental Test Administrations and Evaluations

Not to be confused with screenings, these tests and evaluations involve more extensive services to be rendered. If testing and evaluation are being provided, the table below outlines the necessary elements for billing.

Psychological Test Administration and Evaluation			
CPT Code	**Description**	**Reimbursable Clinicians**	**Applicable Guidelines**
96130	Psychological testing and evaluation; first hour. Integration of patient data, interpretation of standardized test results and clinical data, decision making and interactive feedback to patient, family members/caregiver(s) for ***first hour***, including treatment plan and reporting. Service measures personality, emotions, intellectual functioning, and psychopathology. Psychological tests are formalized measures of mental functioning. Some signs that testing and evaluation may be necessary include significant social withdrawal, difficulties with speech and concentration, and significant difficulties with social activities including school. Examples: Achievement, ability, and personality assessments with full evaluation.	Psychiatric Nurse Practitioner (verification with insurance carriers is required) Licensed Psychologist Post-Doctorate Psychologist (verification to determine if services can be rendered under the direct supervision of a psychologist is required)	Face-to-face service required. A written report must be generated. Because this is a time-based code, the total time rendering and interpreting the service must be documented, including a start and stop time. Documentation should reflect all requirements and services rendered. Frequency limitations are based on medical necessity. Medicaid may reimburse for up to once per day not to exceed 24 units per year (insurance carrier verification is required). Appropriate billing modifier selected to identify the clinician that rendered the service must be appended upon billing.
96131	Psychological testing, evaluation, ***each additional hour after the first hour of service.***		96131 is an add-on code to 96130, signifying it can only be billed with 96130, when an additional hour of service is rendered, after the first hour of service was rendered. Because this is a time-based code, the total additional time rendering and interpreting the service must be documented. Frequency limitations are based on medical necessity. Medicaid may reimburse for up to 5 units per day, not to exceed 24 units per year. Insurance carrier verification is required.

Psychological or Neuropsychological Test Administration and Scoring			
CPT Code	**Description**	**Reimbursable Clinicians**	**Applicable Guidelines**
96136	Psychological or neuropsychological test administration and scoring; two or more tests, any method, **first 30 minutes**. Service measures thinking, reasoning, judgement, and memory to evaluate the patient's neurocognitive abilities. It is an in-depth assessment of skills and abilities linked to brain function. It measures areas such as attention, problem solving, language, memory, visual-motor, and fine motor deficits.	Psychiatric Nurse Practitioner Licensed Psychologist Post-Doctorate Psychologist (verification to determine if services can be rendered under the direct supervision of a psychologist is required)	Face-to-face service required. A written report must be generated. Because these are time-based codes, the total time rendering and interpreting the service must be documented, including a start/stop time. Documentation should reflect all requirements and services rendered. This service differs from psychological testing and evaluation (96130) whereas this service is for administering the test and scoring it. It does not include an evaluation. Frequency limitations are based on medical necessity. Medicaid may reimburse for up to 1 unit per day not to exceed 24 units per year (insurance carrier verification is required). An appropriate billing modifier to identify the clinician that rendered the service must be appended upon billing. This service is recognized as a reimbursable behavioral/mental health service at all clinic types except for FQHCs and RHCs.
96137	Psychological or Neuropsychological Test administration and scoring; two or more tests; any method**, each additional 30** minutes after the first 30 minutes of service.		This service is for administering the test and scoring it, it does not include an evaluation. Frequency limitations are based on medical necessity. Medicaid may reimburse for up to 6 units per day not to exceed 24 units per year (insurance carrier verification is required). This add-on service is recognized as a reimbursable behavioral/mental health service at all clinic types except for FQHCs and RHCs.

Developmental Test Administration reported with CPT codes 96112 and 96113 is only located in the Healthy Connections Physician's Provider Manual, under the procedure codes for vision services. It is not listed in the Healthy Connections behavioral/mental health manuals. Verification of this service and the ability to bill and receive reimbursement must be verified with insurers at the site level.

Psychotherapy

Only one encounter code is allowed to be billed per day at Federally Qualified Health Centers, except for the psychiatry and counseling encounter, which can be billed in addition to another encounter on the same day.

Medicaid reimbursement is available for psychotherapy with the reporting of the following codes:

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90832	Individual psychotherapy with patient - 30 minutes	Licensed Psychologist Post-Doctorate Psychologist under the supervision of a Licensed Psychologist LPC LPCA under the supervision of an LPC LMFT LMFTA under the supervision of an LMFT LISW-CP LMSW under the supervision of an LISW-CP	Psychotherapy is not to be reported with psychiatric diagnostic evaluations. Psychotherapy is the treatment of mental illness and behavioral disturbances in which the mental/behavioral health provider addresses the emotional disturbance, reverses, or changes maladaptive patterns of behavior, and encourages personality growth and development. A signed and dated treatment plan (Individualized Plan of Care or IPOC) is required and must include, but is not limited to: the patient's diagnosis, treatment goals, their progress, and number of sessions ordered by the physician, NP, or PA. The practitioner involved in the treatment plan should sign the plan, certifying medical necessity. Patient consent for therapy should be in the medical record. Documentation for psychotherapy services must include the following: time spent rendering the service (start and stop time), description of the techniques used to treat the patient's condition, and how the patient benefited from the therapy in reaching his/her goal(s) listed in their IPOC. Assessments, plans of care, and progress notes in the patient's medical record must justify, specify, and document the initiation, frequency, duration, and progress of the therapy. Appending the appropriate billing modifier to the billing code is required to identify the clinician that rendered the service. A maximum of 6 therapy sessions per month of a combination of 90832, 90834, and 90837 is reimbursable with Medicaid. Insurance carrier verification should be made for other insurance carriers. Time spent rendering psychotherapy must be included in the documentation.
90834	Individual psychotherapy with patient - 45 minutes		
90837	Individual psychotherapy with patient - 60 minutes		

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90847	Family psychotherapy **with** patient present - 50 minutes (face-to-face with patient and family)	Licensed Psychologist Post-Doctorate Psychologist under the supervision of a Licensed Psychologist LPC LPCA under the supervision of an LPC LMFT LMFTA under the supervision of an LMFT LISW-CP LMSW under the supervision of an LISW-CP	Family therapy is most often used to help treat a patient's problem that is affecting the entire family/caregiver(s), where family dynamics as they relate to the patient's mental status and/or behavioral status, are the focus of the sessions. Attention should be given to the impact the patient's condition has on the family, with a focus on the patient's diagnosis, where therapy includes an aim at improving interactions between the patient and family member(s)/caregiver(s). Services where the patient is not present are not recognized for reimbursement at FQHCs and RHCs. Family psychotherapy without the patient present is not reimbursed at these clinic types. Four sessions of family psychotherapy per month are reimbursable with Medicaid. Insurance carrier verification should be made for other insurance carriers. Attention should be given to the impact the patient's condition has on the family, with family therapy aimed at improving interactions between the patient and family member(s)/caregiver(s). A signed and dated treatment plan is required and must include, but is not limited to the patient's diagnosis, treatment goals, and number of sessions ordered by the physician, NP, or PA, and the time spent with the patient and family providing psychotherapy. The practitioner involved in the treatment plan should sign the plan, certifying the medical necessity. Patient consent for therapy should be in the medical record. Also included in the family therapy codes: reviewing records, communicating with other providers, observing, interpreting patterns of behavior, communication between the patient and family, and decision making. Appending the appropriate billing modifier to the billing code is required to identify the clinician that rendered the service. Time spent rendering family psychotherapy must be included in the documentation.
90846	Family psychotherapy **without** the patient present - 50 minutes (face-to-face with patient's family)		
90849	Multiple family group psychotherapy		Multiple family group psychotherapy is to be conducted with patients and their families where similar issues will be addressed. The number of patients and their families that are allowed in a group session must be verified by the insurance carriers. Multiple family group psychotherapy is not recognized for reimbursement at FQHCs and RHCs. Frequency limitations are based on medical necessity. Medicaid may reimburse for up to 1 session of multifamily group therapy, per day and up to 8 sessions per month.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
90853	Group psychotherapy (not multi-family group)		Group psychotherapy is a recognized mental/behavioral health service at all clinic types. Group psychotherapy is to be conducted in a small group of patients (number of patients must be verified with insurance carriers) who have similar issues, with the purpose of restoring the patient to their best possible function level. 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 patient. A signed and dated treatment plan is required for each patient in either multi-group psychotherapy or group psychotherapy, and it must include, but is not limited to: The patient's diagnosis, treatment goals, and number of sessions ordered by the physician, NP, or PA, and the time spent with the patient and family providing multi-family group psychotherapy or the time spent with the patients during group psychotherapy. The practitioner involved in the treatment plan should sign the plan, certifying the medical necessity. Patient consent for therapy should be in the medical record. Appending the appropriate billing modifier to the billing code is required to identify the clinician that rendered the service.
90839	Psychotherapy for crisis, first 60 minutes		Psychotherapy for crisis cannot be reported with any other mental health service on the same day. Documentation must contain an indication that the psychotherapy was provided for an urgent assessment and history of a crisis state. Required services include a mental status examination, disposition, and that the patient presents in a high level of distress with a complex or life-threatening problem that requires immediate attention. Appending the appropriate billing modifier to the billing code is required to identify the clinician that rendered the service. Documentation and treatment plan guidelines for Psychotherapy are pertinent in Psychotherapy for Crisis and because this is a time-based code, the total time rendering the service must be documented and include a start and stop time. Psychotherapy for crisis is not recognized for reimbursement at RHCs. Insurance carrier verification should be made on frequency limitations for psychotherapy for crisis.

Important Notes for Psychotherapy Services:

The reporting of individual versus family psychotherapy is at the clinical discretion of the provider. Verification of age minimum requirements for reporting individual psychotherapy is required. In addition, guidelines for when to select billing for individual psychotherapy, versus when to bill for family psychotherapy, must be verified with insurance carriers. Please review the guidelines indicated in the family psychotherapy section to assist with your decision in reporting.

Although there are sources indicating the ability to report psychotherapy services when **more than** 50% of the time allotted in billing code descriptions was spent rendering the service, insurance carriers can require the entire time in the billing code description to be rendered, or if insurers have determined a minimum time requirement for reimbursement of services. Verification with insurance carriers is required.

If insurance carriers do allow the billing for psychotherapy services with minimum time requirements, please look to the following source for direction: https://www.apaservices.org/practice/reimbursement/health-codes/psychotherapy.

Interactive Complexity

Interactive complexity is an add-on code specific for reporting with certain psychiatric services. It is billed to report communication difficulties during the visit. Interactive complexity can involve:

- Physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed skills, or
- A patient who has lost either expressive language or communication skills to explain his/her symptoms and respond to treatment, or the receptive communication skills to understand the clinician if she/he were to use ordinary adult language for communication.

Interactive complexity can be reported when **at least one** of the following communication factors is present during the visit (these communication factors are considered to increase the intensity of services):

- The need to manage maladaptive communication related to high anxiety, high reactivity, repeated questions, or disagreement among participants that complicates delivery of care.
- Caregiver emotions or behaviors that interfere with implementation of the treatment plan.

- If reporting to a third party is required due to an incident in the patient's life that may have caused psychological damage. The incident must be newly discovered (e.g., abuse or neglect).

- Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional; and a patient who has not developed, or has lost, either the expressive language communication skills to explain his or her symptoms and respond to treatment, or a patient who lacks receptive communication skills to understand the physician or other qualified health care professional if they were to use typical language for communication.

Note: To align with the Center of Medicaid/Medicare Services (CMS) required language, effective 1/2022, CPT guidelines removed the use of interpreters and translator services from the list of communication factors that support medical necessity when coding for interactive complexity.

The table below highlights the billing code, its description, reimbursable clinicians, and guidelines for reporting interactive complexity.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
90785	Interactive complexity	Licensed Psychologist Post-Doctorate Psychologist under the supervision of a Licensed Psychologist LPC LPCA under the supervision of an LPC LMFT LMFTA under the supervision of an LMFT LISW-CP LMSW under the supervision of an LISW-CP	90785 is an add-on code, meaning it can be billed in conjunction with other services, but cannot be reported on its own. The approved services that interactive complexity can be billed with are: • Psychiatric evaluations (90791, 90792) • Psychotherapy services (90832, 90834, 90837, 90853) (psychotherapy with crisis and family psychotherapy are not approved as reportable services with interactive complexity). When reported with psychotherapy services, the additional time spent with a patient due to interactive complexity should not be calculated towards the time reported for the psychotherapy service. Documentation must include communication factor(s) and how they increased the intensity of the services being rendered by the additional difficulty in either delivering the service or providing treatment to the patient.

Alcohol/Substance Abuse Screening and Intervention Services

Medicaid reimbursement is available for screening for alcohol and substance abuse when the parent/caregiver of the child is also a patient at the practice/site. The below table highlights the billing codes, their descriptions, reimbursable clinicians, and guidelines for reporting the services.

CPT/HCPCS Code	Description	Reimbursable Clinicians	Applicable Guidelines
99408/H0049 99409/H0050	Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 minutes. Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes.	Physician Physician Assistant Nurse Practitioner	South Carolina Department of Health and Human Services (SCDHHS) policy for alcohol and drug screenings, as with all lab tests, must be ordered by a qualified practitioner operating within their scope of practice and as allowed by state law. Direction from CMS advises of their preference of the reporting of H0049 instead of 99408 with no time requirement, and the reporting of H0050 instead of 99409 for 15 minutes of services. Verification with South Carolina Medicaid and other insurance carriers required. Documentation of the time spent rendering the services is required for the reporting of all CPT/HCPCS codes except H0049. Also included in your documentation should be the test, the results, and details of the brief intervention service provided. The Healthy Connections Physicians Services Provider Manual advises that reimbursement for a maximum of one screening per CPT/HCPCS code, per date of service, not to exceed 18 screenings per 12-month period. It also advises that if screening and brief intervention services are performed via a standing order due to a course of treatment for substance abuse disorders, the ordering practitioner must document the medical necessity for the testing as well as the results of each test. When billing for only a screening, without a diagnosis, reporting ICD10 code Z13.89 (encounter for screening for other disorders) to support medical necessity for the screening, is required. When there is a diagnosis in place that involves alcohol or substance abuse, the diagnosis code applicable to the patient is required.

Smoking Cessation

Smoking can negatively affect babies through infancy and childhood. Among the risks are developmental delays and learning disabilities. Furthermore, secondhand smoke is particularly harmful to children because it can increase their risk of multiple health issues. Primary care physicians and nurse practitioners have an excellent opportunity to identify and treat smoking and tobacco use and help prevent adverse outcomes.

Medicaid will reimburse for smoking and tobacco use cessation counseling when the parent(s)/caregiver(s) are also patients at the practice. These services can only be billed under the patient who is directly receiving smoking and tobacco use cessation services. Successful intervention begins with identifying users and providing appropriate interventions based upon the patient's willingness to quit. The table below highlights the billing codes for smoking cessation counseling, their descriptions, the approved diagnosis codes, and applicable guidelines.

CPT Code	Description	Reimbursable Clinicians	Applicable Guidelines
99406	Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes, up to 10 minutes (4-10 minutes)	Physician Nurse Practitioner	Providers are encouraged to screen patients for tobacco use during medical encounters and document nicotine dependence using the appropriate diagnosis code. Tobacco use disorder example diagnoses are: F17.210-Nicotine dependence, cigarettes, uncomplicated; F17.220-Nicotine dependence, chewing tobacco, uncomplicated; O99.332-Smoking (tobacco) complicating pregnancy, second trimester. When pregnant, an additional F code that represents the kind of tobacco used must be coded with the pregnancy diagnosis. Service and documentation requirements include total time spent rendering services, what was discussed including cessation techniques, resources provided, advising of a change in behavior, motivational counseling, arranging follow-up visits, if required, and a treatment plan. Pharmacotherapy records must also be documented and maintained in the patient's medical record. 3 minutes or less of counseling is not eligible for reimbursement and should not be billed. SCDHHS strongly encourages providers to refer patients to the South Carolina Tobacco Quitline at: 1-800-QUIT NOW. Reimbursement for counseling services is limited to four sessions per quit attempt for up to two quit attempts, annually.
99407	Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes (11 minutes or more)		

Family Support

Family Support Services are provided to patients ages 0-21. The function of these face-to-face services is to assist the family or caregiver(s) to be engaged in the child's treatment of their diagnosed illness as defined by the current edition of the Diagnostic Statistical Manual (DSM). The family or caregiver(s), along with the child's providers/care team, can help to develop and/or improve the care of the patient. Family Support Services are intended to be time-limited, where the services provided generally start more intensive and frequent but are expected to decrease over time as the patient's and family/caregiver's skills develop. Services are dependent on medical necessity, as they must be directly related to the patient's diagnostic and clinical needs. Family Support Services are listed under Community Support Services in the South Carolina Department of Health and Human Services Rehabilitative Behavioral Health Provider Manual. All the services listed under Community Support Services can be rendered by state agencies or private providers. If you are a private provider, please refer to the billing and coding guidance below.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
S9482	Family Support Services, 15 minutes	Licensed Psychologist LPC LMFT LISW-CP LMSW under the supervision of an LISW-CP Licensed Bachelor Social Worker under the supervision of a LISW-CP (verification with insurance carriers is required) Verification with insurance carriers is required if doctoral level and associate level providers can render services under supervision	Family support services' primary purpose is for treating the patient's behavioral health. In addition, family support services can also be rendered to a patient's caregiver if they present with a substance use disorder, when they are also a patient. Family support services are intended to: • Equip families with coping skills to independently manage challenges and crisis situations related to the patient's behavioral health and/or caregiver's substance use disorder. • Educate families/caregivers to advocate effectively for the patient in their care. • Provide families/caregivers with information and skills necessary to allow them to be an integral and active part of the patient's treatment team. • Model skills for the family/caregiver. Each unit of service billed is equivalent to 15 minutes of service. South Carolina Medicaid advises that the frequency limitation for the service is 32 units per day. Monthly and yearly limitations are not specified. Insurance carrier verification should be made if the same guidelines apply. Family support services require pre-authorization with the insurance carriers. An IPOC is required for family support services, where a list of specific short and long-term goals and objectives addressing the expected outcome of treatment is included. Goals and objectives should reflect input from the patient and/or the patient's family, as applicable, and should be measurable and individualized, where it is specific to the patient's problem(s), and/or needs. Insurance documentation should include all services rendered and the time spent rendering them. Verification with insurance carriers is required if your facility is eligible to bill for this service. Appending the appropriate billing modifier to the billing code is required to identify the clinician that rendered the service. Please refer to the billing modifiers section of this guide for more information.

Postpartum/Infant Home Visit

Medicaid will reimburse for postpartum/infant home visits to postpartum mothers and newborns that are eligible for a postpartum/infant home visit (PP/IHV) when referred by a physician, and provided by a registered nurse (RN) who meets the following three criteria:

1. Pediatric experience, including a minimum of six months of experience in a hospital or clinic in the last two years.
2. Completion of a community/public health course from an accredited school of nursing.
3. All of the following:
    - Completion of a comprehensive pediatric assessment course followed by a satisfactory demonstration of pediatric assessments skills.
    - In-service review of the postpartum assessment given by a qualified medical doctor or nurse practitioner with experience in this area.
    - A minimum of six months of experience in a community or public health field with a documented experience in performing environmental assessments.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
99501	Postpartum/Infant home visit and repeat visit; for mother and infant or mother only or infant only	Registered Nurse	The PP/IHV is designed to assess the environmental, psychosocial, nutritional, and medical needs of the infant and mother. The visit must include the following where all must be included in the patient's medical record: • Appraisal of the mother's health status (including questions concerning her physical recovery, contraceptive plans, and emotional status). • Information regarding postpartum recovery and assessment of the infant including but not limited to physical, nutritional and elimination assessments. • Assessment of mother-infant bonding. • Appraisal of the household (safety and health factors). • Discussion with the mother/caregiver regarding concerns about the care of the infant and her own well-being. • Discussion and appropriate follow-up to ensure that the mother has a postpartum appointment, the infant has a two week Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit, and referrals to other needed services (i.e., WIC) are made. One repeat visit which can be made within six weeks of the delivery. It is allowed under the following circumstances: • To follow up on an identified medical need. • Occasionally, when the RN makes the initial PP/IHV, the infant, mother, or one of a set of twins (triplets, etc.) is not present. The follow-up visit is to see the absent individual, and it must be billed as a repeat visit by appending a modifier 52 upon claim submission, using the patient's Medicaid number. • A repeat visit must be made within six weeks of delivery.

CPT Code	Description	Reimbursable Clinician(s)	Applicable Guidelines

			It is recommended that the PP/IHV be made within three days of discharge from the hospital; however, the home visit must be made within six weeks after delivery. Although the visit is targeted to mother/infant units, in certain circumstances only the mother or only the infant may be visited (e.g., infant is in foster care or only the mother has been discharged from the hospital).
			
			At a minimum, documentation of the visit must include:
			• Date of the visit
			• Subjective and objective observations regarding the following:
			  ○ Physical and emotional status of the mother
			  ○ Contraceptive plans of the mother
			  ○ Physical status of the infant, including feeding and elimination
			  ○ Mother-infant bonding
			  ○ Household (safety and health factors)
			• Action taken regarding the following:
			  ○ Provision of information regarding the family planning waiver
			  ○ Postpartum appointment for the mother
			  ○ EPSDT appointment for the infant
			  ○ Referrals to other needed services (including WIC)
			  ○ Provision of information (contraception, resources, etc.)
			  ○ Signature of the person conducting the home visit
			
			The following conditions must also be met:
			• The provider must be employed by a physician practice, hospital, home health/nursing agency, health department, or medical clinic and be enrolled as a PP/IHV provider with the state to perform this service. The enrollment information contact number is 1-888-289-0709, or an online inquiry can be submitted at http://www.scdhhs.gov/contact-us.
			• The visit must be in response to a physician referral.
			• The source of the referral must be documented.
			• Copies of the assessment(s) should be sent to the primary medical care provider of the infant and the mother within one week of the visit. A release of information will be necessary.

Pre-Discharge Home Visit

The pre-discharge home visit is designed to assess the condition of the home of an infant who is, or has been, a patient in a neonatal intensive care unit or has had a significant medical problem. The goal is to ensure a safe household conducive to the health of the infant after discharge from the hospital.

CPT/HCPC Code	Description	Reimbursable Clinician(s)	Applicable Guidelines

T1028	Pre-discharge home visit	Registered Nurse (with demonstrated knowledge and skills in maternal and infant health)	The pre-discharge home visit consists of an assessment of the home to determine whether there are obvious health hazards to a fragile infant. This assessment includes discussions with the mother, if possible, as well as other adults living in the home.
			
			The home visit is an assessment of the home and physical family environment to determine suitability to meet the patient's medical needs.
			
			At a minimum, documentation of the visit must include:
			• Date of the visit
			• Referral source
			• Action(s) taken regarding any problems found.
			• Signature and objective observations regarding the following:
			  ○ Readiness of the mother or caregiver to provide care.
			  ○ Readiness of a household to promote the health and safety of a fragile infant.
			
			The visit must be in response to a physician referral.
			
			Documentation of the results of the visit should be sent to the medical primary care provider of the infant and mother (if applicable) within one week of the visit. A release of information will be necessary.
			
			Modifier HA must be appended to the billing code upon claim submission.
			
			The provider must be enrolled with Medicaid to perform this service. The enrollment information contact number is 1-888-289-0709, or an online inquiry can be submitted at http://www.scdhhs.gov/contact-us.
			
			To provide services, verification must be made if there is a medical status requirement of the infant.

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) - Patient Adolescent Pregnancy Prevention Program

MAPPS provides Medicaid-funded family planning services to youth at risk. These services are designed to prevent teenage pregnancy among youth at risk, promote abstinence, and educate youth to make responsible decisions about sexual activity, including to those who are already mothers. MAPPS can be provided in the office setting as well as in schools, homes, and other approved settings. MAPPS can be rendered to the teenage mothers of patients who are also patients at the practice, who are not pregnant at the time the services are rendered.

CPT/HCPC Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
S9445	Patient education, not otherwise classified, non-physician provider, individual per session, per 15 minutes.	LPC LMFT Certified Health Educator Registered Nurse Nurse Practitioner Clinical Nurse Specialist Certified Nurse Midwife LISW-Advanced Practice LISW-CP LMSW under the supervision of an LISW-CP Licensed Bachelor Social Worker under the supervision of an LISW-CP (verification	MAPPS is a Medicaid adolescent pregnancy prevention program whose services are as follows: **Individual Sessions**: • Face-to-face educational/counseling session to assist reproductive age patients in making informed decisions about family planning and appropriate usage of birth control methods. • All documentation must contain the content in the individual or group session form along with a narrative description where the documentation of the session must support time billed and points discussed. • Individual sessions may be provided to the patient or the patient's parent. • The procedure code billed should also be used at least every six months to review the assessment/case plan (progress report/needs assessment). • Individual sessions do not require evidence-based curricula. South Carolina Medicaid will provide reimbursement for a maximum of 16 hours or 64 units (a unit being each 15-minute increment of time billed) of individual sessions each state fiscal year for each patient. Verification with other insurance carriers should be made at the site level. Modifier FP must be appended to both individual and group education code(s), upon billing for individual sessions of patient education and for the screening. In addition, modifier U1 must be appended with modifier FP when rendering individual sessions. **Group Sessions:** • Face-to-face consultation designed to assist reproductive age patients in making informed decisions regarding family planning and voluntary utilization of appropriate birth control methods, preventing unwanted or unintended pregnancies. • Group size is defined as at least two (2) patients, but not more than fifteen (15). • Groups larger than 15 patients are not billable as Medicaid services. • Group sessions must last a minimum of 45 continuous minutes and must address at least five documentation points plus the patient's response from the documentation points list.
S9446	Patient education not otherwise classified, non-physician provider, group per session, per 15 minutes.		

CPT/HCPC Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
		with insurance carriers is required) Licensed Psychologist Physician Assistant Verification with insurance carriers is required if doctoral level and associate level providers can render services under supervision.	• For the documentation point list, please contact Medicaid. • All clinician forms for documentation must contain the content included in the group session form, along with a narrative description of the services. • Evidence-based curricula must be used for group sessions. Curricula must be age/reading level appropriate. Modifier FP must be appended to the code(s), upon billing for group sessions of patient education, and for the screening. SCDHHS will provide reimbursement for a maximum of 16 hours or 64 units (a unit being each 15-minute increment of time billed) of group sessions each state fiscal year for each patient. Clinicians must take steps to ensure that communication with the patient is confidential. A basic screening assessment must be completed and filed in each patient's record that includes all information contained in the progress report/needs assessment, along with a description of services to be provided.
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, per 15 minutes.		SCDHHS will provide reimbursement for screening for the patient education sessions for MAPPS (T1023) for up to a maximum of four units per state fiscal year for assessment/case plan. Relevant information should be documented on social, psychological, environmental and health risk factors that justify the delivery of MAPPS to the patient. The assessment must also identify the capacities and resources of the patient and his or her family that may help address the identified risks. The assessment findings will be used to develop the initial service or case plan. Individual and family member interviews may be used in the completion of the assessment process. All contact for the purpose of gathering information for the assessment must be face-to-face. The assessment must be sent to the patient's primary care physician once in a lifetime and/or sent if the primary care physician changes. The Parent Screening Assessment Form is completed once in a lifetime. Clinicians should bill these services as an assessment annually. A written intervention/case plan must be completed based on the results of the progress report/needs assessment for the individual adolescent and placed in the record. The plan must include family planning

CPT/HCPC Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
			goals and objectives based on the assessment, expected timeframes for completion of the goals and objectives, signature(s) of the patient or the signature of the parent/legal guardian and date of agreement. The intervention case plan is valid until the patient reaches age 19 or becomes pregnant, and/or withdraws from the program. Unlicensed or uncertified staff must be directly supervised (direct supervision) by a licensed or certified health care professional to provide individual and/or group educational counseling. The supervising licensed or certified health care professional must co-sign all documentation. All staff providing direct services must attend a minimum of 20 hours of family planning training each state fiscal year. New staff providing direct services must receive at least 12 of the 20 hours of family planning training during the first quarter of employment as a MAPPS provider. All non-licensed /non-certified staff providing individual counseling/education must receive training that is approved by SCDHHS in individual counseling prior to providing individual sessions. This training may be included in the 20 hours of family planning training required each year. All MAPPS providers are required to maintain a log of training hours attended along with a log of hours and days worked. To enroll in MAPPS and become a provider of services, a provider must complete the following steps: • Review the Medicaid Enhanced Services Manual on the South Carolina Department of Health and Human Services website, in its entirety: http://www.scdhhs.gov/ • Evaluate the organization's ability to provide consistent intensive services by assessing the following: ○ Staff must meet the qualifications as stated in the manual. A licensed/certified person who will be providing MAPPS must be employed directly by the enrolling provider organization. ○ Staff must be trained to facilitate group sessions with adolescents. ○ Designated staff must be responsible for billing claims and filing counseling service documentation. • Identify a source of Medicaid eligible adolescents ages 10-19 with specific risk factors for engaging in early sexual activity. MAPPS eligibility criteria policy identifies risk factors as follows: ○ Patient is a teen parent. ○ Patient is sexually active. ○ Patient is experiencing peer pressure to engage in sexual activity as identified as a problem by the patient. Peer pressure identified by the patient must be defined in the patient's medical record as: ➢ The patient is in a relationship with a partner who is sexually aggressive or is trying to persuade the patient to engage in sex, OR ➢ The patient has friends who are sexually active and are urging the patient to engage in sexual activity with which he or she is uncomfortable.

CPT/HCPC Code	Description	Reimbursable Clinician(s)	Applicable Guidelines
			When providing services, decisions must be made regarding: ○ What age group to target. ○ How often to provide services to this population. ○ Where to provide services. A proposal and completion of the enrollment package must be submitted to SCDHHS. The proposal should include the following: • Background history that documents experience providing family planning/pregnancy prevention services. Family planning services are defined as preconception services that prevent or delay pregnancies and do not include abortion or abortion-related services. • Anticipated curricula to be used for service provision. • Services under "Evaluate the Organization's Ability to Provide Intensive Services," and those under "Identify a Source of Medicaid Eligible Adolescents ages up until the age of 19, with Specific Risk Factors for Engaging in Early Sexual Activity." • A copy or letter of certification of the organization's current liability insurance policy. • A copy of an article of incorporation or other document that establishes the organization as a legal entity. • A listing of the county/counties in which the organization plans to provide MAPPS services. • Copies of the license/certificate of the licensed/certified person(s) (employed by the organization) who will provide MAPPS. The clinician(s) must meet with SCDHHS staff to review the proposal and enrollment package as well as to discuss MAPPS and Medicaid-reimbursable family planning services. • The clinician must complete: ○ Consent to bill form. ○ Needs assessment form. ○ Case plan form. ○ Individual and group service documentation form. SCDHHS and Healthy Connections should be contacted for further information. To contact a provider representative, you can submit your inquiry at: http://www.scdhhs.gov/contact-us. Services provided to a patient known to be pregnant are not considered family planning, therefore, they are not billable.

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