South Carolina Crosswalk of HealthySteps-Aligned Services with Billing Codes and Provider Types

The HealthySteps National Office Policy and Finance Team

About This Document

Have you ever wondered which HealthySteps (HS)-aligned services are reimbursable under South Carolina Medicaid, and which providers are eligible to render and bill for those services? This resource is designed to help answer those questions.

Understanding the HS-aligned services available in South Carolina, the corresponding billing codes, and the provider types eligible to furnish and receive reimbursement for these services can help sites identify potential billing opportunities, support workforce planning, and inform decisions related to the recruitment and integration of HealthySteps Specialists and other interdisciplinary team members.

The table that follows provides an overview of HS-aligned services, associated billing codes, service descriptions, and the provider types that may render and/or bill for each service. At the bottom of the table, the total number of billable codes associated with each provider type offers a quick reference for evaluating potential service and reimbursement opportunities.

In summary, the top four provider types with the most opportunities to currently bill HS-aligned services under South Carolina's Medicaid program are:

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

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Service Billing Codes	Service Description	Primary Care Provider (PCP)	Licensed Psychologist	Licensed Independent Clinical Social – Clinical Practice (LISW-CP)	Licensed Professional Counselor (LPC)	Licensed Marriage & Family Therapist (LMFT)
96110	Developmental milestone survey, speech and language delay with scoring and documentation, per standardized instrument (ASQ-3, M-CHAT-R, PEDS, SWYC, SWYC-MA)	X				
96127	Social emotional/behavioral health screening (SWYC, PHQ-9, PHQ-2, ASQ-SE, BITSEA, SCARED, ECSA)	X				
96161	Maternal depression screening (PHQ-9, EPDS, ACES-Caregiver focused)	X				
90791	Psychiatric diagnostic evaluation		X	X	X	X
H0031	Mental health assessment by a non-physician (e.g., diagnostic assessment)		X	X	X	X
H0032	Mental health service plan development by non-physician		X	X	X	X
90832 90834 90837	Individual psychotherapy: 30 minutes with Patient or Family Member; 45 minutes with Patient or Family Member; 60 minutes with Patient or Family Member		X	X	X	X
90846 90847	Family psychotherapy without Patient Present, Family psychotherapy with Patient Present		X	X	X	X
90853	Group psychotherapy (*other than multiple-family group*)		X	X	X	X
H2011	Crisis intervention service, per 15 minutes		X	X	X	X
96112/ 96113	Developmental test administration; first hour/ each additional 30 minutes	X	X			
96130/ 96131	Psychological testing and evaluation; first hour/each additional hour after the 1st hour of service	X	X	X	X	X
96156	Health and behavior assessment or re-assessment (HBAI) (e.g., health-focused clinical interview, behavioral observations, clinical decision making)	X				
96158/ 96159	Health behavior intervention, individual, face-to-face; initial 30 minutes/each additional 15 minutes	X				
96167/ 96168	Health behavior intervention, family w/patient present; 30 minutes/each additional 15 minutes	X				
96170/ 96171	Health behavior intervention, family without patient present; 30 minutes/each additional 15 minutes	X				
99492 99493 99494	Initial psychiatric collaborative care management, first 70 minutes/first calendar month Subsequent psychiatric collaborative care management, first 60 minutes/subsequent calendar month Initial or subsequent psychiatric collaborative care management, each add'l 30 minutes in a calendar month	X – as part of a collaborative care team consisting of the treating PCP, Behavioral Health Care Manager, and Psychiatric Consultant. All monthly services are billed under the treating PCP's NPI #.				
Number of Codes Eligible for Reimbursement		**17**	**14**	**12**	**12**	**12**

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Notes:

1. Healthy Connections is South Carolina's Medicaid program that provides health coverage for eligible residents, while Healthy Connections Choices is the system used to select and manage Medicaid health plans.

2. Early Periodic Screening, Diagnostic and Treatment, or EPSDT, is the Medicaid program's benefit that covers checkups and health care services for children from birth until age 21 to detect and treat health problems. EPSDT checkups are free for all children and youth who have Healthy Connections Medicaid. Often referred to as well-child visits, EPSDT finds children with actual or potential health problems and screens, diagnoses and treats the problems before they become permanent, lifelong disabilities. EPSDT also offers preventive health services to Healthy Connections Medicaid members under 21 years old. It includes the regular health checkup, the EPSDT screenings as part of a well-child visit, and EPSDT special services (should a referral to a specialist be needed).

3. Z codes, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and allowable in the International Classification of Diseases (ICD) for diagnostic purposes, capture situations where a patient may not have a current illness but requires medical attention for other reasons, such as social and environmental factors or other conditions affecting health. They are also known as "factors influencing health status and contact with health services." The use of Z codes for diagnoses is allowable for Medicaid reimbursement; however, Z codes are considered temporary for those age 7 and older and shall not be used for a period of time greater than six months. After six months, medical necessity must be confirmed by a psychiatric diagnosis for continuation of services. **The use of Z codes is not time-limited for children 0 to 6 years of age and can be used for the duration of the episode of care for confirmation of medical necessity.**

4. While South Carolina Medicaid permits the use of clinically appropriate Z codes to support medical necessity for children ages 0–6 throughout an episode of care, the presence of a Z code alone does not guarantee coverage or reimbursement. Providers must maintain documentation demonstrating ongoing medical necessities, functional impairment and/or clinical need, treatment goals, and the child's response to services. Services remain subject to all applicable Medicaid coverage requirements, authorization criteria, utilization review, and program-specific billing guidelines.

5. Psychotherapy services (individual, family, and group) and Psychological Testing and Evaluation (PTE) services require prior authorization (PA) before services are rendered. Licensed Independent Practitioners (LIPs - psychologist, LISW-CP, LPC, and LMFT), must obtain authorization for applicable services through the South Carolina Department of Health and Human Services (SCDHHS) designated Quality Improvement Organization (QIO). Requests for prior authorization must include supporting clinical documentation that demonstrates the medical necessity of the requested service(s).

6. Psychotherapy services are provided within the context of the goals identified in the member's plan of care. Medical necessity for psychotherapy is determined through the Diagnostic Assessment (DA).

7. H0031 is a mental health assessment by a non-physician, while 90791 is the CPT code for a psychiatric diagnostic evaluation. Both assess mental health needs, but they belong to different code sets and may be reimbursed differently depending on the South Carolina Medicaid program and provider type. Generally, 90791 initiates the episode of care, H0031 updates the episode of care, and 90832-90847 treats the patient/family via individual, family, or group psychotherapy.

8. H0032 (mental health service plan development) is used to document the development or revision of the patient's Individualized Plan of Care (IPOC). The IPOC serves as the treatment plan and must identify the patient's goals, objectives, recommended services, and planned interventions. Initial creation and clinically significant updates to the plan of care should be captured through IPOC development rather than psychotherapy billing.

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9. Although HCPCS code H0032 does not currently appear on the South Carolina Medicaid LIP fee schedule, the LIP Provider Manual identifies the service as a covered benefit for eligible LIP provider types (e.g., Psychologists, LISW-CPs, LPCs, and LMFTs). Given this discrepancy, providers are strongly encouraged to contact South Carolina Medicaid for definitive guidance regarding coverage, claims submission, and reimbursement policies.

10. Authorization is allowable only for a specific individual provider, not the group practice with which an individual provider is linked. When a member is transferred to another provider within the same group or to another practice, the new provider must submit this information to the QIO to ensure a new PA number is issued for the new provider. Circumstances (as determined by the QIO) may require the new provider to resubmit prior authorization.

11. Developmental test administration (96112 & 96113) is typically billed by healthcare professionals who are qualified to conduct in-depth developmental assessments. This includes PCPs (with appropriate training and scope of practice) & psychologists.

12. CPT Code 96113 is an add-on code that must be reported in addition to CPT 96112 and cannot be billed alone.

13. Psychological testing evaluation services (CPT 96130 and 96131) are generally limited to licensed Psychologists and physicians practicing within their scope of practice. Prior authorization may be required; providers should verify coverage, requirements, and limitations directly with South Carolina Medicaid.

14. Modifiers AH (PhD & PsyD), Modifier HO (LISW-CP, LPC, & LMFT) are associated with the behavioral health/LIP program and must be applied to LIP services (e.g., 90791, 96130, 96131, 90832, 90834, 90837, 90846, 90847, 90853, H0031, H0032, and H2011).

15. LMSWs may engage in supervised clinical or advanced practice only in social, medical or governmental agencies and may not practice privately or independently. An LMSW providing clinical services must be clinically supervised by a South Carolina LISW-CP, Psychologist, Psychiatrist, LPC, LMFT or LAC, who is employed by the agency where the LMSW provides these services.

16. All clinical services in independent or private practice must be provided by LISW-CPs (those social workers who have met the education, supervision and examination licensure requirements of the Board for the LISW-CP.)

17. SC Medicaid typically reimburses for health behavior assessment and intervention (HBAI) services (CPT codes: 96156, 96158, 96159, 96167, 96168, 96170, and 96171) when they are considered medically necessary and address behavioral factors affecting a patient's physical health condition (e.g., asthma, obesity, speech delay, aggressive behavior, and oppositional defiant disorder). Currently, these codes are only listed on the base physician's (PCP, NP, PA) fee schedule.

18. SC Medicaid will reimburse primary care providers for delivering mental health services through the Collaborative Care Model (CoCM – CPT code 99492, 99493, and 99494). The psychiatric consultants and behavioral health care manager generally contribute to the service but do not bill CoCM services separately. The services are billed once-per-month under the PCP.

19. Based on payer reimbursement guidelines, CPT 99484 may be included within a bundled payment for care management (CPT codes: 99492, 99493, and 99494) and/or behavioral health services and therefore may not qualify for separate reimbursement. Coverage and payment determinations are subject to individual payer policies, benefit plans, and claim-editing rules. Providers are encouraged to review applicable billing requirements and reimbursement guidelines prior to claim submission.

20. If you're working with FQHCs or RHCs, the individual screening may still be performed by clinic staff according to clinic workflow, but reimbursement rules depend on the clinic's Medicaid billing methodology and the encounter requirements. The billing provider remains subject to SCDHHS provider-type rules.

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21. Generally, SC Medicaid reimburses services when the service is covered in a face-to-face setting. In most cases, those same services are also eligible when delivered via telehealth, provided they meet the same clinical standards and medical necessity requirements as in-person care. It is strongly recommended to verify telehealth coverage and eligible providers for each individual member, as policies and requirements may vary by Medicaid health plan and benefit structure. When billing telehealth services, providers must include the appropriate modifiers (GT) and/or place of service (POS) codes.

Sources

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