SECTION 1

GENERAL INFORMATION AND ADMINISTRATION

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SOUTH CAROLINA MEDICAID PROGRAM

PROGRAM DESCRIPTION

The Medicaid program, as established by Title XIX of the Social Security Act, as amended, provides quality health care to individuals of low income by utilizing state and federal funds to reimburse providers of approved medical services. This care includes the diagnosis and treatment of illnesses and the limiting or correcting of disabilities.

The South Carolina Department of Health and Human Services (DHHS) is the single state agency designated to administer the South Carolina Medicaid program in compliance with state and federal laws and regulations and the South Carolina State Plan.

In addition to providing traditional fee-for-service medical care coverage, DHHS has implemented the South Carolina Medicaid Managed Care Program (SCMMCP). The SCMMCP offers a choice of three voluntary managed care delivery systems:

- Physician Enhanced Program (PEP)
- Medicaid Managed Care Organization (MCO) Program
- Primary Care Case Management/Medical Homes Local Networks (PCCM or PCCM/MHLN)

The PEP is an alternative reimbursement methodology. The PEP Primary Care Provider will furnish a package of basic services for beneficiaries in their practice and will receive a payment at the end of each month based on the number of PEP members enrolled, according to their age, gender, and category of eligibility.

The Medicaid MCO will provide, at a minimum, all services outlined in the core benefit package described in the MCO contract. DHHS will pay a capitated rate per member per month, according to age, gender, and category of eligibility.

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PROGRAM DESCRIPTION (CONT'D.)

The PCCM is a managed care delivery program in which physicians form a board and work with an Administrative Service Organization to deliver coordinated patient care. The board and participating physicians receive a per-member-per-month fee, as well as fee-for-service payments for enrolled beneficiaries.

ELIGIBILITY DETERMINATION

Applications for Medicaid eligibility may be filed in person or by mail. Applications may be obtained and filed at outstationed locations such as county health departments, some federally qualified health centers, most hospitals, and DHHS county eligibility offices. Applications can be mailed to:

DHHS Central Eligibility Processing
Post Office Box 100101
Columbia, SC 29202-3101

Individuals who apply for SSI through the Social Security Administration and are determined eligible are automatically eligible for Medicaid.

Medicaid eligibility may be retroactive for a maximum of three months prior to the month of application when the applicant received medical services of the type covered by Medicaid and the applicant would have met all eligibility criteria had the application been filed at the time. A child born to a Medicaid-eligible pregnant woman is automatically entitled to Medicaid benefits for one year provided that the child continues to live with the mother.

Providers may verify a beneficiary's eligibility for Medicaid benefits by utilizing a Point of Sale (POS) device, the Medicaid Interactive Voice Response System (IVRS), the S.C. Medicaid Web-based Claims Submission Tool, or an eligibility verification vendor. Additional information on these options is detailed later in this section.

If the beneficiary is enrolled in PEP, MCO, or PCCM, certain services will require prior approval and/or coordination through the PEP, MCO, or PCCM providers. For questions regarding PEP, MCO, or PCCM programs, please refer to information specific to your program found in Section 2 and direct questions to your program representative.

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MEDICAID INTERACTIVE VOICE RESPONSE SYSTEM (IVRS)

DHHS has contracted with GovConnect to maintain the Medicaid Eligibility IVRS. To access the IVRS, providers must use a touch-tone phone to call a toll-free number, 1-888-809-3040, and enter their six-character Medicaid provider ID. Providers will be prompted to enter the dates of service and one of the following beneficiary identifiers:

- Medicaid Health Insurance Number (printed on the Partners for Health card)
- Social Security Number and full name or date of birth
- Full name and date of birth

The system then relays the beneficiary eligibility information to the provider over the phone, including:

- Beneficiary Special Programs status
- Medicare coverage
- Third Party Liability (TPL) coverage
- Service limitations
- Visit count information

This automated process will verify Medicaid eligibility for the previous 12 months only. Providers can make an unlimited number of calls to the IVRS and may request up to 10 beneficiary eligibility verifications per call. There is no charge to the provider for IVRS services. Providers may also use the IVRS to access their most recent Medicaid payment information.

MEDICARE / MEDICAID ELIGIBILITY

Medicaid beneficiaries who are also eligible for Medicare benefits are commonly referred to as “dually eligible.” Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries.

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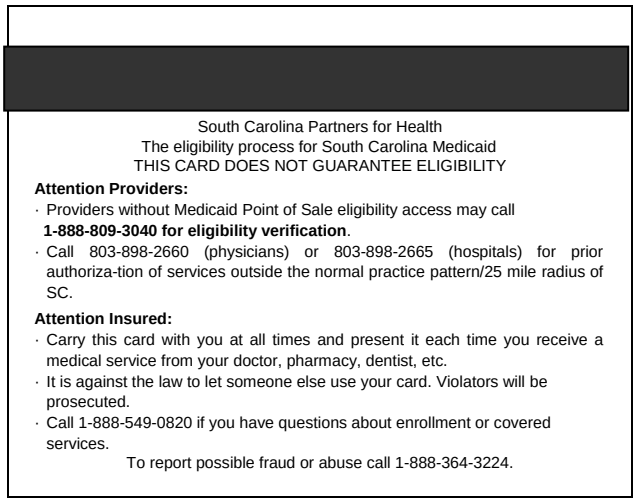
PARTNERS FOR HEALTH MEDICAID INSURANCE CARD

Medicaid-eligible beneficiaries receive a plastic South Carolina Partners for Health Medicaid Insurance card. Only one person's name appears on each card. If more than one family member is eligible for Medicaid, the family receives a card for each eligible member. In addition to the member's name, the front of the card includes the member's date of birth and Medicaid health insurance number. Possession of the plastic card does not guarantee Medicaid coverage. Failure to verify eligibility prior to providing a service leaves the provider at risk of providing services to an ineligible individual.

The following is an example of a Partners for Health Medicaid Insurance card:


South Carolina Partners for Health
The eligibility process for South Carolina Medicaid
THIS CARD DOES NOT GUARANTEE ELIGIBILITY

Attention Providers:

- Providers without Medicaid Point of Sale eligibility access may call **1-888-809-3040 for eligibility verification**.
- Call 803-898-2660 (physicians) or 803-898-2665 (hospitals) for prior authoriza-tion of services outside the normal practice pattern/25 mile radius of SC.

Attention Insured:

- Carry this card with you at all times and present it each time you receive a medical service from your doctor, pharmacy, dentist, etc.
- It is against the law to let someone else use your card. Violators will be prosecuted.
- Call 1-888-549-0820 if you have questions about enrollment or covered services.

To report possible fraud or abuse call 1-888-364-3224.

The back of the Partners for Health Medicaid Insurance card includes:

- A toll-free number that may be utilized by providers to access the Medicaid IVRS. This system is discussed in full on page 1-3.
- A number that providers may call for prior authorization of services outside the normal practice pattern, which is a 25-mile radius of South Carolina
- A magnetic strip that may be used in POS devices to access information regarding Medicaid

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PARTNERS FOR HEALTH MEDICAID INSURANCE CARD (CONT'D.)

eligibility, third-party insurance coverage, beneficiary special programs, and service limitations 24 hours a day, seven days a week in a real time environment. There is a fee to providers for such POS services.

- A toll-free number for the beneficiary if he or she has questions about Medicaid-covered services or eligibility

ELIGIBILITY VERIFICATION VENDORS

Several vendors offer POS devices, PC-based software, and Internet or other eligibility verification services. Presently, the following companies contract with DHHS to provide eligibility verification services. For more information, contact the companies directly as listed below:

Companion Technology PAID System
Contact Person: Jane Brown, 803-264-2597

Health Data Exchange (HDX)
Contact Person: Brian Gill, 610-219-1859

Medifax
Contact Person: Jon Segroves, 800-819-5003

Passport Health Communications
Contact Person: Lloyd Baker, 888-661-5657

Providers may also verify Medicaid eligibility using the HIPAA 270/271 transactions. For information on these transactions, contact the S.C. Medicaid EDI Support Center at 1-888-289-0709.

SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

DHHS provides a free tool, accessible through an Internet browser, that allows providers to submit Dental, UB-92, and CMS-1500 claims, query Medicaid eligibility, and check claim status. Providers interested in using this tool must complete a Trading Partner Agreement (TPA) with DHHS. Once DHHS receives the TPA, the provider will be contacted with the Web site address and login information.

The eligibility query requirements are the same as those found in this section under "Medicaid Interactive Voice Response System (IVRS)." For information on this tool or to receive a TPA, please contact the S.C. Medicaid EDI Support Center at 1-888-289-0709.

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BENEFICIARY RESTRICTED PROGRAM

The Beneficiary Restricted Program is designed to minimize the amount of federal and state tax dollars lost due to waste and abuse of benefits by the Medicaid beneficiaries of South Carolina. When a beneficiary is identified by the Division of Program Integrity as having misused or overused Medicaid services through inappropriate use of a Medicaid card, the beneficiary may be restricted to accessing only designated providers.

Providers are urged to report inappropriate use of a Medicaid card by a beneficiary (such as abuse, card-sharing, etc.) to the Division of Program Integrity's toll-free Fraud and Abuse Hotline at 1-888-364-3224.

REQUIREMENTS FOR PROVIDER PARTICIPATION

In order to participate in the Medicaid program, a provider must meet both of the following requirements:

- Licensure by the appropriate licensing body and/or certification by the standard-setting agency
- Enrollment in the South Carolina Medicaid program

Enrollment

In order to become eligible to participate in the Medicaid program, providers are required to either complete a provider enrollment agreement form or sign a contract with DHHS, depending on what type of service they provide.

By signing the provider enrollment agreement or contract, the provider agrees to comply with all federal and state laws and regulations currently in effect and as may be promulgated pertaining to the Medicaid program. Official notification of enrollment will be sent to the provider and will include the provider's Medicaid ID number. Unless otherwise instructed, the provider must enter this ID number on all claims submitted to DHHS for payment.

In order to be considered for PEP participation, the interested entity must fulfill both of the following conditions:

- Be a Medicaid enrolled provider
- Meet the requirements outlined in the PEP Memorandum of Agreement

Please direct any questions to your program representative.

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Enrollment (Cont'd.)

The MCO network providers/subcontractors do not have to be Medicaid-enrolled providers. Fee-for-service reimbursement from DHHS may only be made to Medicaid-enrolled providers.

A provider must report any change in enrollment or contractual information (*e.g.*, mailing or payment address, telephone number, specialty information, change in group affiliation, etc.) to the appropriate area within DHHS. Not reporting this change of information promptly could result in a delay of payment to the provider.

These areas are listed below:

Contracted Providers	**Non-Contracted Providers**
Division of Contracts DHHS Post Office Box 8206 Columbia, SC 29202-8206 (803) 898-2605	Medicaid Provider Enrollment Post Office Box 8809 Columbia, SC 29202-8809 (803) 788-7622 Ext. 41650

The Medicaid program administered by DHHS is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an individual who is eligible for Medicaid-sponsored medical assistance because of a third party's potential liability for the service(s) *unless the patient is in a Medicaid MCO or Medicaid PCCM and the provider is not in the network of the Medicaid MCO or the Medicaid PCCM.*

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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Extent of Provider Participation (Cont'd.)

determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific questions may be addressed directly to the managed care provider or the provider's DHHS program representative.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

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

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by voluntarily enrolling in a Medicaid managed

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

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Freedom of Choice (Cont'd.)

care option, the beneficiary is required to follow that plan's requirements (*e.g.*, use of designated primary and specialist providers, precertification of services, etc.) for the time period in which the beneficiary is enrolled in the managed care option.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided.

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide access to records. These records should fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries. For the purpose of reviewing and reproducing documents, providers shall grant to staff of DHHS, the State Auditor's Office, the S.C. Attorney General's Office, the Government Accountability Office (GAO), and the U.S. Department of Health and Human Services (USDHHS) and/or any of their designees access to all records concerning Medicaid services and payment. These records may be reviewed during normal business hours, with or without notice.

A provider record or any part thereof will be considered illegible if at least three medical or other professional staff members who regularly perform post-payment reviews are unable to read the records or determine the extent of services provided. If this situation should occur, a written request for a translation may be made. In the event of a negative response or no response, the reimbursed amount will be subject to recoupment.

Assuming that the information is in a reasonably accessible format, the South Carolina Medicaid Program will accept records in accordance with the South Carolina Electronic Commerce Act of 1998 (S.C. Code Ann. §26-5-10 *et seq.*). Reviewers and auditors will accept electronic documentation as long as they can access them and the integrity of the document is ensured. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

The normal retention period for Medicaid records is three years. Exceptions include providers of hospital and nursing home services, who are required to maintain records pertaining to Medicaid beneficiaries for a period of six years. Other Medicaid provider agreements/contracts may require differing periods of time for records retention.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION (CONT'D.)

Providers should contact their Medicaid program representative for specific information. In all cases, records must be retained until any audit, investigation, or litigation is resolved, even if the records must be maintained longer than normally required. Medicaid providers generally maintain on-site all medical and fiscal records pertaining to Medicaid beneficiaries.

Medical and fiscal records pertaining to Medicaid beneficiaries that a provider may maintain at an off-site location/storage facility are subject to the same retention policies, and the records must be made available to DHHS within five days of the request.

Note: These requirements pertain to retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods.

DISCLOSURE OF INFORMATION BY PROVIDER

After the compliance dates of the privacy standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Public Law 104-191 (April 14, 2003, for most covered entities), most Medicaid providers will have provided their patients/clients with a Notice of Privacy Practices. The Notice should include sufficient information to disclose to each Medicaid patient/client the provider's intent to release any medical information necessary for processing claims, including Medicaid claims. Providers who have not issued their patients/clients a Notice of Privacy Practices should obtain authorization to release such information to DHHS. The authorization must be signed and dated by the beneficiary and must be maintained in the patient's/client's record.

Once a Notice of Privacy Practices is acknowledged by the Medicaid beneficiary, or the beneficiary's authorization to release information is obtained, a provider who uses hard-copy claim forms that require the patient's signature is no longer required to have each claim form signed by the beneficiary. Providers who file claims electronically are required under their Trading Partner Agreement (TPA) to ensure ready association of electronic claims with an acknowledged Notice of Privacy Practices or a signed statement from the beneficiary consenting to the release of information necessary to process claims.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

DISCLOSURE OF INFORMATION BY PROVIDER (CONT'D.)

Certain medical services may be subject to more stringent rules or regulations governing the disclosure of information than others. However, if a provider is unable to release information necessary for Medicaid claims processing due to the lack of proper Notice or authorization from the beneficiary, payment may be denied and/or previous payments may be recouped. Consequently, providers who are concerned about releasing patient information to DHHS are advised to obtain specific written authorization from the Medicaid patient/client.

SAFEGUARDING BENEFICIARY INFORMATION

Federal regulations at 42 CFR Part 431, Subpart F, and S.C. Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. As a condition of participation in the Medicaid program, all providers must agree to comply with the federal laws and regulations regarding this protection, either by execution of a contract or a provider enrollment agreement. Questions regarding access to protected information should be referred to your Medicaid program representative.

Beneficiary information that must be protected includes but is not limited to the following:

- Name and address
- Medical services provided
- Social and economic circumstances
- Medical data, including diagnosis and past history of disease or disability
- Any information involving the identification of legally liable third-party resources
- Any information verifying income eligibility and the amount of medical assistance payments

This information may generally be used or disclosed only for the following purposes:

- Establishing eligibility
- Determining the amount of medical assistance
- Providing services for beneficiaries
- Assisting in a Medicaid-related investigation, prosecution, or civil or criminal proceeding

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SAFEGUARDING BENEFICIARY INFORMATION (CONT'D.)

Regarding the release of beneficiary information to billing/collection agencies, the Centers for Medicare and Medicaid Services (CMS) has instructed the states that the requirements for the release of beneficiary information should parallel the limitations on payments. Agents to whom payments could be made are allowed to obtain relevant beneficiary information, since the sharing of that information is for a purpose directly connected with Medicaid administration. However, if no payment could be made to the agent because the agent's compensation is tied to the amount billed or collected, or is dependent upon the collection of the payment, then Medicaid is not allowed to release beneficiary information to that agent.

Note: The manner with which the agent is dealt by the Medicaid program is determined primarily by the terms of the agent's compensation, not by the designation attributed to the agent by the provider. Agents or providers who furnish inaccurate, incomplete, or misleading information to DHHS regarding agent compensation issues may face sanctions.

Confidentiality of Alcohol and Drug Abuse Case Records

Federal law requires providers to observe more stringent rules when disclosing medical information from the records of alcohol and drug abuse patients than when disclosing information concerning other Medicaid beneficiaries. Federal regulations govern the information that must be protected in such cases and the circumstances under which this information may be disclosed. These regulations may be found at 42 CFR Part 2.

SPECIAL / PRIOR AUTHORIZATION

Certain medical services must be authorized by DHHS (or its designee) prior to delivery in order to be reimbursable by Medicaid. Some of the services that are specifically subject to prior authorization and approval are as follows:

- Services provided outside of the South Carolina Medicaid Service Area (SCMSA). The SCMSA is South Carolina and adjacent areas within 25 miles of its borders. For specific information, contact the appropriate Medicaid program representative.
- Services not routinely covered by Medicaid, or other services that require prior approval before payment or before service delivery as a matter of

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

RECORDS / DOCUMENTATION REQUIREMENTS

SPECIAL / PRIOR AUTHORIZATION (CONT'D.)

policy. Please refer to the appropriate section of this manual or contact your Medicaid program representative.

- Services for which prepayment review is required

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

CHARGE LIMITS

Providers may not charge Medicaid any more for services to a beneficiary than they would customarily charge the general public. Providers should bill their usual and customary charges and not the Medicaid reimbursement rate. Retroactive adjustments can only be made up to the billed amount. Medicaid will generally pay the lower of the established Medicaid reimbursement rate, determined by the program, or the provider's charges. The Medicaid program will not pay for services or items that are furnished gratuitously without regard to the beneficiary's ability to pay, or where no payment from any other source is expected, such as free x-rays or immunizations provided by health organizations.

BROKEN, MISSED, OR CANCELLED APPOINTMENTS

The Centers for Medicare and Medicaid Services (CMS) prohibits billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are state-designed and administered with federal policy established by CMS. Federal requirements mandate that providers who participate in the Medicaid program must accept the payment of the agency as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

MEDICAID AS PAYMENT IN FULL

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount established and paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. Only applicable copayments and services not covered by Medicaid may be billed to the beneficiary.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

MEDICAID AS PAYMENT IN FULL (CONT'D.)

For beneficiaries enrolled in a Medicaid managed care option, the managed care entity must accept DHHS's capitated payment as payment in full for all services covered by the capitation arrangement. Managed care network providers must accept their reimbursement from the managed care entity as payment in full. Only services not included in the specified benefits package or not otherwise covered by Medicaid may be billed to a beneficiary enrolled in a managed care option.

PAYMENT LIMITATION

Medicaid payments may be made only to a provider, to a provider's employer, or to an authorized billing entity. **There is no option for reimbursement to a beneficiary.** Likewise, seeking or receiving payment from a beneficiary pending receipt of payment from the Medicaid program is not allowed, except where a copayment is applicable. By virtue of submitting a claim to Medicaid, a provider is agreeing to accept Medicaid as the payer.

REASSIGNMENT OF CLAIMS

In general, Medicaid payments are to be made only to the enrolled practitioner. However, in certain circumstances payment may be made to the following:

1. The employer of the practitioner, if the practitioner is required as a condition of employment to turn over fees to the employer
2. The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim
3. A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim
4. A business agent. Regulations found at 42 CFR Part 447, Subpart A, allow Medicaid to make payment for services to a provider's "business agent" such as a billing service or an accounting firm, only if the agent's compensation is:
    a) Related to the cost of processing the billing
    b) Not related on a percentage or other basis to the amount that is billed or collected

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

REASSIGNMENT OF CLAIMS (CONT'D.)

c) Not dependent upon the collection of the payment

If the agent's compensation is tied to the amount billed or collected or is dependent upon the collection of the payment, Medicaid is not allowed to make payment to the agent. Furthermore, providers are urged to seek advice regarding the HIPAA (Public Law 104-191) provisions when entering into such an agreement.

THIRD PARTY LIABILITY

As a condition of eligibility for Medicaid, federal regulations at 42 CFR Part 433, Subpart D, require individuals to assign any rights to medical support or other third-party payment to the Medicaid agency (DHHS) and cooperate with the agency in obtaining such payments. The S.C. Code §43-7-420 makes this assignment effective automatically upon application for Medicaid.

Medicaid providers may obtain information regarding third-party resources that are known to DHHS by utilizing the Partners for Health Medicaid Insurance card with a Point of Sale (POS) device or by calling the Medicaid Interactive Voice Response System (IVRS). The Medicaid IVRS is discussed in full under "Medicaid Interactive Voice Response System" in this section. Third party resources include but are not limited to health benefits under commercial health insurance plans, indemnity contracts, school insurance, Workers' Compensation, and other casualty plans which may provide health insurance benefits under automobile or homeowner's coverages.

For Medicaid purposes, third-party resources are divided into two general categories: Health Insurance and Casualty Insurance.

Health Insurance

In general, health insurance may include any individual accident and health policy or group policy that provides payment for health care costs. Unless otherwise permitted, a provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third-party resources prior to billing Medicaid. All third-party claims filed must be assigned to the provider.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Health Insurance (Cont'd.)

Should the third-party carrier deny payment or reduce payment to less than the Medicaid approved amount, the provider may then submit the claim to Medicaid. The claim filed to Medicaid must be properly completed with all applicable third-party information entered in the appropriate fields (see Section 3 or other appropriate materials for billing instructions). Under the federally mandated Cost Avoidance program, 42 CFR §433.139, claims for certain services to beneficiaries who have health insurance coverage may automatically reject if the third-party carrier has not been billed first. If a claim is rejected for failure to bill third-party coverage, the resulting Edit Correction Form (ECF) for the rejected claim will contain the carrier code, policy number, and name of the policyholder for each third-party carrier. DHHS will not reprocess the claim unless the provider returns a correctly coded ECF that documents payment or denial of payment by the third-party carrier.

Not all claims are subject to coordination of benefits to ensure Medicaid is the payer of last resort. Federal regulations exempt claims submitted for physicians' services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Maternal Health, Title IV – Child Support Enforcement, and certain Department of Health and Environmental Control (DHEC) services under Title V. While providers are encouraged to file with any liable third party for these claim types, if they choose not to do so, DHHS will pay the claims and bill liable third parties directly through the Benefit Recovery program.

Premium Payment Project

Through the Premium Payment Project, DHHS is able to pay private health insurance premiums for Medicaid beneficiaries who are subject to losing coverage due to non-payment. DHHS will pay these premiums when said payment is determined to be cost effective.

Premium payment is usually cost effective for Medicaid beneficiaries with chronic medical conditions requiring long-term treatment such as cancer, end stage renal disease, chronic heart problems, congenital birth defects, and AIDS. Depending on the amount of the premium, the program may also be appropriate for beneficiaries with short-term costly health needs, such as pregnancy.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Premium Payment Project (Cont'd.)

Providers of services to participating beneficiaries should consider Medicaid the payer of last resort and bill any liable third-party insurance plan prior to billing Medicaid. When DHHS is paying cost-sharing obligations for the beneficiary, it is not a violation of Medicaid policy if the provider receives a total payment amount for a specific service (a combination of insurance payment and Medicaid reimbursement for cost-sharing obligations) that exceeds the Medicaid-allowed amount for that service.

Questions regarding the Premium Payment Project may be referred to the Division of Third Party Liability. Providers who wish to refer a beneficiary for participation in the project may call MIVS at (803) 933-1825 or the Division of Third Party Liability at (803) 898-2939.

Casualty Insurance

Casualty insurance includes policies that provide payment for treatment related to an accident or injury. This type of coverage is most commonly related to incidents such as auto accidents, and in these cases the injured party is frequently represented by an attorney.

Unlike health insurance claims, claims involving casualty insurance are not subject to review under the Cost Avoidance program. The accident questionnaire is the primary referral source and is generated by the Medicaid claims processing system. At times, it is the provider who identifies a potentially liable third party. If there is casualty insurance coverage, the provider may pursue the claim directly with either the beneficiary's attorney or the casualty insurance carrier, or file a claim with Medicaid (provided that the one-year time limit for submission of claims has not been exceeded).

If the provider files a claim with Medicaid and the claim is paid, then DHHS will pursue reimbursement from any liable third party.

Provider Responsibilities – TPL

A provider who has been paid by Medicaid and **subsequently** receives reimbursement from a third party must repay to DHHS either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less. The repayment check should be accompanied by a completed Form for Medicaid Refunds (DHHS Form 205) identifying the third-party payer. An example of this form can be found in Section 5 of this

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Provider Responsibilities – TPL (Cont'd.)

manual. A provider must not bill Medicaid for the difference between the payment received from a third party and the actual charges if the provider's third-party payment was determined under a "preferred provider" arrangement.

The S.C. Code §43-7-440(B) requires Medicaid providers to cooperate with DHHS in the identification of any third-party resource that may be responsible for payment of all or part of the cost of medical services provided to a Medicaid beneficiary. Upon receiving knowledge of third-party coverage that is not verified via a POS system or the IVRS, a provider is encouraged to notify DHHS's Division of Third Party Liability of said coverage. The Health Insurance Information Referral Form may be used for this purpose. An example of this form can be found in Section 5 of this manual.

The Division of Third Party Liability must also be notified in writing if copies of claims submitted to Medicaid are released to anyone, including the beneficiary or the beneficiary's attorney. Before being released, the documents must clearly indicate that third-party benefits are assigned to DHHS pursuant to state law.

Providers should be aware that in no instance will DHHS pay any amount that is the responsibility of a third-party resource. If a provider releases copies of claims submitted to Medicaid and the release of those documents results in third-party payment being made to the beneficiary rather than to the provider, DHHS will not reimburse the provider for the amount of the third-party payment made to the beneficiary.

TIME LIMIT FOR SUBMITTING CLAIMS

DHHS requires that only "clean" claims and related ECFs received and entered into the claims processing system within one year from the date of service (or date of discharge for hospital claims) be considered for payment. A "clean" claim is error-free and can be processed without obtaining additional information from the provider or from another third party. This time limit will not be extended on the basis of third-party liability requirements. However, the one-year time limit does not apply to Medicare cost sharing claims or to claims involving retroactive eligibility.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

Medical Cost Sharing Claims

Claims for payment of Medicare cost sharing amounts must be received and entered into the claims processing system within six months following the date of Medicare payment.

Retroactive Eligibility

Claims and related ECFs involving retroactive eligibility must be received within six months of the beneficiary's eligibility being added to the Medicaid eligibility system or one year from the date of service delivery, whichever is later. Hard copy claims should be submitted with a brief note attached explaining that the case involves retroactive eligibility. If possible, the eligibility worker should furnish as documentation either a statement verifying the retroactive determination or a computer-generated letter that states the date eligibility was added to the Medicaid record.

Payment Information

DHHS establishes reimbursement rates for each Medicaid-covered service. For specific service rates, refer to the appropriate section of this manual or contact your Medicaid program representative.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

REIMBURSEMENT

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SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SURVEILLANCE AND UTILIZATION REVIEW / DIVISION OF PROGRAM INTEGRITY

PROGRAM INTEGRITY

DHHS is mandated by the federal government to provide for surveillance and utilization review of services rendered to Medicaid beneficiaries by providers. The purposes of surveillance and review are to safeguard against unnecessary or inappropriate use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations, and policies. The Division of Program Integrity can fulfill this obligation in one of several ways, including but not limited to performing on-site post-payment reviews of providers' records, requesting documents from providers through the mail, or by requesting that providers perform a self audit. A utilization review can cover several years' worth of paid claims data. (See "Records/Documentation Requirements" in this section for the policy on Medicaid record retention.)

Prior to an on-site review, written notification of the forthcoming review is usually furnished to the provider; however, reviews may be unannounced. Program Integrity staff will conduct the review through analysis of paid claims data. The medical records and all other necessary documents obtained/received from the provider must contain documentation sufficient to disclose the extent of services delivered, medical necessity, appropriateness of treatment, and quality of care. Program Integrity staff thoroughly reviews all the documentation and notifies the provider of the post-payment review results. If the surveillance and utilization review finds that excessive or improper payments have been made to a provider, the provider will be asked to refund the overpayment or have it taken from subsequent Medicaid reimbursement.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

SURVEILLANCE AND UTILIZATION REVIEW / DIVISION OF PROGRAM INTEGRITY

PROGRAM INTEGRITY (CONT'D.)

Some reviews may include scientific sampling, extrapolation techniques, data mining, and payment accuracy analyses that are used for the purpose of projecting identified underpayments/overpayments throughout the claims population of the provider.

Providers who disagree with the review findings are instructed to follow the requested process outlined in the certified letter of notification. The process affords providers the opportunity to discuss and/or present evidence to support their Medicaid claims.

BENEFICIARY EXPLANATION OF MEDICAL BENEFITS PROGRAM

The Beneficiary Explanation of Medical Benefits Program allows Medicaid beneficiaries the opportunity to participate in the detection of fraud and abuse. Each month the Division of Program Integrity randomly selects four hundred beneficiaries for whom claims for services were paid. These beneficiaries are provided with an Explanation of Medical Benefits that lists all non-confidential services that were billed as having been delivered to them and which were paid during the previous 45-day period. Beneficiaries are requested to verify that they received the services listed. The Division of Program Integrity investigates services that beneficiaries deny having received.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS

FRAUD

The South Carolina Medicaid program operates under the anti-fraud provisions of 42 US Code §1396h. This federal law relates to both fraud and abuse of the program and identifies illegal acts, penalties for violations, and the individuals and/or entities liable under this section.

Federal regulations regarding the responsibilities of the Medicaid agency concerning suspected Medicaid fraud are found at 42 CFR Part 455, Subpart A. DHHS must conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. DHHS refers suspected cases of Medicaid fraud to the Medicaid Fraud Control Unit of the State Attorney General's Office for investigation and possible prosecution.

PROVIDER EXCLUSIONS/ SUSPENSIONS

Federal regulations for preventing fraud and abuse in the Medicaid program and for excluding or suspending providers from the Medicaid program for fraud and abuse are found at 42 CFR Part 1002, Subparts A and B. These regulations further require that any party who is excluded, suspended, or terminated from participation in Medicare under 42 CFR Part 1001 must also be suspended from the Medicaid program. Medicaid payment is not available for services furnished directly by, or under the supervision of, an excluded or suspended party.

ADMINISTRATIVE SANCTIONS

State regulations concerning administrative sanctions in the Medicaid program are found in S.C. Regulations at Chapter 126, Article 4, Subarticle 1. DHHS may impose one or more of the following sanctions against a provider who has been determined to have abused the program:

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS

ADMINISTRATIVE SANCTIONS (CONT'D.)

- Educational intervention
- Post-payment review
- Prepayment review
- Peer review
- Recoupment of overpayment
- Suspension
- Termination
- Referral to licensing/certifying boards or agencies

DHHS may impose one or more of the following sanctions against a provider who has been determined to be guilty of fraud or convicted of a crime related to participation in the Medicaid or Medicare programs:

- Recoupment of overpayment
- Suspension
- Termination

CIVIL MONEY PENALTIES

The United States Department of Health and Human Services (USDHHS), Office of Inspector General (OIG), may impose civil money penalties and assessments under the provisions of 42 CFR Part 1003.

FAIR HEARINGS

Proposed exclusion, suspension, or termination from the Medicaid program, as well as recoupment of an overpayment identified by Program Integrity, may be appealed prior to imposition of the sanction.

Any party who has been suspended, excluded, or terminated from the Medicaid program as a result of a similar action by Medicare may exercise appeal rights as set forth in the written notice from the USDHHS OIG. Appeals to the OIG shall be processed in accordance with 42 CFR §1001.2007. Said party shall have no right to separate appeal before DHHS.

REINSTATEMENT

A provider may seek readmission to the Medicaid program at the conclusion of the period of suspension from the Medicaid program or at any time thereafter. Those providers wishing to seek readmission must comply with the provisions outlined in their notice of exclusion from the South Carolina Medicaid program.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS

APPEALS

DHHS maintains procedures ensuring that all Medicaid providers will be granted an opportunity for a fair hearing. These procedures may be found in S.C. Regulations at Chapter 126, Article 1, Subarticle 3. An appeal hearing may be requested by a provider when a request for payment for services is denied or when the amount of such payment is in controversy.

An administrative appeal is a formal process that should be considered as an avenue of last resort to be used in attempting to resolve or settle a dispute(s). Providers should work with their program representative in an effort to resolve or settle a dispute(s) before requesting an administrative hearing.

In accordance with regulations of DHHS, a provider wishing to file an appeal must send a letter requesting a hearing along with a copy of the notice of adverse action or the remittance advice reflecting the denial in question. Letters requesting an appeal hearing should be sent to the following address:

Division of Appeals and Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

The request for an appeal hearing must be made within 30 days of the date of receipt of the notice of adverse action or 30 days from receipt of the remittance advice reflecting the denial, whichever is later. Subsequent hearings will be held in Columbia unless otherwise arranged. The appellant or appellant's representative must be present at the appeal hearing.

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION

MEDICAID ANTI-FRAUD PROVISIONS / PROVIDER EXCLUSIONS / SUSPENSIONS

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