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POLICIES AND PROCEDURES

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PROGRAM REQUIREMENTS

The South Carolina Medicaid Program recognizes all medical services that are medically necessary, unless limitations are noted within the policy restrictions of this manual. The South Carolina Medicaid Program is restricted to services for eligible beneficiaries provided by enrolled or contracted providers and rendered within the South Carolina service area. The South Carolina service area is usually defined as within 25 miles of the state line. Services rendered outside the service area are subject to the outlined prior approval guidelines. All services are subject to the guidelines and limitations established in this manual. The South Carolina Medicaid Program recognizes the services outlined in this manual and will reimburse providers according to the following definitions of appropriate Medicaid providers. All other services are considered non-covered within the South Carolina Medicaid Program.

REQUIREMENTS FOR PARTICIPATION

Clinic services are described as preventive, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. If a facility is owned by or affiliated with a hospital, it must work independently from the hospital. Clinic services include those services furnished at the clinic by or under the direction of a physician or dentist.

The South Carolina Medicaid Program will reimburse for services that are medically necessary and provided in a clinic that is certified by the Centers for Medicare and Medicaid Services (CMS) and licensed by the state licensing authority. Clinics are required to contract with the South Carolina Department of Health and Human Services (SCDHHS) and must be enrolled as Medicaid providers in order to receive reimbursement for services, unless otherwise specified (see Infusion Centers).

The South Carolina Medicaid Program will reimburse for services provided in the following clinics/centers: End Stage Renal Disease (ESRD) Clinics, Ambulatory Surgery Centers (ASC), Outpatient Pediatric AIDS Clinics

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PROGRAM REQUIREMENTS

REQUIREMENTS FOR PARTICIPATION (CONT'D.)

(OPAC), and Infusion Centers. Policies and procedures that govern reimbursement for services provided in these facilities are outlined in this section.

PRE- AND POST-PAYMENT REVIEW

All Medicaid claims are paid through an automated claims processing system. These claims are subject to pre-payment edits that may require documentation. Additionally, post-payment reviews are conducted regarding utilization, appropriateness, medical necessity, and other factors. All claims and reimbursements are subject to post-payment monitoring and recoupment if review indicates the claim was paid inappropriately or incorrectly. Providers are required to maintain and disclose their records in a manner consistent with Section 1 of this manual. SCDHHS reserves the right to request medical records at any time for purposes of medical justification and/or review of billing practices.

MEDICAL RECORDS

Patient records must indicate medical necessity. Documentation in the record must indicate the treatment process, which includes the service(s) to be provided, diagnostic procedures, and treatment goals. Goals should be specific according to patient needs and services to be rendered.

Medicaid requires providers to obtain authorization from each patient to release to SCDHHS any medical information necessary for processing Medicaid claims. Compliance with this requirement is part of the enrollment process.

TREATMENT RENDERED OUTSIDE THE SCMSA

The term "South Carolina Medical Service Area" (SCMSA) refers to the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border. Clinics in Charlotte, Augusta, and Savannah are also considered within the service area and would not require prior authorization.

The South Carolina Medicaid Program will compensate medical providers outside the SCMSA in the following situations:

- A beneficiary traveling outside the SCMSA needs emergency medical services, and the beneficiary's health would be endangered if necessary care were postponed until his or her return to South Carolina.

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TREATMENT RENDERED OUTSIDE THE SCMSA (CONT'D.)

- A physician makes an out-of-state referral because needed services are not available within the SCMSA.

Out-of-state providers must be licensed by their state's licensing authority and must sign an agreement to accept Medicaid's reimbursement as payment in full.

INJECTIONS

Injectable drugs are covered if the following criteria are met:

- They are of the type that cannot be self-administered. The usual method of administration and the form of the drug given to the patient are two factors in determining whether a drug should be considered self-administered. If a form of the drug given to the patient is usually self-injected (*e.g.*, insulin), the drug is excluded from coverage unless administered to the patient in an emergency situation (*e.g.*, diabetic coma).
- The medical record must substantiate medical necessity. When both an acceptable oral and parenteral preparation exist for necessary treatment, the oral preparation should be used. If parenteral administration is necessary, the record should document the reason.
- Use of the drug or biological must be safe and effective and otherwise reasonable and necessary. Drugs or biologicals approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective for purposes of this requirement when used for indications specified on the labeling. FDA-approved drugs are, on occasion, used for indications other than those specified on the labeling. Provided the FDA has not specified such drug use as non-approved, coverage is determined by considering the generally accepted medical practice in the community.

Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise. For a list of injectable drugs, see the procedure code list in Section 4.

Orphan Drugs

An orphan drug is a drug or biological product used for the treatment or prevention of a rare disease or condition. Prior approval is required for orphan drugs that are not listed on the injection code list.

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Unlisted Injections

If an injection is not listed, procedure code J9999 for chemo drugs or J3490 for other drugs should be used. The name of the drug (including the dosage given and the NDC number) must be attached to the claim with an invoice indicating the cost of the drug. Medical necessity must also be documented; the provider should attach a copy of the physician's order and the flow sheet to the claim or the Edit Correction Form.

Claims billed using J9999 or J3490 without documentation will be rejected. Procedure code 90782 is billed per injection for administration.

A list of injection codes for each program is provided in Section 4. Separate reimbursement for supplies is not allowed.

SPECIAL COVERAGE GROUPS

Family Planning Waiver

The Family Planning Waiver (FPW) provides coverage to women for services directly related to family planning. This waiver targets Optional Coverage for Women and Infants (OCWI) eligible women who normally lose their Medicaid coverage 60 days after delivery of a baby or conclusion of the pregnancy, and women of child-bearing age who have gross income up to 185% of the federal poverty level.

OCWI women will automatically be transitioned into the FPW program following the 60-day postpartum OCWI coverage period. No separate application process is necessary. Applications for women who do not qualify through OCWI will be processed at the county Department of Health and Environmental Control (DHEC) clinics. The waiver provides coverage for 22 months for services directly related to family planning. If the card is lost or stolen, beneficiaries may request a replacement card by calling 1-888-549-0820 and asking for their assigned caseworker.

Covered services include preventive contraceptive methods such as IUDs, sterilizations, diaphragms, condoms, sponges, Depo-Provera® injections, etc.

In addition, family planning prescriptions, lab work, counseling, office visits, exams, and other services related

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PROGRAM REQUIREMENTS

Family Planning Waiver (Cont'd.)

to family planning are covered under this waiver. The FPW does not cover treatment for routine side effects or complications associated with the various types of family planning methods. Treatment costs in such situations are the responsibility of the patient. Pregnancy services are non-covered under the FPW. If a woman becomes pregnant while she is covered under the FPW she must reapply with SCDHHS for full Medicaid benefits.

Hospice

Hospice services provide palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals. In addition to meeting the patient's medical needs, hospice care addresses the physical and psychosocial needs of the patient's family and caregiver.

Hospice services are available to Medicaid beneficiaries who choose to elect the benefit and who have been certified to be terminally ill with a life expectancy of six months or less by their attending physician and the medical director of hospice.

Hospice services are provided to the beneficiary according to a plan of care developed by an interdisciplinary staff of the hospice. The services below are covered hospice services:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has at least a bachelor's degree and is working under the direction of a physician
- Physicians' services provided by the hospice medical director or physician member of the interdisciplinary group
- Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient care
- Medical appliances and supplies, including drugs and biologicals. Only those supplies used for the relief of pain and symptom control related to the terminal illness are covered.

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Hospice (Cont'd.)

- Home health aide services and homemaker services
- Physical therapy, occupational therapy, and speech-language pathology services
- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home

A beneficiary who elects the hospice benefit must waive all rights to other Medicaid benefits for services related to treatment of the terminal condition for the duration of the election of hospice care. Specific services that must be waived include:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services:
  - Provided (either directly or under arrangement) by the designated hospice
  - Provided by another hospice under arrangements made by the designated hospice
  - Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for the services

Services Not Related to the Terminal Illness

Services provided for care not related to the terminal illness must be pre-approved by the hospice provider. The hospice provider must be contacted for confirmation that the service does not relate to the terminal illness, and for a prior authorization number to be included on the claim form. The hospice prior authorization number on the claim certifies that the services provided are not related to the terminal illness or are not included in the hospice plan of care. If the authorization number is not included on the claim form, the claim will be rejected and returned to the provider.

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PROGRAM REQUIREMENTS

Services Not Related to the Terminal Illness (Cont'd.)

Services that require prior authorization are:

- Ambulatory Surgical Centers
- Audiology
- County Health Departments
- Drug, Alcohol, and Substance Abuse Services
- Durable Medical Equipment
- Emergency Room
- Health Clinics
- Home- and Community-Based Services
- Home Health
- Hospital
- Medical Rehabilitation Services
- Mental Health
- Occupational Therapy
- Pharmacy
- Physical Therapy
- Podiatry
- Private Duty Nursing
- Psychologist Services
- School-Based Services
- Speech Therapy

If billing issues cannot be resolved with the hospice, contact Medicaid Hospice Services at (803) 898-2590.

MEDICAID MANAGED CARE

SCDHHS offers three voluntary managed care options to Medicaid beneficiaries. The purpose of these options is to link the Medicaid member to a medical home and manage the member's health care service from the primary care level. The goals of managed care are to:

- Improve the health status of members
- Increase access to primary care and preventive care
- Increase access to appropriate, coordinated, quality health care services

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PROGRAM REQUIREMENTS

MEDICAID MANAGED CARE (CONT'D.)

- Improve health outcomes
- Improve overall cost effectiveness of the Medicaid program

Medicaid beneficiaries may choose from one of the following plans:

- Traditional Medicaid Fee-For-Service
- Medical Homes Local Network Program (MHLN)
- A Managed Care Organization (MCO)
- The Physician Enhanced Program (PEP)

Medical Homes Local Network Program (MHLN)

The Medical Homes Local Network Program (MHLN) is a voluntary physician-driven managed care option. Beneficiaries who choose to enroll in this program agree to utilize the primary care physician to provide and/or coordinate all of their medical care needs. This partnership for care affords the beneficiaries the comfort of knowing that they will receive necessary (or all essential) medical services. Primary Care Physicians (PCPs) are contractually required to either provide services or authorize another provider to treat the member. PCPs are reimbursed for services through fee-for-service payments and also receive a monthly case management fee for each member. Certain practices will join together to form a network that will be directed by a board composed of members from each practice. The board will monitor the delivery of services to maximize efficiencies and encourage better health outcomes. The board is also reimbursed through a monthly management fee for each member. Such coordinated care combines disease management concepts with the dynamics of "pay for performance" as incentive for good management of the beneficiary's benefit package.

Beneficiaries ineligible to enroll in the MHLN include:

- Those enrolled in SILVERxCARD
- Those enrolled in the Family Planning Waiver
- Those enrolled in a home- and community-based waiver
- Those enrolled in the Medically Fragile Children's Program
- Those enrolled in hospice

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PROGRAM REQUIREMENTS

Medical Homes Local Network Program (MHLN) (Cont'd.)

- Those who are institutionalized
- Those with Limited Medicaid Benefits
- Those who are enrolled in another managed care entity

Each Medicaid beneficiary will have a plastic South Carolina Partners for Health Medicaid Insurance Card. Possession of this card does not guarantee Medicaid eligibility. Beneficiaries may become ineligible for Medicaid for a given month only to regain eligibility at a later date. It is possible that a beneficiary will present a card during a period of ineligibility. It is very important that providers check each beneficiary's eligibility prior to providing services. Providers may conduct this check through a Point of Sale (POS) device, the Medicaid Interactive Voice Response System (IVRS), or the South Carolina Medicaid Web-based Claims Submission Tool. If a beneficiary is a member of a managed care plan, this information will be provided during the eligibility check. Beneficiaries who are members of an MCO will have an identification card from that plan as well as their Partners for Health card.

MHLN Referrals and Authorizations

Coordination of care is an important component of MHLN. PCPs are contractually required to either provide medically necessary services or authorize another provider to treat the member. This applies even when a member has failed to establish a medical record with the PCP. In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (Refer to the list of exempt services on the following page.) All authorizations and consultations, including services authorized retro-actively, are at the discretion of the PCP. PCPs can refer a member to a specialist by telephone or in writing. The referral should include:

- The numbers of visits being authorized
- The extent of the diagnostic evaluation

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit. It is the PCP's responsibility to

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PROGRAM REQUIREMENTS

MHLN Referrals and Authorizations (Cont'd.)

provide any further diagnosis, evaluation, or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat a member and then needs to refer the member to a second specialist for the same diagnosis, the member's PCP must be contacted for authorization.

In addition to MHLN authorization, prior approval (PA) may be required by SCDHHS to verify medical necessity for some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure beneficiary eligibility on the date of service.

Claims submitted for reimbursement must include the PCP's authorization number.

See the chart "Services Requiring PCP Referral" in this section for services that must be authorized by the PCP.

Exempt Services

Members can obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- Ambulance
- Dentist
- Dialysis/End Stage Renal Disease Services
- Durable Medical Equipment
- Family Planning Services
- Home- and Community-Based Waivers
- Independent Lab and X-ray
- Medical Transportation
- Nursing Home
- Opticians
- Optometrists
- Pharmacy
- Services from most other state agencies: Department of Mental Health (DMH), Continuum of Care, Department of Alcohol and Other Drug Abuse Services (DAODAS), Department of Disabilities and Special Needs (DDSN)

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Exempt Services (Cont'd.)

- Speech and Hearing Clinics

Some services may be sponsored by a state agency and will require a referral from that agency's case manager. The state agency case manager should coordinate with the PCP to ensure continuity of care. These services include:

- Audiologist
- Therapeutic Behavioral Services Group Homes (formerly High/Moderate Management Group Homes)
- Occupational Therapist
- Physical Therapist
- Psychologist
- Speech Therapist
- Therapeutic Foster Care

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MHLN/PEP Providers
Services Requiring PCP Referral

Provider Type/Specialty	Service Requiring Referral
Hospital	• Inpatient services **except** newborn DRGs and Residential Treatment Facilities and Institutions for Mental Disease. • Outpatient services **except** lab and x-ray (70000-89999)
Emergency Room (PEP only)	• Refer to PEP ER Screening and Treatment Guidelines.
Physician	
Anesthesiologist and CRNA	All HCPCS codes **except** 00100-01995, 01999
Hematologist and Pathologist	All HCPCS codes **except** 80001-89999
Ophthalmologist	All HCPCS codes **except** 92002, 92004, 92012, 92014, 92015, 92018, 92019
Radiologist	All HCPCS codes **except** 70010-79999
All Other Physicians	All HCPCS codes **except** Family Planning Services
Podiatrist	All HCPCS codes
Nurse Practitioner and Nurse Midwife	All HCPCS codes, **except** Family Planning Services
DHEC Clinics	All HCPCS codes, **except** Family Planning Services
Ambulatory Surgical Centers	All HCPCS codes, **except** Family Planning Services
FQHC/RHC	All HCPCS codes, **except** Family Planning Services
Home Health	All HCPCS codes
Developmental Evaluation Centers	All HCPCS codes
Chiropractor	All HCPCS codes

Managed Care Organization (MCO)

The MCO is a fully capitated plan that provides a core benefit package similar to the current fee-for-service plan. An MCO may offer expanded benefits that go beyond the core package. Beneficiaries who are ineligible to enroll in an MCO include those who:

- Are dually eligible for Medicare and Medicaid
- Are age 65 or older

SECTION 2 POLICIES AND PROCEDURES

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Managed Care Organization (MCO) (Cont'd.)

- Reside in a nursing home or other institution
- Receive hospice services
- Are enrolled in a Waiver program
- Are enrolled in another MCO through third-party coverage

Each Medicaid beneficiary will have a plastic South Carolina Partners for Health Medicaid Insurance Card. Possession of the card does not guarantee Medicaid eligibility. Beneficiaries may become ineligible for Medicaid for a given month only to regain eligibility at a later date. It is possible a beneficiary will present a card during a period of ineligibility. It is very important that providers check each beneficiary's eligibility prior to providing services. Providers may conduct this check through a Point Of Sale (POS) device, the Medicaid Interactive Voice Response System (IVRS), or the South Carolina Medicaid Web-based Claims Submission Tool. If a beneficiary is a member of a managed care plan, this information will be provided during the eligibility check. Beneficiaries who are members of an MCO will have an identification card from that plan as well as their Partners for Health card.

MCO Program Billing Notes

1. In order to avoid risk of non-payment for services, all providers should check the beneficiary's ID card to see if the beneficiary is a Medicaid MCO program member. A beneficiary who is enrolled in a Medicaid MCO needs to follow the prior approval and/or coordination of care as directed by the Medicaid MCO.
2. Providers should file claims for Medicaid MCO program members to the MCO. Claims should be filed in accordance with the Medicaid MCO's claim filing procedures. Claims submitted to SCDHHS for MCO program members will be rejected if services are within the core benefits for the S.C. Medicaid Program.

Physician Enhanced Program (PEP)

The PEP is a voluntary program managed by SCDHHS. PEP offers a limited benefit package of primary care services for a monthly capitated rate per enrolled member. The primary care provider is responsible for primary

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PROGRAM REQUIREMENTS

Physician Enhanced Program (PEP) (Cont'd.)

prevention, treatment, and prior authorization of services outside the core package. Services outside the limited package are reimbursed on a fee-for-service basis. Beneficiaries ineligible to enroll in PEP are those who:

- Are dually eligible for Medicare and Medicaid
- Are age 65 or older
- Reside in a nursing home or other institution
- Receive hospice services
- Are enrolled in a Waiver program
- Are pregnant and in the Optional Coverage for Women and Infants (OCWI) coverage group

The purpose of the Physician Enhanced Program (PEP) is to manage the Medicaid patient's health care services beginning at the primary care level. The primary care provider (PCP) will provide a medical home for PEP members and provide a package of basic services. The PCP is responsible for providing preventive health exams, immunizations, comprehensive primary care services, limited laboratory procedures, EKGs, hospital care (including emergency room), minor office surgeries, and family planning services.

PEP Referrals

The PCP is responsible for authorizing appropriate care for members. See the chart "Services Requiring PCP Referral" in this section for a list of the providers and services that require a PCP referral.

When a referral has been made, the PCP will give the referred provider an authorization number. This number should be entered in field 19 of the CMS-1500 claim form. Claims may be sent electronically or in hard copy. To obtain prior authorization for treatment or authorization after service delivery, the provider must call the PCP. Services that have not been authorized by the PCP will result in a rejected claim.

For more information on the PEP, please consult the *Physicians, Laboratories, and Other Medical Professionals Medicaid Provider Manual* or call the Division of Physician Services at (803) 898-2660.

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END STAGE RENAL DISEASE PROGRAM

The End Stage Renal Disease (ESRD) program provides dialysis (removal of toxic wastes from the blood) to sustain life for patients who are in renal failure. There are two reimbursable elements of this program:

Technical Component — Policies and procedures are outlined in this section.

Professional Services (Nephrology) — Policies and procedures can be found in the *Physicians, Laboratories, and Other Medical Professionals Medicaid Provider Manual*.

Procedure codes for ESRD services can be found in Section 4 of this manual.

COVERAGE GUIDELINES

Medicaid will reimburse as primary sponsor of ESRD services during the 90-day waiting period required by Medicare for eligibility determinations and when an individual has been denied Medicare coverage. ESRD services include hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), and continuous ambulatory positioned dialysis (CAPD).

Medicaid will not reimburse as primary sponsor for any Medicare-covered services once a determination of eligibility is received from the Social Security Administration. This would include any services provided after the 90-day waiting period even if the Medicare determination is pending.

The ESRD facility, as primary provider, is responsible for ensuring that a Medicare application is made on behalf of the beneficiary. If an individual is denied Medicare coverage, a copy of the Medicare denial letter must be sent to the ESRD program manager at the Department of Health and Human Services immediately.

SECTION 2 POLICIES AND PROCEDURES

END STAGE RENAL DISEASE PROGRAM

PATIENT ENROLLMENT

Each patient must be enrolled in the ESRD program. This includes those patients who have Medicaid only as well as those patients who have Medicare as their primary payer. The enrollment form (DHHS Form 218) must be completed for each patient and submitted along with the first claim form. See Section 5 for a copy of Form 218.

The completed enrollment form, along with the first claim form, should be sent to:

SCDHHS
ESRD Program Manager
Post Office Box 8206
Columbia, SC 29202-8206

This will expedite the processing of claims and ensure that SCDHHS has enrolled all eligible ESRD beneficiaries.

REIMBURSEMENT POLICY

South Carolina requires ESRD services for beneficiaries covered by Medicaid to be submitted only on a CMS-1500 claim form. For dually eligible beneficiaries, vitamins and supplements that are not covered by Medicare but are covered by Medicaid must also be billed on the CMS-1500 claim form.

THE COMPOSITE RATE – MEDICAID ONLY

The composite rate is used to reimburse for dialysis services provided in centers, as well as for persons receiving treatments at home. Items and services included in the composite rate are identified below. Services that are not listed in the composite rate are eligible for separate reimbursement as long as the service is medically necessary and is a covered Medicaid service.

- All equipment, items, and services necessary to provide a dialysis treatment
- Laboratory tests (see Laboratory Services)
- Oral vitamins
- Antacids/phosphate binders
- Oral iron supplements
- Nutritional supplements
- Staff time required to provide treatment

The facility receiving the composite rate is responsible for ensuring that all component services included in the

SECTION 2 POLICIES AND PROCEDURES

END STAGE RENAL DISEASE PROGRAM

THE COMPOSITE RATE – MEDICAID ONLY (CONT'D.)

composite rate are delivered without additional claims being submitted to the Medicaid agency or billed to the beneficiary. Medicaid-only patients who receive dialysis treatments at home must contract with an ESRD clinic for supplies. These supplies will be reimbursed at the same rate paid for in-center dialysis.

When an unusual circumstance exists and uncommon supplies are deemed medically necessary, a request for prior approval, along with documentation to support medical necessity, must accompany the claim before payment is made.

Laboratory Services Included Under Composite Rate

ESRD laboratory services performed by either clinic staff or an independent laboratory are included in the composite rate calculations. Therefore, payment for all tests is included in the composite rate and **may not be billed separately to the Medicaid program**. These tests may be performed either by the provider, in which case payment is included in the composite rate, or by an outside laboratory for the provider, in which case **the laboratory bills the provider who then bills Medicaid and receives the composite rate for these lab charges**.

1. Laboratory Tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), and Continuous Cycling Peritoneal Dialysis (CCPD)

The tests listed below are usually performed for dialysis patients and are routinely covered, *i.e.*, no additional documentation of medical necessity is required, at the frequency specified. When any of these tests are performed at a frequency greater than what is specified, the additional tests are separately billable and are covered only if they are medically justified by accompanying diagnosis and support documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

Included in the composite rate:

- **Per treatment:** All hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments
- **Monthly:** Albumin, Alkaline Phosphatase, AST

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END STAGE RENAL DISEASE PROGRAM

Laboratory Services Included Under Composite Rate (Cont'd.)

(SGOT), Calcium, CO_2 (bicarbonate), Creatinine, LDH, Phosphorus, Potassium, Total Protein, Sodium, and Urea Nitrogen (BUN)

- **Automated battery of tests:** If an automated battery of tests such as the SMA-12 is performed, and contains most of the tests listed in monthly category, it is not necessary to separately identify any tests in the battery that are not listed above.

The following identifies certain separately billable laboratory tests that are covered routinely (*i.e.*, without additional documentation of medical necessity) when furnished at the specified frequencies.

- **Separately billable laboratory tests:**
  - Serum Aluminum and Serum Ferritin once every three months
  - Hepatitis B Surface Antibody or Hepatitis B Core Antibody once every year, but not both per year

If these tests are performed at a frequency greater than what is specified, they are covered only if they are medically justified by accompanying diagnosis and support documentation. A diagnosis of ESRD alone is not sufficient to justify additional payment. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

2. Laboratory Tests for CAPD

The following lab tests are covered routinely at the frequencies specified below if furnished to a CAPD patient in a certified setting. Any tests furnished in excess of this frequency or any tests furnished that are not listed here are covered only if there is a diagnosis code on the claim that supports a medical justification for the service. A diagnosis of ESRD alone is not sufficient to justify payments for the service outside of the composite rate. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring performance of any other tests not listed here must also be present on the form.

- **Weekly:** Creatinine
- **Weekly or 13 per quarter:** Urea Nitrogen (BUN)

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END STAGE RENAL DISEASE PROGRAM

Laboratory Services Included Under Composite Rate (Cont'd.)

- **Monthly:** Potassium, CO_2, Calcium, Chloride, Magnesium, Phosphate, Total Protein, Albumin, Alkaline Phosphatase, Phosphorus, LDH, AST (SGOT), Hct, Hgb, and Protein (total)
- **Separately billable laboratory tests:**
  - WBC, RBC, and Platelet Count every three months
  - Residual Renal Function and 24-hour Urine Volume every six months

Hospital Outpatient Dialysis

Medicaid will sponsor outpatient services related to ESRD treatment under the same guidelines outlined for ESRD clinics and if the hospital is certified as a hospital-based ESRD clinic. Hospitals presently certified are Palmetto Richland Memorial Hospital, St. Francis Hospital, the Medical University of South Carolina, Hampton Regional Medical Center, Charlotte Memorial Hospital, Medical College of Georgia, and Carolinas Hospital System. Hospital outpatient dialysis services are billed on the UB-92 claim form and reimbursed under the OP fee schedule.

Hospital Inpatient Dialysis

Medicaid will sponsor all medically necessary services related to renal disease care according to the regular hospital billing guidelines on the UB-92 form.

Guidelines for Hepatitis B Vaccine

Hepatitis B vaccine may be administered upon the order of a doctor of medicine or osteopathy, three doses of 2 milliliters each. The physician will determine the actual schedules based on medical necessity. Below is a standard schedule for the vaccine:

First dose

Second dose — One month after first dose

Third dose — Six months after first dose

One month after the third dose the patient should be tested for Hepatitis B Surface Antibody to determine whether he or she has responded to the vaccine. If the vaccine was successful, the patient should be tested annually for Hepatitis B Surface Antibody to confirm immunity.

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END STAGE RENAL DISEASE PROGRAM

Guidelines for Hepatitis B Vaccine (Cont'd.)

Patients who received the Hepatitis B vaccine but did not develop an immunity to Hepatitis B should be tested (Hepatitis B Surface Antigen Test) once a month.

Blood Products and Transfusion

The South Carolina Medicaid Program will only reimburse the actual supplier of packed cells. If blood is supplied by the local Red Cross, then the provider who prepares and washes the packed cells may bill for the unit of blood.

ESRD clinics may bill for the blood transfusion only. The type and cross match should be performed by the provider supplying the blood plasma. If the ESRD clinic is performing this service, documentation must be submitted with the claim.

Vitamins and Supplements

The Medicaid program is the primary sponsor for payment of the following list of vitamins and supplements. ESRD clinics may be reimbursed for the actual cost of distributing these vitamins and supplements by using the codes identified.

X6661 Multivitamins

X6711 Vitamin D

X6716 Nutritional Supplements

X6717 Calcium

X6704 Calcium Acetate

X6718 Antacids (Phosphate Binders)

X6719 Iron Salts

X6720 Iron with Vitamins

X6721 Iron Complex

Nephrology Services

See the *Physicians, Laboratories, and Other Medical Professionals Medicaid Provider Manual* for billing information and covered services.

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

INTRODUCTION

An Ambulatory Surgery Center (ASC) is a distinct entity that operates exclusively for the purpose of providing surgical services to patients who are scheduled to arrive, receive surgery, and be discharged on the same day. There are two reimbursable elements of this program:

Facility Services — Policies and procedures are outlined in this section.

Physician's Professional Fee — Reimbursement for professional services can be found in the *Physicians, Laboratories, and Other Medical Professionals Medicaid Provider Manual*.

In order to participate in the South Carolina Medicaid Program, the ASC must have met all conditions prescribed in the Medicare guidelines for reimbursement and be licensed by the South Carolina Department of Health and Environmental Control (DHEC) or, if out of state, a comparable health department or other state/city licensing agency in that state. Once these conditions are met, the ASC may submit a written request to the SCDHHS program manager with copies of the CMS certification and DHEC license. The request must include the date on which services are to be effective (usually the same date as the CMS certification).

The program manager will review this documentation to verify that appropriate information was received and will then forward it to the Division of Contracts. The Division of Contracts will send the provider the appropriate enrollment forms and two copies of the contract. The provider will sign the contracts, complete the enrollment forms, and return all documents to the Division of Contracts. The contracts will then be signed by the director of SCDHHS, and one copy will be returned to the provider along with a unique six-character provider number. The provider number should be used on all claim forms, inquiries, and adjustment requests.

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

COVERAGE GUIDELINES

South Carolina Medicaid has adopted Medicare's guidelines to determine which surgical procedures are covered and at which level they will be assigned. Accordingly, Medicaid will update the list of covered procedures as Medicare updates its list.

Surgical procedures that are not routinely covered by Medicare in an ASC may be considered for reimbursement by Medicaid pending review. Dental procedures, for example, some of which are not covered by Medicare, are included on the Medicaid list of covered services in the ASC setting. Also included are procedures that are not routinely performed for Medicare patients, *e.g.*, pediatric and gynecological procedures. These exceptions are reviewed on a case-by-case basis and must meet the Code of Federal Regulations standards at 416.65 and 416.75 and Medicaid's criteria of medical necessity. These requests must be submitted to SCDHHS before services are rendered. **Requests submitted after the surgery has been performed will be denied.**

If a procedure is not on the list of approved ASC services and prior approval has not been received to perform the service in an ASC, it is the responsibility of the facility to inform the beneficiary that the surgery is not reimbursable by Medicaid. Beneficiaries should be informed that if they choose to have the surgery performed at the ASC, they are responsible for all charges.

A complete list of approved procedure codes, including supplemental codes for dental services, appears in Section 4 of this manual.

REIMBURSEMENT POLICY

ASCs are reimbursed an all-inclusive facility fee based on payment groups. There are nine payment groups categorized according to the surgical procedure performed. Following are the payment groups with current rates:

Group 1	$218.40	Group 6	$549.50
Group 2	$293.30	Group 7	$654.50
Group 3	$335.30	Group 8	$646.10
Group 4	$413.70	Group 9	$1339.00
Group 5	$471.80		

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

REIMBURSEMENT POLICY (CONT'D.)

Claims for facility fees will be paid at 100% of the established Medicaid rate for the primary surgical procedure or the charged rate, whichever is lower, and the second surgical procedure will be paid at 50% of the established Medicaid rate (per operative session). See Section 3 for complete billing instructions for multiple surgeries.

FACILITY SERVICES

ASC facility services include those services that would otherwise be covered under South Carolina Medicaid if furnished in an inpatient or outpatient hospital in connection with a surgical procedure. The ASC facility services include, but are not limited to:

- Nursing services, services of technical personnel, and related services
- The use by the patient of the ASC facility
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of surgical procedures
- Blood and blood products
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure (*e.g.*, Hematocrit, Hemoglobin)
- Administrative, recordkeeping, and housekeeping items and services
- Materials for anesthesia
- Intraocular lenses (IOLs)
- Cornea for transplant (reimbursement included under procedure code 65730)

These items are considered an integral part of the facility fee connected with the performance of a surgical procedure, and may not be billed separately.

Nursing Services, Services of Technical Personnel, and Other Related Services

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the nursing staff, this category includes orderlies, technical personnel, and others involved in patient care.

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

Use by the Patient of the ASC's Facilities

This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

Drugs, Biologicals, Surgical Dressings, Supplies, Casts, Appliances, and Equipment

This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. Drugs and biologicals are limited to those that cannot be self-administered.

The term "supplies" includes those items required for both the patient and ASC personnel in connection with the performance of a surgical procedure, *i.e.*, gowns, masks, gloves, instruments, etc., whether disposable or reusable. Surgical dressings include those dressings that are considered primary dressings, *i.e.*, therapeutic and protective coverings applied directly to the wound as a result of a surgical procedure.

Similarly, the phrase "other supplies, splints, and casts" includes only those furnished by the ASC at the time of the surgery.

Blood and Blood Products

While covered procedures are limited to those not expected to result in extensive loss of blood, in some cases blood or blood products are required and are considered ASC facility services; in such cases, no separate charge is permitted to the program.

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. With respect to diagnostic tests, many ASCs perform simple tests just before surgery, primarily urinalysis and blood hemoglobin or hematocrit, which are generally included in their facility charges.

Administrative, Record Keeping, and Housekeeping Items and Services

These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, and rent.

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

Material for Anesthesia

These include the anesthetic itself and any materials, whether disposable or reusable, necessary for its administration.

Intraocular Lenses (IOLs)

ASC facility services include intraocular lenses approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

FDA has classified IOLs into the following four categories, any of which are included:

1. Anterior chamber angle fixation lenses
2. Iris fixation lenses
3. Irido-capsular fixation lenses
4. Posterior chamber lenses

LABORATORY AND X-RAY SERVICES

All diagnostic tests related to the surgical procedure to be performed in the ASC are considered an integral part of the facility charge and may not be billed separately. The ASC may make arrangements with an independent laboratory or other laboratory (such as a hospital laboratory) to perform diagnostic tests it requires prior to surgery. In general, however, the necessary laboratory tests are done outside the ASC prior to scheduling of surgery, since the test results often determine whether the beneficiary should have the surgery done in the first place.

If a laboratory is within the ASC, the lab may choose to enroll as an independent provider, as long as it meets the regulatory conditions and requirements to participate in the South Carolina Medicaid Program. The clinic or lab must have its own provider number in order to receive reimbursement for services not related to the surgical procedure performed.

The South Carolina Medicaid Program requires that all independent laboratories meet Clinical Laboratory Improvement Amendments (CLIA) regulations and enroll with SCDHHS. For enrollment information, call or write to Medicaid Provider Enrollment, Post Office Box 8809, Columbia, SC, 29202, (803) 788-7622, extension 41650.

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

EXCLUDED SERVICES

Facility services do not include items and services for which payment may be made under other provisions in the Medicaid program. These services include but are not limited to:

- Professional services provided by a physician (surgical procedure, preoperative and postoperative, administration of anesthesia)
- Laboratory and x-ray services which are not directly related to the performance of a surgical procedure
- Ambulance services
- Durable medical equipment for use in the patient's home
- Leg, arm, artificial limb, back, and neck braces
- Prosthetic devices (except IOLs)

These items and services should be billed to SCDHHS by the participating provider. The ASC will not receive separate reimbursement for these services. For example, items such as ace bandages, elastic stockings, and pressure garments are generally used as secondary coverings and would not be considered "primary" surgical dressings. Reimbursement for these items is available through the Medicaid Durable Medical Equipment program (DME) and should be obtained from a DME provider enrolled in the South Carolina Medicaid Program.

PROSTHETICS

Certain implantable prosthetic devices (*e.g.*, orthopedic joints, ocular prosthesis) that the ASC must obtain from an outside source in order to have available at the time of surgery may be covered and should be billed separately from the facility charge. Intraocular lenses (IOLs) are included in the facility group rate.

Reimbursement for these items will be determined on a case-by-case basis. Payment will be based on either the allowable Medicaid amount for the prosthesis or the invoice cost, whichever is lower. To avoid delay in payment of the facility fees, charges for prosthetic devices should be reported on a separate claim form.

The ASC must provide sufficient documentation to justify reimbursement for the item, as well as the charged rate for

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

PROSTHETICS (CONT'D.)

the item (*i.e.*, the invoice). If Medicaid has knowledge that the device could have been purchased from another source at a more reasonable rate, then reimbursement may be considered on the basis of reasonable charge rather than actual cost.

MULTIPLE SURGERY GUIDELINES

South Carolina Medicaid will allow for the reimbursement of two surgical procedures performed on the same date of service. These multiple surgeries include separate procedures performed through a single incision, or separate procedures performed through second and subsequent incisions or approaches.

When more than two surgical procedures are performed at the same operative session, the 51 modifier must accompany the second procedure and any subsequent procedure(s). If the 51 modifier is not used in this fashion, the claim will be rejected.

The operative report must provide sufficient evidence that the additional surgical procedure resulted in additional cost to the facility (*i.e.*, an increase of operating room time and supplies). If documentation does not support justification to bill for the additional procedures, monies may be recouped in a post-payment audit of paid claims.

Examples of situations when it may be appropriate to bill two surgical facility fees on the same date of service are:

- Surgical procedure on two different anatomical sites
- Diagnostic laparoscopy followed by an open abdominal procedure
- Repair of multiple injuries of different anatomical sites (*i.e.*, repair of fracture of right leg and tendon repair of left leg)

Examples of situations when it may not be appropriate to bill for two surgical facility fees are:

- Tonsillectomy and adenoidectomy
- Two endoscopic surgical procedures on the same anatomical site, or two like procedures through the same incision. When a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

MULTIPLE SURGERY GUIDELINES (CONT'D.)

facility may be reimbursed either for the endoscopic procedure or the diagnostic endoscopy, but not for both.

- Incidental procedures (*i.e.*, appendectomy, lysis of adhesions during other abdominal procedure). If a procedure is carried out through the laparotomy incision, the facility may choose to bill for the laparotomy or the actual procedure performed during the surgery. Most likely, it will be the code that reimburses the higher rate. In any case, Medicaid will sponsor payment for one or the other, but never for both.
- Bilateral procedures (through same incision)
- Application of a splint or cast following surgical fracture repair

Payment Guidelines

When multiple surgeries are performed at the same operative session, the procedure that reimburses the highest established rate will be considered the primary procedure and will be reimbursed at 100%. All second and subsequent surgeries performed at the same operative setting will be reimbursed at 50% of the established rate.

Modifiers

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance must be identified by the addition of the appropriate modifier code which must be reported by adding a two-digit number (modifier) after the procedure number. Modifiers commonly used in surgery are listed in the surgery section of the CPT-4 Coding Manual and in Section 3 of this manual. Only the first modifier indicated will be used to process the claim. (Medicaid will key the first modifier indicated for each procedure only.)

Billing Guidelines

Claims for surgery must be filed using the CPT code that most closely describes the surgical procedure that was performed. When this is not applicable, an unlisted procedure code may be used and the appropriate documentation must be attached to the claim for adequate reimbursement.

Claims for more than one surgical procedure performed at the same time must be billed in the following manner:

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

Billing Guidelines (Cont'd.)

- On a single CMS claim form

  Note: If more than one surgical procedure is billed for the same date of service on different claims, the second claim that processes will reject. To avoid this rejection, file all surgical procedures for the same date of service on one claim form.

- Only subsequent procedures that add significantly to the major surgery (not services incidental to the major surgery, *e.g.*, incidental appendectomy, incidental scar excision, puncture of ovarian cyst, simple lysis of adhesions, simple repair of hiatal hernia)
- In order of complexity with the most complex procedure first
- Using the appropriate modifier
- With charges listed separately for each procedure
- With appropriate number of units, if applicable, according to procedure code description

When identical procedures (not bilateral) are billed for the same day, the first should be billed without a modifier, and the second with modifier LT or RT. If the same procedure is billed a third time, the claim must be filed hard copy with supporting documentation. Failure to include documentation will result in an 892 edit. The provider may resubmit an ECF with appropriate documentation indicating a repeat service; or, if there is no ECF but the line rejected, the provider may rebill for the procedure that did not pay with a copy of the original remittance advice.

Separate Procedures Performed on the Same Date of Service

When two surgical procedures are performed on the same date of service at different operative sessions, both procedures will be allowed 100% of the Medicaid established rate. To report, submit the second procedure with the 78 or 79 modifier. This will assure that both procedures will be paid at 100% of the established rate. If not reported in this manner, the lower priced of the two procedures will be reimbursed at 50%. All surgical procedures performed on the same date of service should be filed on the same claim form whenever possible.

SECTION 2 POLICIES AND PROCEDURES

AMBULATORY SURGICAL CENTERS

Separate Procedures Performed on the Same Date of Service (Cont'd.)

78 — When a procedure related to the initial procedure requires a return to the operating room during the postoperative period of that initial procedure

79 — When a procedure unrelated to the initial procedure is performed during the postoperative period by the same physician as the initial procedure

BILATERAL SURGERY

Bilateral surgeries are performed on both sides of the body during the same operative session or on the same day. The description for some procedure codes notes that the service is a "bilateral" or "unilateral or bilateral" procedure. Bill bilateral procedures as two line items.

If the description for a procedure notes the service is a "bilateral" or "unilateral or bilateral" procedure, do not report modifier 50 with the procedure code. Examples of bilateral procedures include CPT codes 27395 (Lengthening of hamstring tendon; multiple, bilateral) and 52290 (Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral).

Bilateral procedures will be reimbursed at 100% for the first procedure, and 50% for the second procedure (same as multiple procedures). If the bilateral procedure is billed in conjunction with another procedure that is normally reimbursed at a higher rate than the bilateral procedure, then each of the bilateral procedures will be reimbursed at 50%.

SECTION 2 POLICIES AND PROCEDURES

OUTPATIENT PEDIATRIC AIDS CLINICS

INTRODUCTION

An Outpatient Pediatric AIDS Clinic (OPAC) operates exclusively for the purpose of providing specialty care, consultation, and counseling services for HIV-infected and exposed Medicaid-eligible children and their families. The mission of the OPAC is to follow children who have been exposed to HIV perinatally as children born to women infected with HIV.

The clinic utilizes a multidisciplinary staff and clinical practices. Clinic personnel provide services that are medical, behavioral, psychological, and psychosocial in nature. All exposed children must be followed with frequent clinical and laboratory evaluations to allow early identification of infection.

COVERAGE GUIDELINES

Children born to HIV-positive mothers but who do not test positive receive services every three months in the clinic until they are two years old. Children who test positive are seen twice a week for eight weeks and then once a month until they are two years old.

Clinics must ensure that, at a minimum, the following services are provided:

- Clinics must provide proper care for infected infants and children, *i.e.*, pneumocystis carinii prophylaxis or specific treatment for HIV infection.
- Clinic personnel must coordinate primary care services with the family's primary care provider (when one is available and identified).
- Clinics must coordinate required laboratory evaluations when clinical evaluations are not needed. Laboratory evaluations may be arranged at local facilities if this is more convenient for the patient/family and if the tests are available locally. These evaluations may be coordinated with the primary care provider and often with the assistance of local health department personnel.

SECTION 2 POLICIES AND PROCEDURES

OUTPATIENT PEDIATRIC AIDS CLINICS

COVERAGE GUIDELINES (CONT'D.)

- Clinic personnel must provide management decisions and regularly see the children and parents when HIV-infected children are hospitalized at a Level III hospital. When HIV-infected children are hospitalized at regional or local hospitals with less severe illnesses, staff must provide consultation to assist in the management of their care.
- Clinic personnel must provide case coordination and social work services to the families to assure specialty and primary care follow-up and to assist in obtaining needed services for the child and family.

REIMBURSEMENT POLICY

OPACs are reimbursed two all-inclusive procedure codes whose rates are established in the contract. They are the Multidisciplinary Clinic Visit with Physician (T1025), which must include each member of the multidisciplinary team, and Lab Only Clinic Visit (T1015), which does not require the services of the pediatric infectious disease specialist and nutritionist. Each clinic must identify in its contract the role of each staff member required for the specified clinic visits. OPAC services must be submitted on the CMS-1500 claim form. Please see Section 3 for complete billing instructions.

Note: Services rendered and paid through grants to the provider should not be billed to Medicaid.

PROVISION OF PERSONNEL

Each OPAC must be staffed with personnel who would be responsible for each task outlined below. Specific personnel assigned to tasks may vary by titles and must be approved by SCDHHS. Responsibilities outlined are core requirements for participation.

Pediatric Infectious Disease Specialist

The pediatric infectious disease specialist will see all patients. His or her role is to perform a medical assessment by history and physical examination and to assess the results of all laboratory studies. The physician makes all decisions regarding therapeutic intervention and communicates results of the clinic assessments and therapeutic plan to the primary care physician. The pediatric infectious disease specialist consults with clinic staff regarding appropriate interval follow-up care, consults with the primary care provider regarding both the

SECTION 2 POLICIES AND PROCEDURES

OUTPATIENT PEDIATRIC AIDS CLINICS

Pediatric Infectious Disease Specialist (Cont'd.)

ongoing care of the children and management of acute problems, and maintains current knowledge related to HIV care through medical literature and continuing medical education.

Case Coordinator

The case coordinator is responsible for scheduling the patient for clinic appointments, taking into account both the medical needs of the patient and the scheduling concerns of the parents. The case coordinator coordinates and facilitates patient flow among various providers, meets individually with each family to provide counseling and education regarding HIV infection and the health and social issues related to the infection, follows up all laboratory studies performed during the clinic visits, conducts and chairs staff meetings for the multidisciplinary clinic providers, serves as liaison to all community-based services involved in the care of the patient/family, and assesses the ability of the family to meet the health care needs of the child and to comply with the recommended treatment plan.

Nutritionist

The nutritionist reviews the chart of each child who has enrolled in the clinic, specifically assessing the results of a formal nutritional questionnaire and the growth of the child. The nutritionist must meet with the parents of children who have been identified by the nutritional assessment as being nutritionally high-risk patients to establish a nutritional care plan and make recommendations for nutritional supplementation to the medical care team when appropriate.

Social Worker

The social worker meets with all families during the multidisciplinary clinic visit to identify non-medical problems such as financial and housing concerns associated with the care of the child, and to arrange appropriate intervention or support for these problems. The social worker seeks to identify all family- and patient-related psychosocial needs, provides counseling or arranges intervention to meet these needs, conducts parent support groups for all interested parents in the clinic on each clinic day, and is involved in responding to both emergent and ongoing medical and psychosocial problems.

SECTION 2 POLICIES AND PROCEDURES

OUTPATIENT PEDIATRIC AIDS CLINICS

Child Life Specialist

The child life specialist is available to assist with child care for all parents during the parents' support group. The child life specialist involves the child in therapeutic play and reports any unfavorable observations to the clinic staff. This is predominantly individualized play therapy and attempts to address the child's perception of his or her illness, that of the parents, and grieving issues.

In addition to the above key personnel requirements, optional staff may include but are not limited to a child psychologist, registered nurse, and others as approved by SCDHHS to carry out the required services to the patient.

ZIDOVUDINE (AZT)

Any newborn who is at risk of perinatal transmission of HIV/AIDS may receive a six-week supply of AZT syrup. SCDHHS will allow the pharmacy or outpatient hospital provider to bill Medicaid for the six-week AZT syrup home supply under the mother's Medicaid ID number. Only the AZT syrup should be billed under the mother's number when the newborn does not have an assigned Medicaid number at the time of discharge.

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

INTRODUCTION AND QUALIFICATIONS

Infusion centers were developed by the Department of Health and Human Services (SCDHHS) to allow Medicaid beneficiaries to receive various types of infusion therapy in a facility setting other than a physician's office or outpatient hospital. The following criteria qualify participants to become infusion centers:

- Centers must be enrolled by SCDHHS and provide cost report information upon request.
- Centers must be freestanding and have a non-physician-type office setting.
- Centers owned by or affiliated with a hospital must work independently from the hospital, and costs associated with the center must not be included in the hospital's inpatient or outpatient cost reporting.
- Professional staff must be licensed and meet South Carolina state laws governing the practice for the services they provide.
- Centers must have the ability to perform the following therapy services:
  - Chemotherapy
  - Hydration
  - IGIV
  - Blood and blood products
  - Antibiotics
  - Intrathecal/lumbar puncture
  - Inhalation
  - Therapeutic phlebotomy

A physician must be on the premises and available to provide services in the event of an adverse reaction or other medical emergency.

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

GENERAL GUIDELINES

All medical activities provided by an infusion center must be directed by a qualified physician. Infusion center services are only considered reimbursable when performed under the specific order of a physician. Professional staff must be licensed and meet South Carolina state laws governing the practice of the services they provide. Since federal, state, and local laws and regulations require licensing of physicians, pharmacists, and nurses, it is the center's responsibility to keep a copy of a current license for professional staff members on file and available to SCDHHS. In addition, infusion centers must have protocols for a medical emergency and management of complications. These must include, at a minimum, a crash cart, emergency drugs, and access to nursing/ physician services. Cost reports must be submitted to SCDHHS annually at the end of the provider's fiscal year. This will enable SCDHHS to review the services provided and rates in order to update pricing information, when necessary.

Medical Record Documentation Requirements

Medical documentation must clearly substantiate the need for services, must include all findings and information supporting medical necessity, and must detail all treatment provided. Each description of treatment in the medical record must include the beneficiary's name, diagnosis, date of treatment, and amount given. A standardized flow sheet to record infusion services is recommended.

Drugs and/or Blood Service Sponsored or Donated

The use of a drug or biological must be safe and effective and otherwise reasonable and necessary. Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise. The use of experimental drugs at any stage is not covered.

Drugs and services sponsored, donated, or otherwise paid for by outside sources are not reimbursed by Medicaid and should not be billed. Billing these services to SCDHHS will result in recoupment. It is recommended that the infusion center have internal measures to identify which services are provided at no expense to the center. This information must be available to SCDHHS upon request.

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

COVERAGE/ REIMBURSEMENT GUIDELINES

Infusion therapies must be ordered by a physician and administered by a licensed physician or licensed nurse acting within the scope of laws governing his or her professional practice limits. Each infusion therapy code is reimbursed at an all-inclusive rate that includes but is not limited to:

- All items and services necessary to provide therapy treatment
- Supplies
- Equipment
- Professional and ancillary personnel

Injectable drugs may be billed in addition to the therapy codes. A complete list of these drug codes can be found in Section 4.

Additional services that may also be billed along with the therapy codes are identified under Therapy Administration Guidelines.

THERAPY ADMINISTRATION GUIDELINES

Chemotherapy Infusion Therapy

Chemotherapy infusion refers to the administration and management of a patient who is receiving a regimen of chemotherapy agents. Regardless of the number of agents and/or medications administered either simultaneously or sequentially, only one charge for chemotherapy infusion therapy (regardless of the method used) should be billed per session. The appropriate codes to bill are CPT codes 96410–96414 and 96422–96425. Routine maintenance of an access device is considered part of the service and is not to be billed separately.

1. **Chemotherapy Administration IV Push Technique (CPT 96408) and Chemotherapy Administration Intra-Arterial Push Technique (CPT 96420) —** An IV push is defined as the administration of a chemotherapy agent via the port nearest to the point of vascular or arterial access. This technique is performed by a provider using a syringe.

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

Chemotherapy Infusion Therapy (Cont'd.)

Regardless of the number of chemotherapy agents given, only one push technique code will be allowed per day. The IV push code may not be used when the code for chemotherapy administration has been billed. Any volume of IV fluids under 250 mls used in conjunction with IV push technique is considered part of the service and is not a separately billable item.

2. **Pump Refills/Maintenance (CPT 96520 and CPT 96530) —** These codes should be used when refilling portable and implanted pumps or reservoirs with chemotherapy agents. They are not to be used for the routine maintenance of an access device.

Inhalation Therapy (94640)

Inhalation therapy services include the administration of gases or drugs in gaseous, vapor, or aerosol form by drawing them into the lungs along with inhaled air for local or systemic effect. The cost of the inhalation agent is included in the 94640 reimbursement. No additional "J" code should be billed.

Antibiotic Infusion Therapy (90780 and 90781)

Antibiotic infusion therapy services include the intravenous administration of antibiotics for systemic effect. It is correct to bill the appropriate drug "J" code in addition to this administration code. 90780 or 90781 are not to be used for antibiotics administered via IV push method if no infusion services are being rendered simultaneously. IV antibiotics administered via IV push should be billed using the appropriate drug "J" code only. This code may also be billed for infusions of amphotericin B.

Blood/Blood Products Infusion Therapy (36430)

Blood and blood products infusion therapy includes the cost of the type and antibody and A, B, O, or Rh typing tests that are generally inclusive charges per patient per blood transfusion. This code may also be used for immunoglobulin infusions.

Code P9010 is used to bill for whole blood. For each unit of whole blood transfused, the appropriate unit(s) should be placed in the column for units. Other blood products should be billed accordingly: P9012 — Cryoprecipitate, each unit; P9016 — Red blood cells, leukocytes reduced, each unit; P9019 — Platelets, each unit; P9021 — Red

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

Blood/Blood Products Infusion Therapy (36430) (Cont'd.)

blood cells, each unit; P9034 — Platelets, pheresis, each unit; and P9035 — Platelets, pheresis, leukocytes reduced, each unit. Code 36430 may also be used when therapeutic phlebotomy is performed in the course of exchange transfusions.

Note: Medicaid does not reimburse for certain factor products (Factor VIII and IX) supplied by DHEC. Medicaid beneficiaries with hemophilia must be enrolled in the state's hemophilia program, which is administered by DHEC. The hemophilia program furnishes clotting factor to enrolled Medicaid beneficiaries. If a Medicaid beneficiary chooses to have this factor product administered by an infusion center, the infusion center may bill Medicaid for the infusion using 36430. It is incorrect to bill for the factor drug using any code.

Hydration Therapy (90780 and 90781)

Hydration therapy is the administration of replacement solutions alone or in conjunction with other drugs to maintain fluid and electrolyte balance in a patient. Hydration therapy is only allowed when the services are administered as a separate procedure. The medical record should clearly indicate the medical necessity for hydration therapy. Payment of hydration therapy is considered bundled into the payment for chemotherapy IV infusion when administered simultaneously as part of the regimen of chemotherapy treatment.

IGIV Infusion Therapy (90780 and 90781)

IGIV infusion refers to the administration of antibodies that are responsible for the humoral aspects of immunity. It is correct to bill the appropriate drug "J" code in addition to this administration code. However, when administering Synagis® no administration code is billed, as Synagis® is given intramuscularly.

ADDITIONAL CODES THAT MAY BE BILLED AS INFUSION CENTER SERVICES

Therapeutic Phlebotomy (99195)

Therapeutic phlebotomy is the removal of blood for purposes of treating certain diseases such as polycythemia and disorders of iron metabolism, etc. This procedure may be billed using the CPT code 99195. Routine venipuncture

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

Therapeutic Phlebotomy (99195) (Cont'd.)

is not a covered infusion center service and should not be billed using CPT code 99195.

When therapeutic phlebotomy is performed in the course of exchange transfusions, it is correct to use code 36430 for blood/blood products infusion. It would not be correct to use code 36430 when blood is only withdrawn from a patient for therapeutic purposes and when no exchange process is performed.

Routine Maintenance/Declotting

Routine maintenance (flushing with heparin or saline) of an access device is included in the infusion therapy service and cannot be billed separately. If this is the only service rendered, CPT code J1642 (Heparin Sodium, Heparin Lock Flush) may be billed. When declotting an access device with Urokinase and this is the only service provided, bill J3364.

Unclassified/Unlisted Drug Injections (J9990, J3490)

For any unclassified chemotherapy drug, use procedure code J9999. For any other unlisted drug, use procedure code J3490. In both cases, indicate the name of the drug along with a description, the NDC number, and total dosage given on the claim form (field 24D). Also, attach a copy of the physician's order, flow sheet, and FDA approval (if available) when submitting documentation for the review and reimbursement of unlisted drugs.

Synagis® (90378)

Palivizumab (trade name Synagis®) or respiratory syncytial virus immune globulin intravenous (RSV-IGIV) prophylaxis is indicated for the prevention of serious lower respiratory tract infection caused by RSV in children under 24 months of age with chronic lung disease (CLD) or a history of premature birth (<35 weeks gestation).

RSV prophylaxis should be initiated at the onset of the RSV season and terminated at the end of the RSV season. Payment for Synagis® administration will be limited to six doses per season given on or after October 1st and no later than March 31st. Prior approval will not be required for up to six doses as long as they are given at least 30 days apart and meet the guidelines of the American Academy of Pediatrics (AAP) for Synagis® administration. Any dose over the limit of six or administered after the RSV season (October–March) will require prior approval.

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

Synagis® (90378) (Cont'd.)

Providers must dose appropriately for each child according to his or her weight. Payment for doses in infants six months to two years of age must be in accordance with AAP guidelines. Providers using more than 50 mg of Synagis® must bill multiple units of the 50 mg vial, not to exceed four units.

SCDHHS will continue to conduct post-payment reviews of medical records relating to Synagis® administration and will recover funds for doses given outside the guidelines noted above.

PHYSICIANS BILLING FOR ADDITIONAL SERVICES

When it is necessary for a physician to render services in an infusion center, *e.g.*, in the event of an adverse reaction or other medical emergency, the physician may bill for the appropriate evaluation and management service using his or her individual provider number. Documentation should reflect the nature of the emergency and necessity for physician intervention. The medical record must also describe the services rendered by the physician and the time spent in treating the patient.

Prolonged Services (CPT 99354—99356)

These codes may be used in addition to the E/M visit code when there is more than 30 minutes of actual face-to-face physician time required beyond the usual service for the level of the E/M code billed. This code should only be used when the physician's expertise is medically necessary in evaluating and managing the patient over a prolonged period and specific documentation describes the content and duration of the service.

Critical Care Services (CPT 99291—99292)

These codes should only be used in situations requiring constant physician attendance of critically ill or unstable patients for a total of 30 minutes to one hour on a given day. These codes should only be used in situations significantly more complex than other chemotherapy situations.

SECTION 2 POLICIES AND PROCEDURES

INFUSION CENTERS

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