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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

A hospital is defined as a general acute care institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) Program.

All hospitals must be enrolled in the South Carolina Medicaid Program. In-state hospitals must also contract with the South Carolina Department of Health and Human Services (SCDHHS) to provide inpatient and outpatient services. Out-of-state hospitals within the medical service areas (normally within 25 miles of the state's borders) may follow the same contractual procedures as in-state providers. Please refer to Section 1, Requirements for Provider Participation, for instructions regarding provider enrollment.

Hospitals located more than 25 miles from the South Carolina borders do not contract with SCDHHS. These hospitals must complete an enrollment form and sign a provider agreement. Out-of-state referrals by physicians when the needed services are not available within the South Carolina Medical Service Area must be pre-authorized. See "Out-of-State Services" in this section for more information.

In order to receive Medicaid reimbursement for services, hospitals must meet the program requirements outlined in this manual.

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

Certification

Hospitals that are currently certified to participate in Title XVIII (Medicare) are deemed to meet all of the requirements for participation in Title XIX (Medicaid). Additionally, the following conditions must be met:

- 1. Personnel**

All patients must be treated by or under the direct supervision of a physician licensed to practice medicine in the state of South Carolina. When ancillary personnel are to be used in patient care, the written plan of care must indicate the extent of their involvement. The physician must demonstrate continued interest by professional encounters during the course of treatment. Evidence of staff supervision must be documented in the patient's record when interns and residents are providing a service. Please refer to Professional Services for policy on physician supervision.

- 2. Emergency Service Personnel**

A physician must screen all patients who arrive for treatment in the emergency room to assess level of care as mandated by COBRA/OBRA legislation.

Certification, Licensing, Contracts, and Enrollment

For Certification and Licensing contact:

Department of Health and Environmental Control
(DHEC)
Division of Certification and Licensing
2600 Bull Street
Columbia, SC 29201

For Medicaid Contract Negotiation contact:

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Certification, Licensing, Contracts, and Enrollment (Cont'd.)

For problems with enrollment, or to order provider enrollment forms, please write or call:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809
(803) 788-7622, ext. 41650

Contracts

In-state hospitals that want to contract with SCDHHS must submit a written request for participation to:

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

Copies of the Medicare/Medicaid Certification and Transmittal, CLIA Certification, and ESRD Certification, if appropriate, must accompany the request. The provider will then be requested to submit cost report information. New facilities will be requested to submit a report of projected costs. If this information is satisfactory, SCDHHS will send the provider two copies of the contract and Provider Enrollment forms. The provider will sign the contracts, complete the enrollment forms, and return all documents to the Contracts Division. The contracts will then be signed by the director of SCDHHS and one copy will be returned to the provider along with unique six-character provider numbers, one for inpatient and another for outpatient services. Provider numbers should be used on all claim forms, inquiries, and adjustment requests. Hospitals that bill for professional services provided by hospital-based physicians will be assigned an additional provider number for billing these services.

Clinical Laboratory Improvement Act (CLIA)

In accordance with federal regulations (42 CFR 493.1809), SCDHHS requires that all laboratory testing sites, including hospital laboratories, have a CLIA Certificate of Waiver, Certificate of Registration, or Regular Certificate (issued after successful completion of the lab survey), along with a unique 10-digit number, in order to perform laboratory tests. This 10-digit number must be on file with SCDHHS.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

BENEFICIARY REQUIREMENTS

Eligibility

Medicaid pays for covered medical services for individuals who are eligible during the month in which the services are rendered. Medicaid beneficiaries enrolled in Waiver programs may have limits and restrictions for Medicaid-reimbursable services. Refer to Section 1 for further information on Medicaid eligibility.

Medicaid beneficiaries in the following coverage groups are eligible for limited services. Please refer to Special Coverage Groups in this section for additional information on these groups:

- Family Planning
- Hospice

Beneficiaries in the following programs may have certain restrictions in obtaining covered services. For additional information on these programs refer to Medicaid Managed Care in this section.

- Managed Care Organizations (MCOs)
- Physician Enhanced Program (PEP)
- Medical Homes Local Network Program (MHLN)

Medicare/Medicaid (Dually Eligible)

Medicare is a hospital and medical insurance program administered by the Social Security Administration for eligible persons who have reached 65 years of age or have been determined blind, totally and permanently disabled, or who have end stage renal disease. Dually eligible individuals also qualify for Medicaid coverage.

Medicare has two parts. Part A (Hospital Insurance) pays the expenses of a patient in a hospital, skilled nursing facility, or at home when receiving services provided by a home health agency. Part B (Medical Insurance) helps pay for physician services, outpatient hospital services, inpatient ancillary charges when Part A benefits are exhausted or nonexistent, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicare/Medicaid (Dually Eligible) (Cont'd.)

Medicaid will pay the allowed amount less the amount paid by Medicare or the coinsurance and deductible amount, whichever is less. Medicaid does not cover any charges during Lifetime Reserve Days (LRD), the 91st to 150th day, or the continued stay when a patient has elected to use or not to use LRD. Medicaid does not cover a continued stay after LRDs are exhausted. Subsequent admissions in the same spell of illness are covered. Refer to Section 3 for billing guidelines for Lifetime Reserve Days.

When a beneficiary's Medicare eligibility is limited to Part B coverage only, Medicaid pays for all inpatient services except for those ancillary services covered by Part B. It is very important to see the beneficiary's Medicare card to determine the extent of his or her coverage. If the Medicare card is not available, you may use the Interactive Voice Response System (IVRS) at (888) 809-3040 or the Medicare Direct Data Inquiry (DDI) to verify eligibility.

Claims submitted to SCDHHS that have been denied by Medicare for medical necessity based on Medicare Local Medical Review Policies (LMRP) will not be paid by Medicaid. If Medicare has an LMRP in which the service/test is considered to be not medically necessary, then Medicaid will not pay the deductible or co-insurance for these non-covered charges. The notice of non-coverage by Medicare to notify patients that the service(s) is not covered may also serve as the notification to the patient that Medicaid will not cover the service. If the patient is given advance notice of non-coverage then the patient may be billed for the non-covered charges.

All services rendered to dually eligible Medicare/Medicaid patients should be filed to Medicare first. Refer to Section 3 for billing guidelines.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Days in a Spell of Illness	Medicare Part A	Medicaid
1 through 60	Pays all but the deductible, plus blood deductibles of three pints	Pays deductible including blood*
61 through 90	Pays all but coinsurance, equal to one-quarter of deductible per day	Pays daily coinsurance*
91 through 150	Lifetime Reserve Days — Pays all but coinsurance, equal to one-half of deductible per day	Does not pay during this period
151+	Does not pay after Lifetime Reserve Days are exhausted unless spell of illness is broken for 60 days	Does not pay during this period

* Medicaid will pay the allowed amount less the amount paid by Medicare or the coinsurance and deductible amount, whichever is less.

Medicare/Medicaid (Dually Eligible) (Cont'd.)

As of January, 2005:

Deductible = \$912

Regular Coinsurance = $\$228 \times 30 = \6840

Total = $\$912 + \$6840 = \$7752$

As of January, 2004:

Deductible = \$876

Regular Coinsurance = $\$219 \times 30 = \6570

Total = $\$876 + \$6570 = \$7446$

As of January, 2003:

Deductible = \$840

Regular Coinsurance = $\$210 \times 30 = \6300

Total = $\$840 + \$6300 = \$7140$

Medicaid as Primary Insurer

Medicaid is considered the payer of last resort. The programs listed below are some exceptions to the payer of last resort mandate. In these cases Medicaid must be billed as the primary insurer.

- BabyNet
- Best Chance Network
- Black Lung
- Community Health
- Crime Victims Compensation Fund

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Medicaid as Primary Insurer (Cont'd.)

- CRS Children's Rehabilitative Services
- DHEC Family Planning (DHEC Maternal Child Health)
- Indian Health
- Migrant Health
- Ryan White Program
- State Aid Cancer Program
- Vaccine Injury Compensation
- Veterans Administration
- Vocational Rehabilitation Services

UTILIZATION REVIEW

Hospital Utilization Review

Federal regulations require hospitals to have in effect a written utilization review plan that provides for a review of each beneficiary's need for services (42 CFR 456, Subpart C).

Notice of Non-Coverage Letter

A hospital (acting directly or through its utilization review committee) may issue a South Carolina Medicaid Notice of Non-Coverage letter during a stay if the hospital determines that the beneficiary no longer requires hospital care, and either of the following applies:

- The attending physician concurs with the decision in writing (*e.g.*, written discharge order).
- The Quality Improvement Organization (QIO) reviews the care and concurs with the decision of the hospital.

After receipt of the concurrence of either the physician or the QIO, the hospital must notify the beneficiary, in writing, that:

- The hospital has determined, with concurrence of the attending physician or the QIO, that the beneficiary no longer requires hospital care.
- The patient will be liable for the hospital's customary charges for continued stay.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Notice of Non-Coverage Letter (Cont'd.)

- If the patient remains in the hospital after he or she becomes liable, the QIO will make a formal determination of the medical necessity and appropriateness of the hospitalization.
- This formal determination is subject to reconsideration at the request of the patient, hospital, or attending physician.
- If a finding is subsequently made that the patient required continued hospital care, any monies for continued stay collected from the patient will be refunded by the hospital.
- A reconsideration upheld by the QIO is binding and is not subject to an appeal.

Once the hospital's utilization review committee determines that acute care is no longer required, the hospital must administratively discharge the patient within 48 hours of issuing the notice of non-coverage. The patient is then responsible for any days he or she remains in the hospital after the non-coverage letter is issued. Refer to Section 5 for copies of the notice of non-coverage letters.

Quality Improvement Organization

SCDHHS contracts for external utilization review services with a Quality Improvement Organization (QIO). Carolina Medical Review (CMR) is the current QIO contractor. The QIO review consists of:

- Pre-surgical review for all hysterectomies
- A retrospective review of a sample of paid inpatient/outpatient hospital claims
- Select project studies
- Managed care organizations' external quality assurance evaluations
- Medical record review for select procedures

Screening criteria for the above may be obtained upon request from CMR.

The QIO may also review or reconsider cases in the following situations:

- The hospital and/or physician may request a reconsideration of any case initially denied by the hospital utilization review committee.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Quality Improvement Organization (Cont'd.)

- The patient may request that the QIO review any admission or partial admission denied by the hospital UR committee.
- The patient may request that the QIO review the termination of administrative days issued by the hospital.
- When the attending physician and hospital UR committee disagree, the case should be referred to the QIO. The QIO will make a determination within one business day of the time medical records are received.

In the above situations, the decision of the QIO is final and binding upon all parties (CFR 473.38).

All Medicaid hospital claims are subject to both prepayment and postpayment review by SCDHHS and/or the QIO. Should either determine that procedures were not followed, services were not medically necessary, or the proper diagnosis and procedure codes were not indicated (resulting in improper DRG coding for inpatient claims or upcoding for outpatient claims), payment will be denied or reduced. If the claim has been paid, action will be taken to recoup the payment.

SCDHHS reserves the right to review retrospectively any case that has received prior approval to assure accuracy and compliance with South Carolina Medicaid guidelines and federal requirements. Telephone or written approval is not a guarantee of Medicaid payment. All cases are subject to retrospective review to validate the medical record documentation.

Pre-Surgical Justification for Elective Hysterectomies from CMR

All prior approval requests for hysterectomies must be made in writing using the South Carolina Medicaid Program Surgical Justification Form for Hysterectomy and the Acknowledgement of Receipt of Hysterectomy Information (DHHS Form 1729). Copies of these forms are located in the Section 5 of this manual. Completed forms must be submitted at least 30 days prior to the scheduled date of surgery to:

Hysterectomy Review
Carolina Medical Review
250 Berryhill Road, Suite 101
Columbia, SC 29210

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Pre-Surgical Justification for Elective Hysterectomies from CMR (Cont'd.)

CMR staff can be reached locally at (803) 731-8225 or (800) 922-3089.

Urgent and emergent hysterectomy cases will be reviewed retrospectively. Please refer to Special Coverage Issues in this section for additional Medicaid policies for hysterectomies.

Cases that do not meet the QIO criteria will be referred for physician consultant review. The physician consultant will use clinical judgment to determine whether the proposed treatment was appropriate to the individual circumstances of the referred case. Pre-approved cases will not be subject to retrospective review by the QIO. However, SCDHHS reserves the right to review any paid claim and recoup payment when medical necessity requirements are not met.

The patient and physician shall make the final decision as to whether to undergo surgery. Medicaid will not sponsor the hospital-related expenses associated with the surgery if the QIO physician consultant determines that the proposed surgery is not appropriate.

Retrospective Reviews

Medicaid requires the QIO to retrospectively review a sample of paid hospital claims. The review policies applicable to retrospective review include but are not limited to medical record documentation, DRG validation, hospital-issued denials, and discharge planning. Screening criteria may be obtained upon request from CMR.

When the QIO retrospective review determines that the service/procedure did not require an inpatient admission, SCDHHS will recoup the paid inpatient claim and allow the hospital to receive payment for a one-day stay. The hospital receives notification from SCDHHS that a recoupment is forthcoming.

Time Limit for Submitting Records for QIO Review

Medical records requested by the QIO must be submitted to CMR within 30 days of the letter requesting the records. Medicaid will reimburse providers for copying medical records requested by the QIO and for postage. All other records requested by SCDHHS must be provided free of charge.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Technical Denials

Technical denials occur when medical records or other documents requested by the QIO are not received within 30 days.

Once CMR sends notification that a technical denial has been issued, hospitals are given an additional 60 days to produce the records or documents. If records or documents are not received within 60 days, SCDHHS will recoup the hospital payment. Once a recoupment is made by SCDHHS on a technical denial, it is not subject to reconsideration.

All correspondence related to technical denials along with a copy of the CMR technical denial letter should be sent to:

Carolina Medical Review
Attention: Technical Denial
250 Berryhill Road, Suite 101
Columbia, SC 29210

Project Studies

SCDHHS has contracted with CMR to conduct select project studies. The project studies will look for patterns of care and positive outcomes which, when shared with physicians and the hospital community, will lead to systematic improvement in the overall health care delivery system. These studies enable hospitals and physicians to compare their performance with recognized optimal levels of practice. Project studies involve pattern analysis, feedback of individual and comparative data to participating hospitals and physicians, and collaboration with hospitals to develop plans for improvement of processes and outcomes.

Documentation Requirements

The appropriate documentation must appear in the patient's medical record, including the illness, history, physical findings, diagnosis, and prescribed treatment to justify medical necessity for the level of service reimbursed. **Documentation must be legible** and must also meet the standards outlined in Section 1 of this manual.

Medicaid requires that providers 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Authorization

SCDHHS contracts with a quality improvement organization (QIO), Carolina Medical Review (CMR), to perform presurgical review of select surgical procedures.

CMR will answer questions regarding pending reviews only. General prior approval (PA) questions should be directed to the appropriate program representative. CMR staff can be reached at (803) 731-8225 or 1-800-922-3089.

All documentation must be mailed. Providers must send all available information along with the request (*i.e.*, history and physical, photographs, and recommendations). **CMR will not accept medical review documentation via facsimile.**

Prior approval (PA) requests for beneficiaries enrolled in PEP, MHLN, or hospice programs must receive a PA from these programs before contacting the QIO.

Prior approval requests for beneficiaries enrolled in a Managed Care Organization (MCO) program must be handled by the MCO only. At present, the Medicaid-enrolled MCOs are Select Health and Better Health Plans (BHP). Select Health may be contacted toll free at (888) 559-1010. BHP may be contacted toll free at (800) 600-9007.

Requesting physicians are responsible for providing the PA number to any facility or medical provider who will submit a Medicaid claim related to the service.

A list of procedure codes requiring prior authorization from CMR can be found in Section 4 of this manual.

Support Documentation

All support documentation must be attached hard copy to the UB-92.

A list of procedure codes requiring support documentation from CMR can be found in Section 4 of this manual.

Instructions for Obtaining Prior Authorization

The responsibility for obtaining pre-admission/pre-procedure review rests with the attending physician. The physician must submit all necessary documents including the Request for Prior Approval Form to:

Carolina Medical Review
Attn: S.C. Medicaid Prior Authorization Request
250 Berryhill Road, Suite 101
Columbia, SC 29210

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Instructions for Obtaining Prior Authorization (Cont'd.)

The QIO (Quality Improvement Organization) reviewer will screen the medical information provided using the appropriate QIO criteria.

If criteria are met, the procedure will be approved and an authorization number assigned. The approval and authorization number will be given by written confirmation to the physician. Enter this number in item 63 of the UB-92.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician consultant. If the physician consultant cannot approve the admission/procedure based on the initial information provided, he or she will make a reasonable effort to contact the attending physician for additional supporting documentation.

The physician consultant will document any additional information provided, as well as his or her decision regarding the medical necessity and appropriateness of the procedure.

Review personnel will assign an approval number (if the procedure is approved), and a written copy of the authorization number will be sent to the physician.

If the physician consultant cannot approve the procedure based on the additional information, he or she will document the reasons for the decision. QIO review personnel will notify the attending physician's office of the denial.

Procedure for Reconsideration of Denial of Prior Approval

- The physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was a pre-procedure or post-procedure review. The request should be in writing to CMR.
- If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFR 473.38).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Medicaid will only pay for services that are medically necessary and are covered services as outlined in this manual. “Medically necessary” services include those services directed toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain. The service must (1) be consistent with the diagnosis and treatment of the patient’s condition, (2) be in accordance with standards of good medicine, (3) be required for reasons other than the convenience of the patient or the physician, and (4) be performed in the least costly setting required by the patient’s condition. Federal regulations require hospitals to certify the accuracy of the diagnostic and procedural information, as well as to attest to the accuracy of each claim before it is submitted.

Reimbursement for inpatient hospital admissions is made to a hospital on a prospective payment basis. All covered services are included in this payment, and the Medicaid beneficiary cannot be billed for any of these services. **Services specifically excluded from coverage may be billed to Medicaid beneficiaries provided they are advised in advance that such services are non-covered.**

Reimbursement for outpatient hospital services is based on a fee schedule. All covered services are paid by one of three reimbursement types. A Medicaid beneficiary cannot be billed for a non-covered service unless he or she is advised before the service is rendered that it is non-covered. **A Medicaid beneficiary cannot be charged for services if he or she is unaware of his or her responsibility.**

When a patient is Medicaid eligible for only part of a hospital stay, the non-covered portion may be billed to the patient. However, charges for the entire admission should appear on the UB-92 and the system will prorate accordingly.

If the hospital stay is for a non-covered procedure only, then no payment will be made by Medicaid. The patient may be billed. If the hospital stay is for a procedure that is covered and a procedure that is non-covered, payment for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PROGRAM SERVICES (CONT'D.)

the covered procedure can be made. The patient may be billed for the non-covered procedure. Charges for the non-covered procedure should appear in the non-covered column on the UB-92. Refer to Section 3 for specific billing instructions.

INPATIENT HOSPITAL SERVICES

An inpatient is a patient who is admitted to a medical facility on the recommendation of a physician or dentist, is receiving specialized institutional and professional services on a continuous basis, and is expected to require such specialized services for a period generally greater than 24 hours. Exceptions to the 24-hour requirement for inpatients include but are not limited to deaths (including ER admission), false labor, deliveries, and medical transfers.

Inpatient services are defined as those items and services which are medically appropriate to the inpatient hospital setting and meet the medical necessity requirements outlined in the criteria and policies of the QIO. These items and services must be directed and documented by a licensed physician in accordance with hospital bylaws in a facility meeting hospital criteria.

Inpatient hospital reimbursement is based on the hybrid prospective payment system methodology. All services rendered during an inpatient stay are included in the diagnosis related group (DRG) reimbursement. Outpatient services that result in an inpatient admission are deemed to be inpatient services and are included in the DRG payment. Outpatient services rendered on the day of admission are included in the DRG payment regardless of relation to the inpatient admission. All outpatient services rendered during an inpatient stay are included in the DRG payment, including charges for tests or procedures performed by another general acute care hospital. In such cases the admitting hospital is responsible for reimbursing the performing hospital for its services. The formulas used to calculate inpatient hospital payments are located in Section 4 of this manual.

The South Carolina Medicaid State Plan limits coverage of inpatient hospital services to general acute care hospital and psychiatric hospital services for individuals under age 21. Inpatient rehabilitative services provided in a distinct medical rehabilitation facility or a separately licensed

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

INPATIENT HOSPITAL SERVICES (CONT'D.)

specialty hospital are not reimbursable. Medicaid will reimburse rehabilitation services rendered to Medicaid beneficiaries on an inpatient or outpatient basis at a general acute care hospital.

Covered Days

The number of days of care provided to Medicaid patients is always counted in units of full days. For Medicaid purposes, a day begins at midnight even if the hospital uses a different definition of a day. The day of discharge is not counted as a covered day. Services provided on the day of discharge beyond checkout time for the comfort or convenience of the patient are not covered under Medicaid and may be billed to the patient.

Outliers

There are two types of outliers: day and cost outliers. A day outlier occurs if the beneficiary's length of stay exceeds the statewide average by a specified amount. A cost outlier occurs if a hospital's charges exceed a specified amount above the statewide average price. Claims that qualify for both a day and a cost outlier receive the greater of the two payments. The Medicaid Management Information System (MMIS) will automatically calculate outliers.

Note: Cost and day outlier thresholds are established using statewide data. Additional information regarding these calculations may be obtained by calling the Division of Acute Care Reimbursement at (803) 898-1030.

Admission/Discharge Criteria

An admission occurs when the Severity of Illness/ Intensity of Service (SIIS) criteria are met and the physician expects the patient to remain in the hospital longer than 24 hours. SIIS requirements are outlined in the criteria and policies of the QIO under contract with SCDHHS. If the SIIS criteria are met, an admission is then appropriate regardless of the time spent in the hospital.

A person is considered discharged when formally released from an acute care facility. A patient is also considered discharged (1) when the patient is transferred to another acute care facility, (2) when the patient is discharged to a long term care facility, (3) when the patient dies, (4) when the patient leaves against medical advice, or (5) when the patient is transferred to a psychiatric or rehabilitation unit.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Types of Inpatient Admissions

Elective Admission

An elective admission occurs when a patient's condition requires non-urgent treatment that can be anticipated or scheduled in advance without posing a threat to the patient's health outcome. When a physician calls to schedule an admission for non-urgent treatment and finds a bed immediately available and admits the patient, the admission is still considered elective. Admissions for elective procedures must take place on a weekday unless there is a valid medical reason for a weekend admission. Friday is considered part of the weekend.

One-Day Admissions

A one-day admission occurs when a patient is admitted to a hospital one day and discharged anytime during the next calendar day. This stay may be billed as an inpatient admission when the admission criteria have been met.

Admission From an Observation Unit

When a patient is admitted to the hospital from an observation stay, bill the date the beneficiary was switched from observation to inpatient status as the first day of the inpatient admission. Only if the observation stay is unrelated to the inpatient admission, excluding the day of admission, can the observation days be billed as outpatient services. Observation stays related to and within 72 hours of the inpatient admission are considered inpatient services and are included in the DRG payment. Refer to Pre-Admission Services (72-hour Rule).

Readmission

A re-admission occurs when a patient is admitted to the same or any other facility within 30 days of discharge for the same DRG or general diagnosis as the original admission. Re-admissions are subject to postpayment review and may be paid as two separate admissions unless the postpayment reviewer denies one of the admissions.

Transfers

A patient is considered transferred when moved from one acute inpatient facility to another acute inpatient facility. A transfer does not occur until the patient is actually moved by the transport team. SCDHHS will consider a transfer for social reasons provided the medical records justify the need for the transfer and the patient still requires acute hospital care.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Segmented Care/Leave of Absence

A hospital may place a patient on a leave of absence (LOA) when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples include but are not limited to situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. The hospital stay must be billed as one admission and charges for the LOA days must be shown as non-covered.

Mother/Newborn Admissions

Charges for the mother and newborn child must be separated and submitted on two claims. All charges associated with the mother must be submitted on one claim using the mother's Medicaid ID number. Charges associated with the newborn child must be submitted on another claim using the newborn's Medicaid ID number. Providers should contact the SCDHHS county office for a newborn's Medicaid Number. See Section 5 for a list of county offices.

Exception: In an effort to ensure timely access to critical AZT therapy for at-risk newborns and to maximize patient compliance, SCDHHS allows the pharmacy or hospital provider to bill Medicaid using the mother's Partners for Health Insurance Number when dispensing the initial six weeks' home supply of AZT syrup. Billing this drug to the mother's Medicaid identification number is permissible only in those instances where the newborn has not yet been assigned a Partners for Health Insurance Number at the time of discharge.

The Department of Health and Environmental Control (DHEC) has recommended that the first injection of the Hepatitis B series be administered while the infant is in the hospital. The hospital reimbursement is an all-inclusive payment for services rendered during that hospital stay and thus includes the Hepatitis B vaccine.

When billing for the administration of the Hepatitis B vaccine the appropriate procedure code is 99.55, prophylactic administration of vaccine against other diseases. Code V05.3, inoculation against Viral Hepatitis, should not be used for the administration of the Hepatitis B vaccine to infants unless it is justified by the medical condition of the infants. This diagnosis code will be disallowed unless the medical record documentation justifies its use.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Inpatient Covered Services

Accommodations

The Medicaid program sponsors semi-private or ward accommodations. A private room or other accommodations more expensive than semi-private will be allowed when such accommodations are certified as medically necessary by the attending physician or when the hospital only has private rooms. Private rooms will be considered medically necessary only when the patient's condition requires him or her to be isolated to protect his or her own health or welfare, or to protect the health and welfare of others. Patients requesting a private room or more expensive room may be billed the difference between the private/more expensive and the semi-private room rate.

Drugs

Drugs prescribed for and dispensed to an inpatient are covered and are included in the DRG payment. Those drugs furnished by a hospital to an inpatient for use outside the hospital are generally not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital and a limited supply is required until the patient can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service. Drugs furnished to a patient on discharge shall be limited to a maximum five-day supply and are covered as part of the inpatient stay.

The Hepatitis B vaccine and Respigam/Synagis® administered to an infant in the hospital are included in the hospital's DRG payment. For newborns, Medicaid will allow a six weeks' supply of zidovudine (AZT) syrup to be billed by the hospital or pharmacy provider. The AZT syrup can **only** be billed under the mother's Medicaid ID number when the newborn does not have an assigned Medicaid ID number at the time of discharge.

Supplies, Appliances, and Equipment

Items furnished by the hospital for the care and treatment of the patient during his or her inpatient stay are covered inpatient hospital services and are included in the DRG payment. Under certain circumstances, supplies, appliances, and equipment used during the inpatient stay are covered even though they are taken with the patient when he or she is discharged. These are circumstances in which it would be unreasonable or impossible from a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Supplies, Appliances, and Equipment (Cont'd.)

medical standpoint to limit the patient's use of the items to the periods during which the individual is an inpatient. Examples of items covered under this policy include but are not limited to cardiac valves, cardiac pacemakers, and artificial limbs, which are permanently installed in or attached to the patient's body while an inpatient of the hospital.

Items such as tracheostomy tubes or drainage tubes that are temporarily installed or attached to the patient's body during inpatient treatment, are necessary to permit or facilitate the patient's release from the hospital, and are required until the patient can obtain a continuing supply, are covered as an inpatient hospital service. Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not covered as inpatient hospital services.

Cancelled or Incomplete Surgery

When there are charges associated with surgery such as operating room, anesthesia, or recovery room and the surgery is incomplete or cancelled, Medicaid can be billed. Refer to Section 3 for billing instructions.

Services for Mental Disease

Medicaid patients admitted to a general acute care hospital for the treatment of mental disease are sponsored in the same way as patients for any other disease. Patients may be any age, and coverage is the same as for any other patient. Treatment furnished under the direction of the attending physician is covered.

Treatment for Medicaid patients in a psychiatric hospital is subject to the federal regulations regarding "institution for mental diseases" as cited in 42 CFR 441 Subpart D. Medicaid funds are available for inpatient psychiatric services rendered in a psychiatric hospital for individuals under age 21. If the beneficiary is receiving services immediately before he or she reaches 21, Medicaid will sponsor services until the beneficiary no longer requires the services or until the beneficiary reaches age 22, whichever is earlier. For further information, call the Department of Behavioral Health Services at (803) 898-2565.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OUTPATIENT HOSPITAL SERVICES

Outpatient hospital services are diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished by or under the direction of a physician or dentist to an outpatient in an institution licensed and certified as a hospital. Outpatient services may include scheduled services, surgery, observation room and board, and emergency services provided in an area meeting licensing and certification criteria.

An outpatient is a patient who is receiving professional services at a hospital for a period generally not to exceed 24 hours. An outpatient may be admitted to a room by an attending physician for either daytime or overnight observation. For additional information on observation, refer to Outpatient Observation in this section.

Outpatient Services

Medicaid outpatient hospital services are paid by a fee schedule. Outpatient services are divided into three major categories. The category and reimbursement types for outpatient services are as follows:

- Outpatient Surgical Services — Reimbursement Type 1
- Outpatient Non-Surgical Services — Reimbursement Type 5
- Treatment/Therapy/Testing Services — Reimbursement Type 4

The outpatient fee schedule is designed to reimburse for actual services rendered. Only one category of service, based on the highest classification billed, is paid per claim. Reimbursement is based on the fee schedule rate or the charges reflected on the claim, whichever is less.

The fee schedule can be found in Section 4 of this manual and on the SCDHHS Web site at **www.dhhs.state.sc.us**.

A. Outpatient Surgical Services — Reimbursement Type 1

When an outpatient claim includes a covered HCPCS surgical procedure code, it will be paid as a reimbursement type 1. Reimbursement type 1 is an all-inclusive payment determined by the rate assigned to the surgery performed. The all-inclusive fee includes charges for laboratory and radiology services, anesthesia, blood, drugs and supplies, nursing services, use of the operating room and recovery room, and all other services related to the surgery. Pre-

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

A. Outpatient Surgical Services — Reimbursement Type 1 (Cont'd.)

surgical services performed prior to the actual day of outpatient surgery must be reflected on the same bill as the surgery and should not be submitted as a separate bill.

Multiple surgical procedures will be paid at the highest surgical rate. A list of surgical procedure codes and their rates can be found on the SCDHHS Web site. Surgeries covered by Medicaid that are not on this list will be assigned a rate by SCDHHS. Diagnostic and therapeutic procedures, non-surgical HCPCS codes, are not reimbursed as surgeries by Medicaid and will be paid at the next appropriate reimbursement type.

The following services may be paid as add-ons to reimbursement type 1 claims:

- Observation room, revenue code 762 or 769
- Vitrasert® implant, revenue code 636 with HCPCS code J7310
- Depo-Provera®, revenue code 636 with HCPCS code J1055
- Synagis®, revenue code 636 with HCPCS code 90378

B. Outpatient Non-Surgical Services — Reimbursement Type 5

An outpatient claim is classified as non-surgical, reimbursement type 5, when the claim shows an emergency room (revenue code 450), clinic visit (revenue codes 510, 511, 512, 513, 514, 515, 516, 517, 519), or treatment room (revenue code 761) without an appropriate HCPCS surgical procedure code present. Reimbursement type 5 with an emergency room service (revenue code 450) is paid as an all-inclusive fee determined by the level of the diagnosis, *i.e.*, non-emergent, urgent, or emergent visit. The fee includes all services performed during the day of the visit except for the allowed add-ons listed below. This would include patients that are sent to multiple areas of the hospital for additional services.

Claims with multiple diagnosis codes will be paid at the highest level. A list of diagnosis codes by reimbursement level can be found on the SCDHHS Web site. Diagnosis codes covered by Medicaid that are not on the list will be assigned a payment level by SCDHHS.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

B. Outpatient Non-Surgical Services — Reimbursement Type 5 (Cont'd.)

Only one payment per day will be made for emergency room, clinic visit, and/or treatment room for the same or related diagnosis. If a beneficiary is seen in the emergency room, clinic, and/or treatment room on different dates of service for unrelated conditions, all visits are eligible for reimbursement and can be submitted on one bill as long as the revenue code, date of service, HCPCS code, and units are not duplicated on any line. Medical records may be requested in order to verify that the services were unrelated. See Section 3 for billing instructions.

The following services may be paid as add-ons to reimbursement type 5 claims:

- Observation room, revenue code 762 or 769
- Vitrasert® implant, revenue code 636 with J7310
- Depo-Provera®, revenue code 636 with HCPCS code J1055
- Synagis®, revenue code 636 with 90378

C. Treatment/Therapy/Testing (TTT) Services — Reimbursement Type 4

An outpatient claim falls into the treatment/therapy/testing (TTT) category when it does not meet either of the previous two criteria. TTT services are reimbursed a rate for the revenue code or HCPCS code as outlined in the outpatient fee schedule.

Payment for TTT services is based on the revenue code alone, except for two distinct types of services: radiology and laboratory/pathology. For these revenue codes, HCPCS codes must also be identified. HCPCS codes for radiology services fall in the 70000–79999 range; HCPCS codes for laboratory/pathology services fall in the 80000–89999 range. A list of the HCPCS codes and the Medicaid reimbursement can be found on the SCDHHS website.

Revenue codes that do not require a HCPCS code may be reimbursed as an all-inclusive rate per unit of service or per date of service. Multiple revenue codes may be reimbursed per date of service. TTT services may be span billed for the same or related diagnosis.

The payment amounts for TTT services include all related non-physician services. Separate payment **will not** be made for drugs, injections, supplies, room charges, etc.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Therapies

Physical, occupational, and speech therapies are sponsored benefits on an outpatient basis under the following conditions:

- The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded.
- The attending physician prescribes therapy as a direct result of outpatient surgery.
- The attending physician prescribes therapy to avoid an inpatient hospital admission.

The patient's record must substantiate one of these requirements for therapy. The payment for outpatient therapies includes all related non-physician services.

Outpatient Observation

Observation services are furnished by a hospital on its premises and include the use of a bed and periodic monitoring by a hospital's nursing or other staff. Such services must be reasonable and necessary to evaluate an outpatient's condition or to determine whether there is a need for admission as an inpatient. These services usually do not exceed one day and must be ordered verbally and/or authenticated by signature of a physician or another individual authorized by state licensure law and hospital bylaws to admit patients to the hospital. The period of observation begins when the physician orders observation and when the monitoring of the patient actually begins. Observation ends when ordered verbally and/or authenticated by signature of a physician or another individual authorized by state licensure law and hospital bylaws to discontinue such treatment.

The observation room revenue code (762 and 769) units **do not** multiply. Each 24 hours of observation can be filed on one claim for multiple dates of service. While observation services usually do not exceed 24 hours, they may exceed 24 hours in some cases and are not explicitly limited in duration.

Note: In cases where the observation stay must span two calendar days, to equal 24 hours, observation should not be billed for both days.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Observation (Cont'd.)

Outpatient observation charges must be billed using either revenue code 762 or 769 for up to 24 hours of continuous service. The observation period shall commence when the patient is formally admitted to an observation room. The attending physician may admit the patient for daytime or overnight observation. Observation charges may be reimbursed in addition to the surgical and non-surgical payment.

Observation days prior to an inpatient admission can be billed as outpatient services when the observation stay is unrelated to the inpatient admission, excluding the day of admission. Bill the date the beneficiary was switched from observation to inpatient status as the first day of the hospital admission. Observation stays related to and within 72 hours of an admission are considered inpatient services and are included in the inpatient DRG payment. Refer to Section 3 for specific billing instructions.

Observation should only be billed if the patient meets the conditions for observation. Do not substitute outpatient observation services for medically appropriate inpatient admissions. Test preparation, whether performed by the patient or the facility by itself, does not qualify for observation and observation should not be billed concurrently with the test. In addition, observation services should not automatically be billed because the time for normal recovery from a surgical procedure is exceeded. Observation would be appropriate when the recovery period exceeds normal expectations for the type of surgery and when the patient's condition requires observation.

Treatment Room

The use of a treatment room may be appropriate for procedures that do not require the resources of a surgical suite or for facilities that do not have an endoscopic suite. Treatment room charges should normally be limited to no more than two hours, and usually less. Treatment room charges are a substitute for those room charges and not an additional line item. It is not appropriate to show treatment room charges in order to augment reimbursement. Refer to Section 3 for specific billing instructions.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Pre-Admission Services (72-hour Rule)

Outpatient services rendered to a beneficiary within the three days prior to the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient diagnosis-related group (DRG). This provision applies when the outpatient services are related to the admission, *i.e.*, they are furnished in connection with the principal diagnosis that necessitates the patient's admission as an inpatient. For example, if a patient is admitted on a Wednesday, services provided by the hospital on the previous Sunday, Monday, and Tuesday are included in the inpatient DRG payment.

All outpatient services rendered on the day of an inpatient admission are included in the DRG payment regardless of diagnosis. **Pre-admission services may not be billed separately as outpatient services.**

Specimen Collection Fees

Specimen collection fees are not billable to Medicaid as a separate line item. Specimen collection fees are considered part of the specimen test.

Immunizations

Immunizations are compensable as part of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Drugs

Drugs administered to patients during outpatient treatment are not separately reimbursed. The reimbursement for drugs and biologicals is included in the all-inclusive outpatient payment with the exception of the add-ons: Depo-Provera®, Vitrasert®, and Synagis®.

Self-Administered Drugs

Self-administered drugs (SADs) given in an outpatient setting are not separately reimbursed by SCDHHS. Payment for SADs is instead included in the all-inclusive outpatient reimbursement, to include dually eligible beneficiaries.

Two factors are used in determining whether a drug should be considered self-administered:

- The usual method of administering the drug
- The form of the drug (*i.e.*, oral, injected, etc.)

For example, oral medications provided to patients in an outpatient setting are considered SADs since such drugs are usually self-administered.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Self-Administered Drugs (Cont'd.)

As a further illustration, according to these guidelines, insulin is excluded from coverage unless administered to the patient in an emergency situation (*e.g.*, diabetic coma), in which case the SAD is covered in the all-inclusive emergency room reimbursement.

Laboratory Tests, EKGs, and X-rays

Laboratory tests, EKGs, and x-rays are covered under Medicaid if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. The physician must specify the actual tests to be performed.

For clinical laboratory tests, if a panel is requested, the professional judgment of the physician must dictate the medical necessity of the complete panel instead of an individual test. Likewise, individual tests ordered by a physician must indicate a medical reason for the individual test in lieu of a panel that is less expensive. All the tests in the definition of a panel must be performed for the provider to use that panel's HCPCS codes. The physician should review what tests are in the panels and not order individual tests that might duplicate tests.

Laboratory tests, EKGs, x-rays, and similar ancillary services must be medically justified as a necessary part of the patient's care. To justify the use of many special tests where the final diagnosis is uncomplicated, the record must substantiate why a more complicated test was considered. The requirements for ancillary tests must be indicated and authenticated by signature of the physician. The results of the ancillary testing must be entered into the patient's record.

Note: SCDHHS will allow a hospital to bill for services performed at another laboratory, provided that the following requirements are met: (1) the hospital and the laboratory must have a written agreement that the laboratory will look solely to the hospital for reimbursement and will not independently bill S.C. Medicaid for these services; (2) the arrangement will result in no additional cost to the S.C. Medicaid program (*e.g.*, no "mark-up" by the hospital, no administrative fees, no handling charges, etc.); and (3) the hospital should bill the charge which is submitted to all other payers. SCDHHS should not receive two bills for the same service and SCDHHS should not incur any additional expenses as the result of this practice.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Depo-Provera®, Vitrasert®, and Synagis®

Depo-Provera® may be billed in addition to a clinic visit when family counseling is provided or separately under the TTT category. Vitrasert® may be billed in addition to a surgical claim. These codes must be billed using revenue code 636 and the following HCPCS codes:

- Depo-Provera®, HCPCS code J1055
- Vitrasert®, HCPCS code J7310
- Synagis®, HCPCS code 90378

Physician Services

The physician component (services for direct patient care) for outpatient services must be billed separately on a Health Insurance Claim (CMS-1500) form. **Payment is based on the physician's Medicaid fee schedule.** All hospital-based physician services not included in the outpatient fee schedule may be billed under the hospital-based physician or group number assigned to the hospital, except hospital-based neonatologists and anesthesiologists, who must bill under their individual provider numbers. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for specific policy and billing requirements.

When a physician establishes an office within a hospital or other institution, reimbursement for services and supplies furnished in the office must be determined in accordance with the “incident to a physician's professional service” criteria as outlined by federal regulation.

A distinction must be made between the physician's office and the institution of which the physician is the administrator or owner. For services to be covered, the auxiliary medical personnel must be members of the office staff rather than the institution's staff, and the cost of supplies must represent an expense of the physician's office practice.

Outpatient Medical Records

When a patient is seen on repeat outpatient visits, the patient's record must show that the supervising physician is keeping abreast of the patient's progress and need for continuing care. If the patient's condition warrants more than one visit per month, the record must reflect a specific plan of care that justifies the need for these visits. Outpatient medical records must also meet the standards outlined in Section 1 of this manual and in Medical Record and Documentation Requirements in this section.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Fee Schedule

The outpatient fee schedule can be found in Section 4 of this manual.

PROFESSIONAL SERVICES

The following professional services may be rendered in a hospital inpatient, outpatient, or clinic setting. Guidelines for coverage and reimbursement can be found in the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual. Services rendered must be billed on a CMS-1500 claim form.

Hospital-Salaried/Hospital-Based Physician

A hospital-salaried or hospital-based physician is a physician licensed to practice medicine or osteopathy. This individual is employed by a hospital; payment for the physician's services is claimed by the hospital as an allowable cost under the Medicaid program and billed by the contracted hospital.

Physician's Assistant

A physician's assistant is a health professional who performs such tasks as are approved by the State Board of Medical Examiners in the state where he or she renders services in a dependent relationship with his or her supervising physician and under personal supervision as defined in the Direct Physician Supervision section of the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual. Medicaid reimbursement will be made to the supervising physician, clinic, or hospital where the professional is employed and where the service is rendered under the criteria in the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual.

Certified Registered Nurse Anesthetist/Anesthetist Assistant

A Certified Registered Nurse Anesthetist (CRNA) or Anesthetist Assistant (AA) must be licensed to practice as a registered nurse and CRNA/AA in the state where he or she is rendering services. CRNAs may work independently or under the supervision of an anesthesiologist. AAs may only work under the supervision of an anesthesiologist. CRNA services rendered by a hospital-based CRNA may be billed under the hospital-based physician's number assigned to that hospital. However, each CRNA must be enrolled in the Medicaid program and his or her individual CRNA provider number must appear on the CMS-1500 claim form.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Certified Nurse Midwife

A Certified Nurse Midwife (CNM) must be licensed to practice as a registered nurse and as a certified nurse midwife in the state where he or she is rendering services. The CNM practices under the supervision of a physician preceptor according to mutually agreed-upon protocol. CNM services may be reimbursed under the midwife's Medicaid provider number or the supervising physician's Medicaid number.

Nurse Practitioner/Clinical Nurse Specialist

A Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) has completed an advanced formal education program and has been certified by the State Board of Nursing as a nurse practitioner or clinical nurse specialist. The NP/CNS practices under a physician preceptor according to mutually agreed-upon protocol. The NP/CNS may be reimbursed under their individual Medicaid provider number or the supervising physician's Medicaid number.

Supervision

For Medicaid professional billing purposes, direct supervision means that the teaching physician is accessible as defined in Subsection I, and the teaching physician is responsible for **all** services rendered, fees charged, and reimbursement received.

Teaching Physician Policy

When interns or residents provide service, the following definitions apply:

- Resident — A resident is either an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.
- Medical Student — A medical student is an individual who is enrolled in a program culminating in a degree in medicine. Any contribution of a medical student to the performance of a billable service or procedure must be performed in the physical presence of a teaching physician or jointly with a resident in a service meeting the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Teaching Physician Policy (Cont'd.)

requirements set forth for teaching physician billing.

- Teaching Physician — A teaching physician is an individual who, while functioning under the authority and responsibility of a residence program director, involves residents and/or medical students in the care of his or her patients or supervises residents in caring for patients.

Services provided by residents under the direct supervision of a teaching physician are billable to Medicaid. For Medicaid professional component billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I, when the services being billed are provided by the resident. The teaching physician is responsible for all services rendered, fees charged, and reimbursements received. The services must be documented, as defined in Subsection II, in the patient's medical record. The supervising physician must sign the patient's medical record indicating that he or she accepts responsibility for the services rendered.

Subsection I

Accessibility of the teaching physician while the resident is providing services is defined as follows:

- Ambulatory — Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient's history, personally examine the patient as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.
- Inpatient — Accessibility of the teaching physician for supervision of non-procedural inpatient services requires that the teaching physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching physician must review the patient's history, personally examine the patient as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Subsection I (Cont'd.)

- Procedures
 - Minor Procedures — For supervision of procedures that take only a few minutes to complete or involve relatively little decision-making once the need for the procedure is determined, the definition of accessibility requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.
 - All Other Procedures — Accessibility for supervision of all other procedures requires that the teaching physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

Subsection II

Documentation for services must include a description of the presence and participation of the teaching physician. The resident may document the encounter to include a note describing the involvement of the teaching physician. The teaching physician's signature is then adequate to confirm agreement. Documentation of an encounter by the teaching physician may make reference to portions of a medical student's notes. The combined entries of the medical student, resident, and teaching physician must be adequate to substantiate the level of service required and billed. Documentation must include the teaching physician's signature for each encounter that will be billed as a professional charge.

Note: A hospital may bill Medicaid a clinic visit (facility charge) for patients seen by a resident even though the encounter has not been signed by the teaching physician.

NON-COVERED SERVICES

Convenience Items

Items provided for the convenience or comfort of the patient at his or her request are non-covered. Non-covered charges include but are not limited to the difference between a private and semi-private room when requested by the patient and not medically necessary. Items routinely covered in room rates must be offered to Medicaid patients under the same conditions as non-Medicaid patients.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Incidental Procedures

Incidental procedures are performed at the same time as major surgery in anticipation of possible future problems. Examples include but are not limited to incidental appendectomies, incidental scar excisions, simple lysis of adhesions, puncture of ovarian cysts, and simple repair of hiatal hernias. No reimbursement will be made for subsequent procedures that do not add significantly to the complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery. Incidental procedures should not be shown on the claim.

Cosmetic Procedures

Cosmetic surgery or expenses incurred in connection with such services are non-covered under Medicaid. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (*i.e.*, as soon as medically feasible) repair of accidental injury **or** for the improvement of the functioning of a malformed body part. This does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, webbed fingers and toes, congenital ptosis, and other birth defects which impair bodily function.

Experimental/ Investigational Procedures

Procedures that are experimental/investigational are non-covered. Procedures that are performed in only a few medical centers across the United States are considered part of this group.

Partial Hospitalization

Partial hospitalization rendered in an outpatient hospital setting is non-covered by Medicaid. Partial hospitalization is a comprehensive, structured program that uses a multidisciplinary team to provide comprehensive coordinated services within an individual treatment plan to individuals diagnosed with one or more psychiatric disorders.

Infertility Procedures

Any medications, tests, services, or procedures performed for the diagnosis or treatment of infertility are non-covered. Codes related to hystosalpingographs (58345 and 74742) are non-covered by Medicaid.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OUT-OF-STATE SERVICES

Treatment Rendered Outside of the S.C. Medical Service Area

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. Charlotte, Augusta, and Savannah are considered within the service area. Services provided to Medicare/Medicaid beneficiaries in the SCMSA do not require prior approval from Medicaid.

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

- When 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. Emergency medical services are determined by the diagnosis codes listed on the claim, and medical review.
- Out-of-state referrals by physicians when needed services are not available within the SCMSA
- All services rendered to beneficiaries aged two years and under
- All pregnancy-related services, including delivery

Out-of-state hospital services are limited to true emergencies or those services for which prior approval from SCDHHS has been obtained. A true emergency is described as an accident or disease in which the health of the beneficiary would be endangered if necessary care and services were postponed until return travel to South Carolina.

Out-of-State Hospitals

In order to participate in the Medicaid program, an out-of-state hospital must enroll with South Carolina Medicaid by completing a provider enrollment package. By signing the provider enrollment forms, the provider agrees to payment at the South Carolina rate of reimbursement and to comply with all federal and state laws and regulations. Claims and all needed information must be submitted within one year from the date of service or date of discharge for inpatient claims or reimbursement will be denied.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Out-of-State Hospitals (Cont'd.)

Out-of-state hospital claims should be sent in hard copy to:

SCDHHS
Division of Hospital Services
Attention: Out-of-State Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

For assistance with out-of-state hospital claims, please contact the out-of-state program representative at (803) 898-2665 or by fax at (803) 255-8351.

For policies regarding organ transplants, please refer to Organ Transplants in this section.

Out-of-State Referrals by Physicians When Needed Services Are Not Available Within the SCMSA

In all but emergency situations, approval should be requested prior to the out-of-state service. For out-of-state referrals, the South Carolina referring physician must contact the Physician Services out-of-state coordinator at (803) 898-2660 or by fax at (803) 255-8255 to obtain prior approval. Written requests should be submitted to:

SCDHHS
Division of Physician Services
Attention: Out-of-State Coordinator
Post Office Box 8206
Columbia, SC 29202-8206

The written request must include all of the following information:

- Beneficiary's name and Medicaid number
- Date of service (state as "tentative" if unscheduled at the time of request)
- Diagnosis (past and current history if pertinent to show medical necessity)
- An explanation as to why the physician believes these services must be rendered out-of-state instead of within the SCMSA
- Name, address, and telephone number of the out-of-state provider(s) who will render the medical services (for example, hospital and physician(s) involved in that patient's medical treatment)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Out-of-State Referrals by Physicians When Needed Services Are Not Available Within the SCMSA (Cont'd.)

- Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in only a few medical centers across the United States

Transportation may be provided to Medicaid patients who are referred out-of-state, as well as to the patient's escort, when necessary. Transportation and other assistance are only provided when there are no other means available to the patient to meet the needs connected with out-of-state travel. Adequate advance notice as well as prior approval is mandatory in order to make the necessary travel arrangements. Transportation arrangements are handled by the Division of Family Services at (803) 898-2565.

Note: Medicaid will accept and review for medical necessity any out-of-state claims from medical providers who did not seek approval before filing the claim. However, experience has shown that these providers put themselves under an otherwise avoidable risk of non-payment or delayed payment due to the lack of knowledge of S.C. Medicaid claim filing policies and procedures.

Foster Children Residing Out of the SCMSA

The Department of Social Services (DSS) will be responsible for all Medicaid-eligible foster children when they reside out-of-state. The SCDHHS county case manager assigned to the case should assist with medical services.

Prior approval is not required for services rendered to foster children who live out-of-state; however, medical necessity remains a requirement. The out-of-state coordinator should be contacted at (803) 898-2660 for two reasons:

- The coordinator must determine whether the medical services can be reimbursed through the Medicaid program or whether DSS will reimburse the medical provider.
- If Medicaid can reimburse for the services, proper enrollment and billing information needs to be sent to the medical providers involved.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Ancillary and Other Out-of-State Services

Other health care services are compensable under the S.C. Medicaid Out-of-State Program. Listed below are the appropriate numbers to call for the specific out-of-state referral:

Service	Department	Phone Number
Physicians	Physician Services	(803) 898-2660
Hospitals	Hospital Services	(803) 898-2665
Mental Health	Behavioral Health Services	(803) 898-2565
Ambulance	Transportation	(803) 898-2565
Pharmacy	Pharmacy and DME	(803) 898-2876
Durable Medical Equipment (DME)	Pharmacy and DME	(803) 898-2882
Home Health	Home Health and Nursing Homes	(803) 898-2698
Vision	Physicians Services	(803) 898-2660
Dental	Preventive and Ancillary Health Services	(803) 898-2568
Transportation	Transportation	(803) 898-2565

SPECIAL COVERAGE ISSUES

Administrative Days

The Department of Health and Human Services sponsors administrative days for Medicaid-eligible patients (regardless of age) who no longer require acute hospital care but are in need of nursing home placement that is not available at that time. Medicaid sponsors administrative days in any South Carolina acute care hospital contracted within the South Carolina service area. The patient must meet either Medicaid intermediate or skilled level-of-care criteria.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Administrative Days (Cont'd.)

Coverage for administrative days may begin with the day of discharge from acute care. It is not necessary to allow for patient grace days. Medicaid coverage terminates once a nursing home bed becomes available within a 50-mile service area that is within the South Carolina state boundaries. Should the patient or family refuse to accept the bed, the patient is then responsible for charges incurred for any remaining days.

Dually eligible beneficiaries (Medicare/Medicaid) may be eligible for administrative days if they are below Medicare's skilled level of care or have exhausted their Medicare benefits. If the beneficiary is below Medicare's skilled level of care, the initial claim must include a copy of the Hospital Issued Notice of Non-Coverage (HINN) letter. If the Medicare benefits are exhausted, a statement from a representative of the hospital indicating the date benefits were exhausted must accompany the initial bill. If available, Medicare lifetime reserve days must be exhausted before administrative days can be approved.

Swing bed hospitals may furnish administrative days only when all swing beds in the hospital are occupied.

Level of Care Determination

Community Long Term Care (CLTC) is responsible for assessing administrative days beneficiaries to determine if the beneficiary meets the intermediate or skilled Medicaid level of care criteria. A Long Term Care Assessment Form (DHHS Form 1718) will be completed. CLTC will determine a level of care or tentative level of care. The tentative level of care is reserved for those beneficiaries who are expected to be admitted to a nursing facility within 14 days. Level-of-care determinations will be documented on either a Level of Care Certification Letter (DHHS Form 185) or Community Long Term Care Notification Form (DHHS Form 171). Either of these forms can be used when billing administrative days.

Once a certification letter is issued, CLTC will close the case. It will be the responsibility of the hospital staff to assure that the client continues to meet the level-of-care criteria. If the beneficiary goes from administrative days to acute care and back to administrative days within the same hospital stay, a new certification letter or notification form does not have to be completed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Level of Care Determination (Cont'd.)

Before an administrative days beneficiary transfers to a nursing home, the hospital discharge planner must contact CLTC and request that the client's case be reopened. CLTC will reprocess the case to ensure that the client continues to meet the level of care criteria for Medicaid-sponsored nursing home care. A certification letter will be sent to the nursing home upon the client's discharge.

Note: Do not contact CLTC when a beneficiary enters a nursing home as Medicare-skilled. In these cases, certification letters do not apply and will not be issued. CLTC must be notified when a beneficiary is transferred to another hospital for administrative days coverage.

If the beneficiary has been discharged from the hospital and was seen by CLTC while in the hospital, administrative days can be billed using either the Notification Form (DHHS Form 171) issued with the tentative level of care or a Certification Letter (DHHS Form 185) which may have been issued based on the status of the beneficiary when seen by CLTC.

Retroactive Certification

In cases of retroactive Medicaid or where a dually eligible beneficiary has been denied or has exhausted Medicare benefits, the CLTC area office may complete a certification retroactive to the date of admission to the Administrative Days program or the date Medicare benefits were exhausted. The Certification Letter (DHHS Form 185) will be issued based on current conditions. If the beneficiary does not appear to meet level-of-care criteria at present but appeared to meet level-of-care criteria for the date of request based on the medical records, CLTC will put an end date on the Certification Letter. Support documentation such as copies of the medical record or any correspondence from Medicare may be requested from the hospital to ensure the patient met the level-of-care criteria for the period for which Medicaid coverage is being requested.

If the beneficiary has been discharged from the hospital and was never seen by CLTC, the hospital should contact the Administrative Days program representative. The hospital will be asked to send the beneficiary's discharge summary and physician's progress notes from the inpatient admission for review. SCDHHS staff will then determine if the beneficiary is eligible for administrative days.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospital-Issued Notification Letters

When the hospital UR committee determines that acute care is no longer necessary, the hospital should issue to the patient a Notification of Administrative Days letter. When a nursing home bed becomes available, issue the Notice of Termination of Administrative Days letter. The hospital has the option of giving a three-day grace period if the patient needs time to arrange for the transfer. The Notice of Termination of Administrative Days should be included in the patient's record and be available to SCDHHS if requested. The patient has the right to appeal the termination of administrative days. Refer to Utilization Review Services in this section.

Dually Eligible Beneficiaries

Dually eligible beneficiaries who fall below Medicare's skilled level of care or have exhausted their Medicare benefits may be eligible for administrative days. If the beneficiary is below Medicare's skilled level of care, the initial claim must include a copy of the HINN letter. If the Medicare benefits are exhausted, a statement from a representative of the hospital indicating the date benefits were exhausted must accompany the initial bill. If available, Medicare lifetime reserve days must be exhausted before administrative days can be approved. If Medicare grace days are provided, administrative days cannot be billed for these days.

Medical Record Requirements

A discharge summary must be completed when a patient is discharged from acute care. If during the administrative days period the condition of the patient changes to acute, a new admission is warranted. However, an admitting history/physical and discharge summary must be completed for each acute care stay. Should a hospital wish to use one medical record for both the acute and administrative days stay, an "interim type" discharge summary outlining the acute stay must be included in the patient's file.

If the beneficiary goes from administrative days to acute care and back to administrative days within the same hospital stay, a new Certification Letter or Notification Form does not have to be completed. However, the beneficiary must meet the Medicaid skilled or intermediate level of care criteria for each administrative days period.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes

When acute care is terminated, the hospital should administratively discharge the patient and bill Medicaid as usual. Administrative days should not be billed in cases under QIO reconsideration until the final QIO determination has been issued.

It is recommended that administrative days claims be filed monthly. Bill revenue code 100 (all-inclusive fee) to reflect all charges applicable to administrative days. Reimbursement for administrative days is an all-inclusive per diem rate depending upon the level of care; it includes drugs and supplies. Administrative days may be billed as routine or ventilator-dependent. Ancillary services rendered to patients in administrative days may be billed under the hospital outpatient provider number and will be reimbursed according to the outpatient fee schedule.

The following documentation must be sent to SCDHHS with the initial claim for administrative days:

- CLTC Level of Care Certification Letter (DHHS Form 185) or CLTC Notification Letter (DHHS Form 171)
- Notification of Administrative Days Coverage letter
- A signed statement that a nursing home bed was not available
- Medicare's HINN (when appropriate)

Subsequent administrative days claims must be submitted with a dated statement indicating the unavailability of a nursing home bed on a monthly basis. Documentation to support a weekly nursing home bed search should be kept in the patient's medical record or on another form.

All claims for administrative days must be submitted in hard copy to:

SCDHHS
Division of Hospital Services
Attn: Administrative Days Program Representative
Post Office Box 8206
Columbia, SC 29202-8206

Note: Administrative days claims are subject to all third party regulations and will reject if the patient has skilled nursing coverage.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes (Cont'd.)

Administrative days claims must meet the Medicaid policy on time limits for submitting claims. Please refer to Section 1 for this information. Exceptions to this policy are:

1. **Retroactive Eligibility** — Administrative days claims must be received within six months of the beneficiary's eligibility determination. The claim must be one that can be processed without additional information from the provider or from another third party, and must be error free. Claims must be submitted in hard copy form with a note attached explaining that the case involves retroactive eligibility.
2. **QIO Retrospective Review** — SCDHHS will accept an administrative days claim when the QIO retrospective review determines that part of the hospital inpatient admission did not meet the acute level of care and could have been billed as administrative days. Once the hospital receives the notification letter from the QIO, the administrative days claim must be received by SCDHHS within 90 days from the date of the letter or one year from the date of service, whichever is less. The QIO letter must be sent with the claim.

You are encouraged to call your provider representative for assistance on problem claims to make certain you are reimbursed for all services within the time limit. Please refer to Section 3 of this manual for specific billing instructions.

Physician Services

Physicians who are treating patients in administrative days can bill for services rendered using the same procedure codes that they use for their patients in nursing homes and rest-home facilities. Those procedure codes are in the 99301–99333 range and are listed in the CPT manual. The specific code used will depend on whether the patient is new or established and on the level of care given. Physician services must be billed on the CMS-1500 claim form using place of service 21.

One limited examination per 30 days is required for all administrative days patients. However, Medicaid does not have a limit on codes 99311 or 99331, though the visits

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Physician Services (Cont'd.)

must be medically necessary. Codes 99312 and 99332 are limited to five per month and codes 99313 and 99333 are limited to four per month. Additional visits may be allowed if medical justification is submitted. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for billing instructions.

Organ Transplants

Medicaid coverage of transplant services falls into two groups. Group I includes corneal transplants. Group II includes kidneys, bone marrow (autologous and non-autologous mismatched), pancreas, heart, liver, small bowel, liver with small bowel, liver/pancreas, liver/kidney, kidney/pancreas, lung and heart/lung.

Group I

Corneal

Corneal Transplants (Keratoplasty) — Corneal transplantations are compensable. The reimbursement to the hospital includes all technical services including donor testing and preparation. Professional services can be billed separately.

Transportation for Medicaid Beneficiaries Requiring Group I Transplants

Transportation arrangements for Group I transplants are coordinated through the Division of Preventive Care. For information on the transportation program, you may call or write to:

SCDHHS
Division of Preventive Care
Post Office Box 8206
Columbia, SC 29202
(803) 898-2655

Group II

Kidney, Bone Marrow (Autologous and Non-Autologous Mismatched), Pancreas, Heart, Liver, Small Bowel, Liver with Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung and Heart/Lung

1. Kidney Transplants — Medicaid will reimburse the hospital an all-inclusive kidney transplant fee which includes all organ procurement, donor testing, and all other services considered as the technical component, for both living-related and cadaver donation. Inclusive charges are compensable for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Group II (Cont'd.)

the services rendered on behalf of the Medicaid-eligible beneficiary. Medicare coverage is primary, and Medicaid will only pay if Medicare benefits are either not available or have been denied.

A Medicare denial of benefits must accompany the claim and the patient must be end stage renal disease (ESRD) enrolled with Medicaid (see ESRD in this section). Professional services, including the nephrectomy and transplantation of the new organ performed by a physician team, are reimbursed separately.

Medicaid contracts with the Medical University of South Carolina (MUSC) in Charleston, SC as the authorizing agent for all Group II transplants. All requests for Group II transplants must be arranged through MUSC. No other providers will be reimbursed for Group II transplant services. The patient must be referred to MUSC for evaluation. Medical necessity and clinical acceptability will be determined by the appropriate transplant team using uniform professional and administrative guidelines. Donor charges are included in the payment for the transplant.

For information concerning the referral for medical evaluation and transplant arrangements, please call one of the following:

Organ	Coordinator	Physician Contact
Bone Marrow	Theo Fouts Cindy Kramer (843) 792-8382	Dr. Debra Frei-Lahr (843) 792-6668
Kidney, Pancreas	Laura Hildebrand Lucia Miles Jennifer Wood (843) 792-4177	Dr. Prabhakar Baliga (843) 792-3368
Liver w/Small Bowel w/Pancreas w/Kidney	Paula Auble Kara Cole Stacy Sipple (843) 792-0332	Dr. Prabhakar Baliga (843) 792-3368

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PROGRAM SERVICES

Organ	Coordinator	Physician Contact
Heart	Lanna Smith Kathy Law Hwajoo Haynes Barbara Ryan Baillie (843) 792-9259	Pager: 792-2123, ID #14220 Dr. Adrian Van Bakel (843) 792-3953
Lung	Lanna Smith Kathy Law Hwajoo Haynes Barbara Ryan Baillie (843) 792-9259	Pager: 792-2123, ID #14115 Dr. Marc Judson (843) 792-3162

Hysterectomy

Medicaid requires pre-admission surgical justification for hysterectomies. Urgent and emergent cases will be reviewed retrospectively by the Quality Improvement Organization (QIO). Carolina Medical Review (CMR) is the current QIO contracted by SCDHHS.

All prior approvals for hysterectomies must be requested in writing. The Surgical Justification Form for Hysterectomy and the Hysterectomy Acknowledgment Form (DHHS Form 1729) must both be completed and submitted to CMR at least 30 days prior to scheduled surgery. Forms should be sent to:

Carolina Medical Review
Attention: Hysterectomy Review
250 Berryhill Road, Suite 101
Columbia, SC 29210

A hysterectomy must be medically necessary and meet the following requirements:

- The beneficiary or her representative, if any, must be informed orally and in writing that the hysterectomy will render the beneficiary permanently incapable of reproducing.
- The beneficiary or her representative, if any, must sign and date the Hysterectomy Acknowledgment Form, DHHS 1729, prior to the hysterectomy.

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PROGRAM SERVICES

Hysterectomy (Cont'd.)

The hysterectomy acknowledgement is acceptable when signed after the surgery only if it clearly states that the patient was informed before the surgery that she would be rendered incapable of reproduction.

The Hysterectomy Acknowledgement Form is not required if the individual was already sterile before the surgery or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible. In these circumstances, a physician statement is required. The statement must indicate the cause of the sterility or the diagnosis and description of the nature of the emergency.

Reimbursement for a hysterectomy is not available if the hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing. A hysterectomy may not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

Retroactive Eligibility

A hysterectomy is reimbursed by Medicaid in cases of retroactive eligibility only if the physician certifies one of the following in writing:

- The individual was informed before the surgery that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy and the physician who performs the hysterectomy certifies in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.
- The individual required a hysterectomy because of a life-threatening emergency situation and the physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening situation in which the physician determined that prior acknowledgement was not possible. The certification must include a diagnosis and description of the nature of the emergency.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Retroactive Eligibility (Cont'd.)

Note: The sterilization consent form is not an acceptable substitute for the hysterectomy acknowledgement statement. Claims submitted with only the sterilization consent form will not be considered for reimbursement.

Elective Sterilization

SCDHHS is required to have a completed DHHS Form 1723 (Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients, March 1997 edition) for all elective sterilizations. Sterilization claims and consent forms are reviewed for compliance with Federal Regulation 441.250 – 441.259. It is the physician's responsibility to obtain the consent and submit this form to SCDHHS. Photocopies are accepted if legible.

Definitions

The following definitions are from the Code of Federal Regulations, Section 441.250-441.259:

1. Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual, male or female, permanently incapable of reproducing.
2. Institutionalized individual means an individual who is (a) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or (b) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
3. Mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Sterilization Requirements

For Medicaid financial coverage of an elective sterilization for male or female, the following requirements must be met:

1. The individual must be 21 years old at the time the consent form is signed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization Requirements (Cont'd.)

2. The individual cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, please call Physician Services at (803) 898-2660.
3. The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. A witness of the patient's choice may be present during the consent interview.
4. A copy of the consent form must be given to the patient after Parts I, II, and III are completed.
5. At least 30 days, but no more than 180 days, must have passed between the signing of the consent form and the date of the sterilization procedure. The date of the beneficiary's signature is not included in the 30 days (*e.g.*, day one begins the day after the signature). Only the beneficiary may sign Part I of the consent form.
6. Exceptions to the 30-day waiting period are:
 - a) Emergency abdominal surgery. The emergency does not include an operation to sterilize the patient. At least 72 hours must have elapsed since the informed consent to sterilize was given. An explanation must accompany the claim.
 - b) Premature delivery. The sterilization consent must have been signed at least 30 days before the expected date of delivery. In cases involving a Cesarean section, the scheduled date of the Cesarean is considered the expected date of delivery. For premature deliveries, at least 72 hours must have elapsed since the informed consent to sterilize was given.

Informed consent may not be obtained while the individual to be sterilized is:

- In labor or childbirth
- Seeking or obtaining an abortion
- Under the influence of alcohol or other substances which may affect the patient's judgment

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization Requirements (Cont'd.)

Although hospitals are not required to submit a sterilization consent form with their claim, payment will be recouped if no such documentation is present in SCDHHS records or if the documentation is inaccurate. Hospital providers will be notified in writing and given 30 days to submit the consent form before a recoupment is made.

Sterilization Consent Form Requirements

All sections of the Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients form (DHHS Form 1723) must be completed. Consent forms are correctable, except for the beneficiary's signature and date. A consent form, along with instructions for its completion, can be found in Section 5.

Abortions

Non-Elective Abortions

All non-elective abortions including spontaneous, missed, incomplete, septic, hydatidiform mole, etc., require only that the medical record show such a diagnosis. If unable to determine whether the patient was in the process of an abortion from the hospital records, SCDHHS will ask the hospital to obtain additional physician's office or clinic notes and/or ultrasound reports. Medical procedures necessary to care for a patient with ectopic pregnancy are not modified by this section and are compensable services.

Therapeutic Abortions

SCDHHS requires documentation for all claims submitted for therapeutic abortions. This includes claims for the attending physician, the anesthesiologist, the hospital, etc.

Pursuant to 42 CFR 441.203 and 441.206, therapeutic abortions are sponsored only in cases that a physician has found and certified in writing to the Medicaid agency that, on the basis of his or her professional judgment, the pregnancy is the result of an act of rape or incest, or the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

The Abortion Statement is required and must contain the name and address of the patient, the reason for the abortion, and the physician's signature and date. The patient's certification statement is only required in cases of rape or incest. A blank Abortion Statement can be found in Section 5 of this manual.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes for Abortions

When billing for any type of abortion, the principal procedure code must be the abortion. **Vaginal Delivery codes should not be used to report an abortion procedure.** The **only** exception to this rule is when the physician delivers the fetus, the gestation is questionable, and there is probability of survival. The medical record must contain documented evidence that the fetus was delivered by the physician.

1. Non-elective abortion procedure codes for outpatient hospital are 59812, 59820, 59821, 59830, 59870, and 59200. For inpatient hospital, ICD-9 CM surgical procedure codes are 68.0, 69.02, 69.52, 69.93, and 96.49. These procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code.
2. Elective therapeutic abortions must ONLY be billed with diagnosis 635 range and 779.6. Appropriate procedure codes for elective therapeutic abortions for outpatient hospital are CPT procedure code 59840, 59841, 59850, 59851, 59852, 59855, 59856, and 59857. Inpatient elective therapeutic abortion ICD-9 CM surgical procedure codes are 69.01, 69.51, 74.91, and 75.0.
3. Legible medical records should be included with all abortions and should include admission history and physical, discharge summary, pathology report, operative report, physician progress notes, etc.
4. The following diagnosis codes do not require documentation: 630, 631, 632, 656.4(0,1,3), 658.1 (0,1,3), and 658.2 (0,1,3).

Questions or difficulty with the processing of claims for abortion services should be directed to the Division of Hospital Services at (803) 898-2665.

Reduction Mammoplasty

Reduction mammoplasty for large, pendulous breasts on a female may be considered medically necessary and not a cosmetic procedure when the criteria discussed below are met.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Reduction Mammoplasty (Cont'd.)

Prior authorization is required for all ages. The attending physician shall obtain prior authorization by completing the South Carolina Medicaid Program Request for Prior Approval Review form.

Adult Female Reduction Mammoplasty

Reduction mammoplasty for large pendulous breasts on an adult female may be considered for payment when the following criteria are met.

- Photographs must be submitted with all requests.
- Current preoperative weight and weight six to twelve months prior to anticipated surgery must be recorded.
- Sternal notch to nipple measurement should be at least 18-22 cm.
- Neck, shoulder, and back pain must have been present for at least one year.
- In addition, one of the following symptoms must have been present for at least one year:
 - Strap mark indentations
 - Restriction of physical activities
 - Poor posture and/or skin irritation
- A physician must estimate that at least 400 grams of tissue from each breast must be removed.

Adolescent Female Reduction Mammoplasty

Surgery should be delayed when possible to allow the ultimate contour and shape of the breast to develop and avoid the possible complications of deformity from scar tissue and continued growth developing after surgery.

In addition to the above adult female criteria:

- Documentation must indicate the female is fully mature at Tanner sex maturation stage 5.
- Preoperative psychological counseling must be provided. Surgical complications including infection, scarring, and future inability to breastfeed must be discussed and documented.

Repeat Female Reduction Mammoplasty

Repeat Female Reduction Mammoplasty may be considered when documentation is submitted supporting the criteria cited above.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Reconstructive Breast Surgery

Reimbursement is allowed for reconstructive breast surgery following a mastectomy when performed for the removal of cancer or for prompt repair of accidental injury.

Prior authorization and/or support documentation must be obtained. Medical records should include surgeon's history, photographs, and recommendation. Carolina Medical Review (CMR) is responsible for prior authorization and support documentation requests.

Breast reconstruction done for cosmetic reasons is non-covered. Augmentation is non-covered under all circumstances. Payment is made for special bras through the Durable Medical Equipment program for women who have undergone any type of mastectomy.

For a list of codes requiring PA or support documentation, see "Procedure Codes Requiring Prior Authorization and Support Documentation" in Section 4.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary and the following criteria are met:

1. Prior authorization is obtained by the attending physician. The South Carolina Medicaid Program Request for Prior Approval form and all necessary documentation should be sent to CMR. Requests must be mailed within 30 days of the surgery.
2. Photographs must be submitted with all requests.
3. Documented evidence of at least one of the following should be in the patient record:
 - The nodule size of non-fatty breast tissue
 - Pathologic conditions; endocrinopathy or chromosomal abnormality
 - Drug-related gynecomastia (digitalis, non-steroidal agents, antifungal drug)

Adolescent Male Gynecomastia

Surgery should be delayed when possible to allow the enlargement of the adolescent male mammary glands to regress.

In addition to the above adult gynecomastia criteria the following conditions must be met:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Adolescent Male Gynecomastia (Cont'd.)

- Complaints of psychological effect, as determined by the primary care physician, psychologist, or psychiatrist, must be documented.
- Documentation must indicate that the gynecomastia is not normal physiologic-pubertal gynecomastia or that the nodule has not regressed to less than 2 cm diameter after two years.
- The patient's medical record must clearly document the following:
 - a) Complaints of pain which have persisted for at least a three-month duration
 - b) One of the following:
 - Drug-related gynecomastia (DES, Dilantin)
 - Enlargement secondary to endocrinopathy, chromosomal abnormality, tumor, or hormonal imbalance associated with change of puberty

Repeat Male Gynecomastia

Repeat Male Gynecomastia may be considered with documentation to support the criteria listed above.

Obesity

Obesity itself cannot be considered an illness. The most common cause is caloric intake that is persistently higher than caloric output. Reimbursement may not be made for treatment of obesity alone since this treatment cannot be considered reasonable and necessary for the diagnosis or treatment of an illness or injury. However, although obesity is not in itself an illness, it may be caused by illnesses such as hypothyroidism, Cushing's disease, and hypothalamic lesions. In addition, obesity can aggravate many cardiac and respiratory diseases as well as diabetes and hypertension. Therefore, services related to the treatment of obesity could be covered services when such services are an integral and necessary part of a course of treatment for one of these illnesses. The following services are not covered by Medicaid:

- Supplemental fasting
- Intestinal bypass surgery
- Gastric balloon for treatment of obesity

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PROGRAM SERVICES

Gastric Bypass Surgery/ Vertical-Banded Gastroplasty

Gastric bypass surgery and vertical-banded gastroplasty are performed for patients with extreme obesity. Gastric bypass surgery or vertical-banded gastroplasty for morbid obesity can be covered by Medicaid if **both** of the following conditions are met:

- It is medically necessary for the individual to have such surgery.
- The surgery is to **correct** an illness that caused the obesity or was aggravated by the obesity.

At a minimum the individual must meet the following medical criteria:

- Failure of a major weight loss program
- Weight of 100 pounds over the individual's ideal body weight
- Presence of a co-morbidity condition such as diabetes, respiratory insufficiency, hypertension, pseudotumor cerebri, sleep apnea, degenerative joint disease, severe venous stasis disease, etc. that may be relieved if the individual were to lose weight

An annual evaluation will be required for all individuals who receive gastric bypass surgery or vertical-banded gastroplasty. This evaluation will be used by Medicaid to assess the long-term effectiveness of this procedure in the treatment of obesity.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. This procedure code, 15831 (Lipectomy and Abdominoplasty), can be covered by Medicaid if both of the following conditions are met:

- It is medically necessary for the individual to have such surgery.
- The surgery is performed to correct an illness which was caused by the pannus or aggravated by the pannus.

Documentation must be submitted to support at least **one** of the following indications:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Panniculectomy (Cont'd.)

- The beneficiary has intertriginous infections with documented evidence of serious problems with intertriginous infection control.
- The apron of the panniculus interferes with ambulation.
- The panniculus is causing prolapse of a ventral hernia.

Photographs must be submitted with each request for consideration.

Prior authorization is needed and may be obtained by calling Carolina Medical Review. Approval will be based on medical records that document the above criteria.

The **Request for Prior Approval Form** must be used when submitting documentation for PA.

Dental Services

Adults

Dental services for beneficiaries 21 years of age or older are non-covered. Exceptions to this policy are emergencies and MR/RD Waiver adults over age 21. Emergency dental services are those services necessary:

- To repair traumatic injury
- To control severe bleeding
- To relieve acute severe pain (associated with an emergency situation)
- To control an acute infectious process
- Due to a catastrophic medical condition

Coverage must be consistent with South Carolina Medicaid emergency dental procedure codes. Adjunctive emergency dental services provided to an inpatient admitted for a separate medical condition are covered services as part of the original admission. Emergency dental services may be provided in the hospital setting for patients who are physically or mentally handicapped, patients needing health maintenance supervision, or who for other medical reasons or conditions are unable to be treated in an office setting. In these cases, medical records may be required to establish medical necessity.

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PROGRAM SERVICES

Children Under Age 21

Comprehensive dental services for beneficiaries under age 21 are covered services. Emergency and non-emergency dental services may be provided in the hospital setting for patients who are physically or mentally handicapped, patients needing health maintenance supervision, or patients who for other reasons or conditions are unable to be treated in an office setting. In these cases, medical documentation may be required to establish medical necessity.

For further information regarding dental services, call the Division of Preventive and Ancillary Health Services at (803) 898-2655.

End Stage Renal Disease (ESRD) and Dialysis

The following guidelines define policy and procedures as they relate to patient services and providers involved in end stage renal disease treatments.

Medicare/Medicaid (Dually Eligible)

Medicare is the primary sponsor for ESRD services. Medicaid reimburses as **primary** sponsor for the initial 90-day waiting period required for Medicare coverage. If Medicare coverage is denied after the 90-day waiting period, notify your hospital program representative at (803) 898-2665.

Medicaid will not reimburse for ESRD services after the initial 90-day waiting period when a Medicare determination is still pending. Medicaid will not reimburse as primary sponsor for any Medicare-covered services until a denial of eligibility from the Social Security Administration is received. The 90-day waiting period is not required by Medicare for individuals who are candidates for a renal transplant or for those on home dialysis.

Claims submitted to Medicaid prior to the patient being enrolled with Medicaid as an ESRD patient will reject. All ESRD Enrollment Medicaid Recipient forms must be submitted to:

SCDHHS
Division of Hospital Services
Attn: ESRD
Post Office Box 8206
Columbia, SC 29202-8206

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Inpatient Dialysis

When an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. Medicaid sponsors all medically necessary services related to renal disease care according to the above guidelines regardless of the reason for admission.

Outpatient Dialysis

Medicaid will sponsor outpatient services related to end stage renal disease treatment under the guidelines outlined above provided the patient is enrolled with Medicare and Medicaid as an ESRD patient **and** the hospital is certified as a hospital-based ESRD facility. Hospitals presently certified are Palmetto Richland Memorial Hospital, St. Francis Community Hospital, the Medical University of South Carolina, Carolinas Hospital System, Hampton Regional Medical Center, Charlotte Memorial Hospital, and the Medical College of Georgia. The facility is responsible for ESRD enrollment of the patient with Medicare and Medicaid. See the ESRD Enrollment Medicaid Recipient, DHHS Form 218, in Section 5 of this manual. The initial outpatient claim must indicate the date of the first dialysis treatment and certify that a Medicare application has been submitted.

Home Dialysis

Medicare is the primary sponsor for patients receiving home dialysis services and Medicaid, if available, is the secondary sponsor. The Social Security Administration does not require a 90-day delay for home services and Medicare will reimburse from the initial course of treatment.

Should Medicare deny coverage for a patient entered on a program of home dialysis, Medicaid will sponsor treatment only if the hospital is certified for such procedures. Note that being certified for maintenance dialysis does not automatically certify the facility for home dialysis.

The hospital-based facility is responsible for the procurement, delivery, and maintenance of the equipment and supplies. The reimbursement rate includes all medically necessary services for home dialysis. Additional charges for home supplies or equipment are non-covered and claims indicating such will be denied.

Kidney Transplants

Prior approval is required for kidney transplants. Please refer to "Organ Transplants" in this section for additional information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hyperbaric Oxygen Therapy

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.

Covered Conditions

Reimbursement for HBO therapy is limited to that which is administered in a chamber (including the one-man unit) for the following conditions only:

- Acute carbon monoxide intoxication
- Decompression illness
- Gas embolism
- Gas gangrene
- Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb, or life is threatened.
- Crush injuries and suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment, when loss of function, limb, or life is threatened.
- Acute peripheral arterial insufficiency
- Preparation and preservation of compromised skin grafts
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management
- Osteoradionecrosis as an adjunct to conventional treatment
- Cyanide poisoning
- Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
- Soft tissue radionecrosis as an adjunct to conventional treatment

Pain Management Services

The complaint of pain remains the single greatest reason for seeking medical attention. It is of the utmost importance that any medical provider seek the source of the pain as well as work to relieve and resolve the pain.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Pain Management Services (Cont'd.)

Patient history must be reviewed to ensure all areas of treatment have been explored. The primary objectives of pain management must be to:

- Eliminate the use of optional health care services for primary pain complaints
- Increase physical activities and return the patient to productive activity
- Increase the patient's ability to manage pain and related problems
- Reduce the use and misuse of medication
- Decrease the intensity of subjective or illusory pain

External Infusion Pumps

The condition of external infusion pumps is covered for the following conditions:

- Opioid drugs for intractable cancer pain
- Treatment for acute iron poisoning or iron overload
- Chemotherapy for liver cancer
- Treatment for thromboembolic disease and/or pulmonary embolism

Other uses of the external infusion pump may be reimbursable if the provider can document the medical necessity and appropriateness of this type of therapy and pump for the individual patient. Prior approval must be requested in writing for a condition other than those listed above.

Non-Covered External Infusion Pumps

External infusion pumps are non-covered for insulin in the treatment of diabetes mellitus.

Spinal Cord Neurostimulators

The implantation of spinal cord neurostimulators will be covered for the treatment of severe and chronic pain. Implantation of this device, related services, and supplies are covered if and only if all of the following conditions are met and documented:

1. Treatment is used as a late, if not last, resort. Other appropriate treatment methods (pharmacological, surgical, psychological, etc.) have been tried and failed or are judged to be unsuitable or contraindicated for the patient.

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PROGRAM SERVICES

Spinal Cord Neurostimulators (Cont'd.)

2. Patients are carefully screened, evaluated, and diagnosed by a multidisciplinary team prior to implantation. The screening must include psychological as well as physical evaluation.
3. Demonstration of pain relief with a temporary implanted electrode preceded the permanent implantation.
4. Claims must be filed in hard copy and documentation must be attached to verify the necessity of the procedure.

The implantation of the neurostimulator may be performed on an inpatient or outpatient basis according to medical necessity.

Implantable Infusion Pumps

The use of implantable infusion pumps is covered for the following conditions:

1. Chemotherapy for Liver Cancer — The implantable pump is covered for the treatment of liver cancer in patients in whom the metastases are limited to the liver, and where either of the following applies:
 - a) The disease is unresectable.
 - b) The patient refuses surgical excision of the tumor.
2. Anti-Spasmodic Drugs for Severe Spasticity — An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (*e.g.*, Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:
 - a) As indicated by at least a six-week trial, the patient cannot be maintained on non-invasive methods of spasm control such as oral anti-spasmodic drugs, because either these methods fail to adequately control the spasticity or produce intolerable side effects.
 - b) Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Implantable Infusion Pumps (Cont'd.)

3. Treatment of Chronic Intractable Pain — An implantable pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for the treatment of severe or chronic intractable pain in patients who have a life expectancy of at least three months and who have proven unresponsive to less invasive medical therapy, as determined by the following criteria:
 - a) Medical documentation must reflect the coordination and treatment of the cause of pain.
 - b) The patient's history must indicate that he or she would not respond adequately to non-invasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated reaction to pain).
 - c) A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief and an acceptable degree of side effects (including effects on the activities of daily living).

Determinations may be made on coverage of other uses for implantable infusion pumps if the provider can verify the following:

- The drug is reasonable and necessary for treatment of the individual patient.
- It is medically necessary that the drug be administered by an implantable infusion pump.
- The FDA-approved labeling for the pump must specify that the drug being administered and the purpose for its administration is an indicated use for the pump.

Non-Reimbursable Services

There is no reimbursement to physicians or CRNAs for the setup or subsequent daily management of patient-controlled analgesia (PCA) pumps. Behavioral modification, physical therapy, psychiatric services, and related services are non-compensable as pain management or pain therapy services.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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. Please ask for the assigned case worker.

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 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 these types of situations are the responsibility of the patient. Pregnancy services are non-covered under the FPW. If a woman becomes pregnant during the time 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

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.
- 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:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

- 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 by hospitals for care not related to the terminal illness must be pre-approved by the hospice provider. The hospital will contact the hospice provider for confirmation that the service does not relate to the terminal illness and a prior authorization number to be included on that provider's 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 it will be rejected and returned to the provider. Services that require prior authorization are:

- Hospital
- Emergency Room
- Pharmacy
- Mental Health
- Drug, Alcohol, and Substance Abuse Services
- Audiology
- Psychologist Services
- Speech Therapy

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

- Occupational Therapy
- Ambulatory Surgery Clinics
- Medical Rehabilitation Services
- School-Based Services
- Physical Therapy
- Private Duty Nursing
- Podiatry
- Health Clinics
- County Health Departments
- Home Health
- Home- and Community-Based Services
- Durable Medical Equipment

The authorization number should be entered in field 63 of the UB-92. Claims submitted by these service providers without the required hospice authorization will reject. If billing issues cannot be resolved with the hospice, contact Medicaid Hospice Services at (803) 898-2590.

Alcohol and Other Drug Abuse Treatment Services

The SCDHHS and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) implemented a statewide system to coordinate all alcohol and other drug (AOD) treatment services that are critical to serving Medicaid beneficiaries with AOD-related problems.

Inpatient AOD services, DRG 433 through 437, and AOD services rendered by Medicaid-enrolled AOD providers require prior authorization from DAODAS. To obtain prior authorization, providers should call (800) 374-1390 or (803) 898-5988, or send a fax to (803) 896-5984. Phone coverage is available 24 hours a day, seven days a week.

When calling for inpatient prior authorization, the provider should have ready the following information: the patient's admitting diagnosis, vital signs, current medications, detoxification medications (if applicable), suicidal or homicidal ideation, and the time needed to stabilize the patient. For detoxification rehabilitation, DAODAS will request standard biological and social information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Alcohol and Other Drug Abuse Treatment Services (Cont'd.)

The authorization number assigned by DAODAS for the inpatient admission should be entered in item 63 of the UB-92 claim form. Claims that are submitted without a prior authorization number will reject.

Special Conditions

Medicaid beneficiaries who are Physician Enhanced Program (PEP) members or members of the Medical Homes Local Network Program (MHLN) and need inpatient AOD hospital services **must have prior authorization from their PEP primary care provider or the MHLN provider**. The local county AOD provider should coordinate outpatient AOD services with the PEP provider or the MHLN provider. Outpatient AOD services rendered by AOD providers must be prior authorized by DAODAS.

Medicaid beneficiaries who are Managed Care Organization (MCO) program members will require prior authorization by DAODAS.

For further information, call the Division of Family Services at (803) 898-2565.

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
- 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)

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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
- 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

that providers check each beneficiary's eligibility prior to providing services. Providers may conduct this check through either a Point of Sale (POS) device or through the Medicaid Interactive Voice Response System (IVRS). 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 Emergency Services

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient services does require authorization. The hospital should contact the PCP for authorization within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

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 below). All authorizations and consultations, including services authorized retroactively, 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 provide any further diagnosis, evaluation, or treatment not identified in the scope of the original referral or to authorize additional referrals.

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PROGRAM SERVICES

MHLN Referrals and Authorizations (Cont'd.)

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 before rendering 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 below 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)
- Speech and Hearing Clinics

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Exempt Services (Cont'd.)

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

MHLN/PEP Providers Services Requiring PCP Referral

Provider Type/Specialty	Service Requiring Referral
Hospital	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Refer to PEP ER Screening and Treatment Guidelines.
Physician Anesthesiologist and CRNA Hematologist and Pathologist Ophthalmologist Radiologist All Other Physicians	All HCPCS codes except 00100-01995, 01999 All HCPCS codes except 80001-89999 All HCPCS codes except 92002, 92004, 92012, 92014, 92015, 92018, 92019 All HCPCS codes except 70010-79999 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

MHLN/PEP Providers Services Requiring PCP Referral (Cont'd.)

Provider Type/Specialty	Service Requiring Referral
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
- 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 either a Point Of Sale (POS) device or through the Medicaid Interactive Voice Response System (IVRS). 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

MCO Emergency Room Services

The MCO must make provisions for, and advise all Medicaid MCO program members of the provisions governing, in- and out-of-service area use of emergency visits. The MCO is responsible for payment to providers and for determining whether or not an emergency exists for Medicaid MCO program members. The MCO must make prompt payment for covered emergency services that are furnished by providers that have no contractual arrangements with the MCO to provide such services.

For additional information on the MCO program, please call the Department of Managed Care at (803) 898-4614.

MCO Program Billing Notes

1. In order to avoid risk of non-payment for services, all hospital 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. Hospital 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.
3. A beneficiary's program status on date of admission to the hospital will determine which program requirements the hospital will follow.
4. When reporting inpatient and outpatient data to the Office of Research and Statistics (ORS) for Medicaid MCO program members, the payer carrier code (item 50A-C) should list the carrier code assigned to the MCO.

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 prevention, treatment, and prior authorization of services outside the core package. Services outside the limited package are reimbursed on a fee-for-service basis.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

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.

Referrals

The PCP is responsible for authorizing appropriate care for members. All inpatient and outpatient hospital care except for laboratory/pathology and radiology services billed as treatment/therapy/testing will require a PCP referral. The following table provides a listing of the providers and services that require a PCP referral.

When a referral has been made, the PCP will provide the referred provider with an authorization number. This number must be entered in item 63 of the UB-92 claim form. 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.**

PEP Emergency Room Services

PEP members are directed to contact their PCP before seeking emergency room (ER) care except in life-threatening situations. The PCP is responsible for authorizing appropriate care and denying authorization for inappropriate care. When emergency services are denied, PEP members must be reintegrated into the PCP practice

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PEP Emergency Room Services (Cont'd.)

within one working day for urgent care and three business days for elective care. Please refer to the PEP Emergency Screening and Treatment Guidelines earlier in this section.

Some members will go to the ER without contacting the PCP first. The ER physician should contact the PCP after screening the member to determine the level of care, *i.e.*, elective, urgent, or emergency care. The hospital will be reimbursed a triage fee when the member has been assessed by the ER physician but the ER visit is either inappropriate or has been denied by the PCP. The hospital will use revenue code 459, other emergency room, to bill for the triage fee. If the ER service is authorized by the PCP or meets the requirements of the ER screening and Treatment Guidelines, the appropriate ER visit level is reimbursed. **The hospital may be reimbursed for the triage fee or the ER visit but not both.**

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

PEP Emergency Room Screening and Treatment Guidelines

<ul style="list-style-type: none"> • Medicaid beneficiary presents at the emergency room (ER). • Emergency room will verify Medicaid eligibility. • If the beneficiary is enrolled with a PCP, the ER physician will perform a screening to assess the level of care required by the member's condition. • The screening will be performed in accordance with COBRA/OBRA legislation. • The level of care required will be determined as: Elective, Urgent, Emergency 				
ELECTIVE CARE		URGENT CARE		EMERGENCY CARE
<u>PCP must be contacted to authorize further medical treatment.</u> PCP authorizes services in the ER <ul style="list-style-type: none"> • ER physician will provide necessary services. • ER physician will provide discharge instructions that emphasize the need for the member to return to the care of the PCP. 		<u>PCP must be contacted to authorize further medical treatment.</u> PCP authorizes services in the ER or does not respond within 30 minutes <ul style="list-style-type: none"> • ER physician will provide necessary medical services. • ER physician will provide discharge instructions that emphasize the need for the member to return to the care of the PCP. • ER will notify the PCP within 24 hours of providing urgent care services in the ER if the PCP did not respond. 		<u>ER will provide appropriate emergency care services.</u> <ul style="list-style-type: none"> • ER will contact the member's PCP. • ER physician will provide discharge instructions that emphasize the need for the member to return to the care of the PCP. • ER will contact the member's PCP within 24 hours of providing services if they were unsuccessful in reaching the PCP during the visit.
ER Visit	Screening Fee	ER Visit	Screening Fee	ER Visit

SECTION 2 POLICIES AND PROCEDURES

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Healthy Options Program (HOP)

The Healthy Options Program (HOP) is designed to promote access to care for all Medicaid-eligible beneficiaries age 18 and under by establishing a medical home for the patient. The medical home should give the physician an opportunity to establish a relationship of mutual responsibility and trust with the patient and family by providing on-site preventive and primary medical care. Beneficiaries and their guardians will be asked to sign an agreement at their provider's office that states they accept their provider as their medical home.

In the HOP, it is the physician's responsibility to manage or facilitate a patient's health care including but not limited to:

- Immunizations
- Childhood growth and development assessments
- Pediatric screening
- Health care supervision
- Patient and family counseling regarding health and psychosocial issues

HOP providers must assist in arranging necessary specialty care which may include but is not limited to:

- Hospital care
- Preventive/rehabilitative services for primary care enhancement
- Special needs population services
- Other required ancillary services

Billing Note: A prior authorization number is not required when billing for hospital services rendered to an HOP beneficiary.

For further information regarding HOP participation requirements, call the Division of Physician Services at (803) 898-2660.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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