

South Carolina
Department of Health and Human Services
P O Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov

**Policy for medical treatment outside of the
South Carolina Medical Service Area**

This serves to clarify our policy for reimbursement of services rendered to a South Carolina Medicaid beneficiary outside the South Carolina Medical Service Area (SCMSA). The service area includes all of South Carolina and regions of North Carolina and Georgia that are within 25 miles of the South Carolina border. All services performed outside of the SCMSA require prior approval. Prior approval guidelines are listed below.

The South Carolina Department of Health and Human Services (SCDHHS) provides compensation to medical providers outside the SCMSA for services rendered to beneficiaries only in the following situations:

- ❖ When emergency medical services, pregnancy related services and/or delivery are necessary to protect the health of the beneficiary traveling outside the SCMSA.
- ❖ When a SCMSA physician certifies that needed services are not available within the SCMSA and follows SCDHHS protocol in referring the beneficiary to an out-of-state provider. All available resources must have been considered and indicated in the request to SCDHHS for the out-of-state referral. The following guidelines outline the requirements for an out-of-state referral.

Prior to contacting SCDHHS, the referring physician must contact the out of state provider rendering service to the beneficiary and inform them of the beneficiary's Medicaid status. The out-of-state provider must confirm, in writing, that they will enroll in the South Carolina Medicaid program and will accept the Medicaid reimbursement as payment in full. The written confirmation must be submitted to SCDHHS along with a completed Referral Request Form (attached) for out-of-state services.

The written request for out-of-state referrals must include the following information:

- ✓ Beneficiary's name and South Carolina Medicaid identification number
- ✓ Date of Service (state as "tentative" if unscheduled at the time of request)
- ✓ Name, address, telephone number and fax number of the out-of-state provider(s) who will render the medical services (i.e. hospital and physician(s) involved in the beneficiary's medical treatment)
- ✓ An explanation why these services must be rendered out-of-state versus within the SCMSA
- ✓ Identification of any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States
- ✓ A copy of the beneficiary's medical records for the past year relating to the treatment of the condition

Services outside of SCMSA *will not* be approved if:

- ✓ All information on the referral form is not provided
- ✓ The provider rendering the service(s) will not enroll in the South Carolina Medicaid program and adhere to the enrollment criteria
- ✓ The provider rendering the service(s) will not accept the South Carolina Medicaid reimbursement as payment in full

For out-of-state referrals, the referring physician may fax the attached Referral Request Form with supporting documentation to (803) 255-8255 or mail the information to the following address:

SC DHHS
Division of Physician Services
ATTN: Out-Of-State Coordinator
P O Box 8206
Columbia, South Carolina 29202-8206

For information concerning enrollment and claims submission for out-of-state **hospital** providers see section 2, “Out-of-State Hospitals” in the Hospitals Services Provider Manual.

When a beneficiary is in one of the Managed Care Organizations (MCO) the request for out-of-state services needs to be completed through the MCO.

For a complete copy of current policy, please refer to the Physicians, Laboratories and Other Medical Professionals Provider Manual. The most current version of the provider manual is maintained on the SCDHHS web site at www.scdhhs.gov. Section two (2), Policies and Procedures outline the Out-of-State policy and further detail. If you have any additional questions please contact your Hospital Services program representative at (803) 898-2665, your Physician Services program representative at (803) 898-2660, or your Managed Care program representative at (803) 898-4614.

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**Referral Request Form for
Out-of-State Services**

BENEFICIARY INFORMATION

NAME: _____

SC MEDICAID ID#: _____ DATE OF BIRTH: _____

NAME OF GUARDIAN: _____

CONTACT NUMBER: _____

REFERRING PHYSICIAN

NAME: _____

NPI#: _____ SC MEDICAID #: _____

PATIENT IS BEING REFERRED TO: _____
NAME OF FACILITY AND/OR PHYSICIAN (S)

CONDITION REQUIRING TREATMENT: _____

DIAGNOSIS CODE (S): _____

PROCEDURE CODE (S): _____

DATE OF SERVICE: _____ DATE OF RETURN: _____

Medicaid patients, as well as their escort, being referred out-of-state may be provided transportation when necessary. Adequate advance notice, as well as prior approval is mandatory in order to make the necessary travel arrangements. Call Preventative and Ancillary Health Services at (803) 898-2565 to make travel arrangements.

WILL THE BENEFICIARY REQUIRE TRANSPORTATION? YES _____ NO _____

RECOMMENDED MODE OF TRANSPORTATION: _____

Please include as an attachment, an explanation why these services must be rendered out-of-state instead of within the SCMSA. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, or performed in few medical centers across the United States. Also, a copy of the beneficiary's medical records, relating to treatment of the condition, for the past year must be included.

I certify that contact has been made with the out-of-state provider. I certify that these services are not available and cannot be provided within the South Carolina service area, which includes North Carolina and Georgia (within 25 miles of the South Carolina border).

SIGNATURE OF REFERRING PHYSICIAN

DATE

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**Referral Request Form for
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OUT-OF-STATE PROVIDER

NAME: _____
NAME OF PHYSICIAN (S) AND/OR FACILITY

ADDRESS: _____

TELEPHONE#: _____ FAX#: _____

I certify that I have agreed to enroll in the South Carolina Medicaid program and I am willing to accept South Carolina Medicaid reimbursement as payment in full.

SIGNATURE OF OUT-OF-STATE PHYSICIAN

DATE