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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. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States. 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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PROGRAM OVERVIEW

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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.

3. **Supervision**

SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25-mile radius of the SC border.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

For Medicaid Contract Negotiation contact:

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

To request a Medicaid enrollment packet, please contact Medicaid Provider Enrollment via the SCDHHS Provider Service Center at 1-888-289-0709, or you may submit a request in writing to:

Medicaid Provider Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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.

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 the Medicaid Managed Supplement.

- Managed Care Organizations (MCOs)
- Medical Homes Network (MHN)

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

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.

Medicaid will pay the allowed amount less the amount paid by Medicare or the coinsurance, deductible, and blood 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 Medicare Direct Data Inquiry (DDI) to verify eligibility.

Claims submitted to SCDHHS that have been denied by Medicare for medical necessity based on Local Coverage Determination (LCD) will not be paid by Medicaid. If Medicare has an LCD in which the service/test is considered to be not medically necessary, then Medicaid will not pay the deductible, blood deductible, or coinsurance 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

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

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, deductible, and blood deductible amount, whichever is less.**

As of January 2012:

Deductible = \$1156.00

Regular Coinsurance = $\$289 \times 30 = \8670

Total = $\$1156 + \$8670 = \$9826$

Medicaid Blood Deductible = \$100 per unit
(not to exceed 3)

Outpatient Deductible = \$140.00

Outpatient Coinsurance = 20% of Medicare allowed charges

As of January 2011:

Deductible = \$1132.00

Regular Coinsurance = $\$283 \times 30 = \8490

Total = $\$1132 + \$8490 = \$9622$

Medicaid Blood Deductible = \$100 per unit
(not to exceed 3)

Outpatient Deductible = \$162.00

Outpatient Coinsurance = 20% of Medicare allowed charges

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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

As of January 2010:

Deductible = \$1100.00

Regular Coinsurance = $\$275 \times 30 = \8250

Total = $\$1100 + \$8250 = \$9350$

Medicaid Blood Deductible = \$100 per unit

(not to exceed 3)

Outpatient Deductible = \$155.00

Outpatient Coinsurance = 20% of Medicare allowed charges

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
- 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).

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

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.
- 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 the Forms section of this manual for copies of the notice of non-coverage letters.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Quality Improvement Organization

SCDHHS contracts for external utilization review services with a Quality Improvement Organization (QIO). Alliant Health Solutions is the current QIO contractor. The QIO review consists of:

- Pre-surgical review for all hysterectomies
- Select preauthorization review
- Support documentation review

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.
- 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

QUALITY IMPROVEMENT ORGANIZATION (CONT'D.)

retrospective review to validate the medical record documentation.

Pre-Surgical Justification for Elective Hysterectomies from Alliant Health Solutions

All prior approval requests for hysterectomies must be in writing. Forms are accepted via facsimile 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 Forms section of this manual. Completed forms must be submitted via facsimile to (803) 255-8260 at least 30 days prior to the scheduled date of surgery.

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 review. The physician 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.

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

Support Documentation

All support documentation must be attached hard copy to the UB-04.

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

Prior Authorization

SCDHHS contracts with a quality improvement organization (QIO), Alliant Health Solutions, to perform presurgical review of select surgical procedures. Providers must submit via facsimile to (803) 255-8260 all appropriate clinical information along with the Request For Prior Authorization Form to Alliant Health Solutions within 30 days of the surgery.

Prior approval requests for beneficiaries enrolled in a Managed Care Organization (MCO) must be handled by the MCO. For a current list of participating MCOs with plan contact information, see the Managed Care Supplement.

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 Alliant Health Solutions 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 via facsimile to (803) 255-8260_ all necessary documents including the Request for Prior Approval Form to Alliant Health Solutions.

The QIO (Quality Improvement Organization) reviewer will screen the medical information provided using the appropriate QIO or InterQual criteria for non-physician review.

If criteria are met, the procedure will be approved and an authorization number assigned. The provider will be notified of the approval and authorization number. Enter this number in field 63 of the UB-04.

If criteria are not met or a case is otherwise questioned, the QIO reviewer will refer the procedure request to a physician reviewer. If the physician reviewer cannot approve the admission/procedure based on the initial

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

INSTRUCTIONS FOR OBTAINING PRIOR AUTHORIZATION (CONT'D.)

information provided, he or she will make a reasonable effort to contact the attending physician for additional supporting documentation.

The physician reviewer 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 notification of the authorization number will be given to the physician's office.

If the physician reviewer 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 via facsimile 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 via facsimile to Alliant Health Solutions.
- If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFR 473.38).

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PROGRAM REQUIREMENTS

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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 an inpatient hospital stay, the non-covered portion may be billed to the patient. However, charges for the entire admission should appear on the UB-04 and the system will prorate accordingly.

When an outpatient hospital stay crosses two months and the patient is only eligible for Medicaid for one of the months, the non-covered portion may be billed to the patient. Only bill Medicaid for the outpatient services that

SECTION 2 POLICIES AND PROCEDURES**PROGRAM SERVICES****PROGRAM
SERVICES
(CONT'D.)**

occurred during the period that the patient was Medicaid eligible.

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 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-04. 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 3 of this manual.

SECTION 2 POLICIES AND PROCEDURES**PROGRAM SERVICES****INPATIENT HOSPITAL SERVICES (CONT'D.)**

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 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

A cost outlier occurs if a hospital's estimated costs exceed a specified amount above the DRG base payment. The Medicaid Management Information System (MMIS) will automatically calculate outliers.

Cost 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) 898-1040.

Admission/Discharge Criteria

An admission occurs when the acute inpatient hospital criteria are met and the physician expects the patient to remain in the hospital longer than 24 hours. These criteria requirements are outlined in the criteria and policies of the QIO under contract with SCDHHS. If the acute inpatient hospital 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 readmission 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. Readmissions 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, or when transferred to a psychiatric unit or a rehabilitation unit within the 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.

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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. Routine circumcisions for newborns are non-covered. 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 South Carolina Healthy Connections Medicaid card 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 South Carolina Healthy Connections Medicaid card 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

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PROGRAM SERVICES

Mother/Newborn Admissions (Cont'd.)

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.

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.

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PROGRAM SERVICES

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 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.

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.

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PROGRAM SERVICES

Depo-Provera

When revenue code 636 and J1055 are listed on an inpatient claim an add-on payment for Depo-Provera will be added to the DRG payment.

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; however, each category can include an additional reimbursement for clinical lab services. Reimbursement is based on the fee schedule rate or the charges reflected on the claim, whichever is less. All outpatient services, with the exception of clinical lab services, will be subject to an outpatient hospital multiplier.

The fee schedule can be found in Section 4 of this manual and on the SCDHHS Web site at <http://www.scdhhs.gov/>.

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PROGRAM SERVICES

A. Outpatient Surgical Services — Reimbursement Type 1

When an outpatient claim includes a covered CPT surgical procedure code, it will be paid as a reimbursement type 1. The total payment for reimbursement type 1 equals the rate assigned to the surgery and the established rate for clinical lab services when applicable. The surgery rate includes charges for non-clinical 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-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 CPT 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 CPT surgical procedure code present. The total payment for reimbursement type 5 equals the all inclusive rate and the established rate for clinical lab services when applicable. The rate includes all services performed during the day of the visit except for the allowed add-ons listed below and clinical lab services. This would include patients that are sent to multiple areas of the hospital for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

additional services. Reimbursement type 5 with an emergency room service is paid as an all-inclusive fee determined by the level of the diagnosis, *i.e.*, non-emergent, urgent, or emergent visit. ER claims with multiple diagnosis codes will be paid at the highest level. Reimbursement type 5 with clinic services or a treatment room is paid an all-inclusive fee based on Level 1 (non-emergent) regardless of the diagnosis codes. 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.

Only one payment per day will be made for emergency room, clinic visit, and/or treatment room for the same or related diagnosis. Medical records may be requested in order to verify that the services were unrelated.

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
- Implanon™, revenue code 636 with HCPCS code J7307

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. The total payment for reimbursement type 4 services equals the rate for the revenue code or CPT code as outlined in the outpatient fee schedule and the established rate for clinical lab services when applicable.

Payment for reimbursement type 4 services is based on the revenue code or the procedure code as indicated on the fee schedule. A list of the CPT codes and the Medicaid reimbursement can be found on the SCDHHS website.

Revenue codes that do not require a CPT 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.

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PROGRAM SERVICES

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

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.

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.

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PROGRAM SERVICES

Outpatient Observation (Cont'd.)

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

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.

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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.**

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 "Modifiers on Outpatient Surgery Claims" in Section 3 for billing instructions.

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

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PROGRAM SERVICES

Self-Administered Drugs (Cont'd.)

- 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.

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.

Clinical Lab Services

In order to comply with Title XIX of the Social Security Act, Section 1903(i)(7), Medicaid reimbursement for clinical lab services must not exceed the rates established by Medicare.

Rates for clinical lab procedures, as identified by CMS, will be updated yearly based on the Medicare Fee Schedule rates. The Medicaid Management Information Systems will identify Clinical Lab Panels and Individual Automated Tests and reimburse the amount based on the Automated Test Panel (ATP) pricing schedule. Clinical lab panels will only reimburse one unit per date of service. Claims with multiple units of the same clinical lab panel on the same date of service will be rejected.

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 CPT codes. The physician should review what tests are in the panels and not order individual tests that might duplicate tests.

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.

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

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PROGRAM SERVICES

Laboratory Tests, EKGs, and X-rays (Cont'd.)

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.

Prior Authorization for High-Tech Radiology

Effective July 1, 2011, SCDHHS contracted with MedSolutions for prior authorizations (PA) of high-tech radiology procedures. All CT, CTA, MRI, MRA, Pet Scans, Nuchal Cardiac Imaging, and 3D Rendering Imaging (CPT 76376-76377) will now require a PA. Please see Section 4 for a list of all radiology procedure codes requiring prior authorization.

Providers may request a prior authorization by:

- Telephone: (888) 693-3211 - Available Monday through Friday, 8:00 a.m. to 9:00 p.m. (EST)
- Fax: (888) 693-3210 - Available 24 hours a day
- Online: <http://www.medsolutionsonline.com/> - Available 24 hours a day
- Customer Service: (888) 693-3211 - Available Monday through Friday, 8:00 a.m. to 9:00 p.m. (EST)

The prior authorization request applies to all high-tech imaging studies that are received in an outpatient setting that are elective, non-emergency, and diagnostic procedures. Prior authorization requests are not required for high-tech imaging studies that performed in an emergency room or an inpatient hospital or for a 23-hour

SECTION 2 POLICIES AND PROCEDURES

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Prior Authorization for High-Tech Radiology (Cont'd.)

observation stay.

The following Medicaid beneficiaries do not require prior authorization through MedSolutions:

- Dually Eligibles (beneficiaries with both Medicare and Medicaid)
- Beneficiaries in the Family Planning Only Program
- Beneficiaries that are incarcerated (including those in DJJ Facilities)
- Illegal Aliens
- Beneficiaries enrolled in an MCO Health Plan
- Beneficiaries with Private Primary HMO coverage
- Beneficiaries in Hospice
- Beneficiaries in the Palmetto Senior Care program (PACE)
- Beneficiaries in the Health Opportunities Account Program

Providers must refer members in an MCO to the appropriate MCO provider in order to determine if prior authorization applies to radiology services.

For any outpatient emergency study, providers may render the necessary care first, and then seek prior authorization within five business days of the date of service. MedSolutions will conduct a retrospective review to determine if the request was for an urgent condition and medically necessary. An emergency procedure is defined as one that is performed on a patient facing immediate loss of life or limb.

For outpatient urgent studies, providers should contact MedSolutions to request an expedited prior authorization review and provide the necessary clinical information. An urgent procedure is defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the Medicaid member's ability to regain maximum function, based on a prudent layperson's judgment, or (b) in the opinion of a practitioner with knowledge of the Medicaid member's medical condition, would subject the member to severe pain that cannot be adequately managed without the

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Prior Authorization for High-Tech Radiology (Cont'd.)

care or treatment that is the subject of the request. Moreover, urgent care services must be rendered within 12 hours in order to avoid the likely onset of an emergency medical condition.

Any changes in a study, rendering location, or CPT coding (upcoding or downcoding) require an update to the prior authorization request. Providers should contact MedSolutions by phone to update this information.

Prior authorization requests must be approved prior to the delivery of the service except in cases of an emergency or urgent nature or in cases where the beneficiary was not enrolled in Medicaid at the time the procedures were performed. Providers must submit any prior authorization requests where the beneficiary received retroactive Medicaid eligibility to the South Carolina Healthy Connections program staff. The provider must also, submit a copy of the retroactive Medicaid letter and all other related clinical information along with the request in order to be considered for approval.

Depo-Provera®, Vitrasert®, Synagis®, and Implanon™

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. Implanon™ is a single-rod implantable contraceptive that is effective for up to three years. Providers should continue to use the appropriate Family Planning diagnosis codes and CPT codes for the insertion and removal of the device.

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
- Implanon™, HCPCS code J7307

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,

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PROGRAM SERVICES

Physician Services (Cont'd.)

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.

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.

SECTION 2 POLICIES AND PROCEDURES**PROGRAM SERVICES***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.

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.

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PROGRAM SERVICES

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 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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.
- 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Subsection II (Cont'd.)

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.

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Cosmetic Procedures (Cont'd.)

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 that 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.

Hospital-Acquired Conditions (HACs)

The Centers for Medicare and Medicaid Services (CMS) requires Medicaid programs nationwide to demonstrate that they are not paying for Hospital-Acquired Conditions (HACs). The CMS list of HACs can be found at <http://www.cms.gov/HospitalAcqCond>. The APR-DRG software will identify diagnoses that meet the definition of a HAC. The grouper software will then ignore the HAC and assign a DRG as if it were not present. During the cost settlement process, adjustments will be made so that hospital costs associated with HACs are not reimbursed by SCDHHS. The proposed regulation also extends the nonpayment policy to Medicaid contracts. Therefore, the Managed Care plans will be required to not pay for HACs.

The CMS list of HACs includes, but is not limited to, surgeries performed erroneously. An inpatient claim with diagnosis codes for surgeries performed erroneously, E876.5 (Performance of wrong operation/procedure on correct patient), E876.6 (Performance of operation/procedure on patient not scheduled for surgery) or E876.7 (Performance of correct operation/procedure on wrong side/body part) will not be paid and will reject with

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospital-Acquired Conditions (HACs) (Cont'd.)

edit code 334 (Erroneous Surgery – Do Not Pay). The regulation allows states to define HACs (or “provider preventable conditions”) that the state may add to the list published by Medicare. At this time, South Carolina will not add to the CMS listing.

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. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

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 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

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.

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

SCDHHS
Division of Hospital Services
Attn: 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
Attn: 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

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PROGRAM SERVICES

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

- 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)
- 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. Once the out of state referral is approved, the provider should notify the beneficiary that if transportation is needed, the beneficiary should contact the SCDHHS transportation broker in his or her region.

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

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PROGRAM SERVICES

Foster Children Residing
Out of the SCMSA
(Cont'd.)

enrollment and billing information needs to be sent to the medical providers involved.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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.

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 the South Carolina service area. 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Level of Care Determination (Cont'd.)

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.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Retroactive Certification (Cont'd.)

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.

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

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PROGRAM SERVICES

Medical Record Requirements (Cont'd.)

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.

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:

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PROGRAM SERVICES

Billing Notes (Cont'd.)

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.

Administrative days claims must meet the Medicaid policy on time limits for submitting claims. Please refer to Section 1 for this information. An exception to this policy is retroactive eligibility.

For 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.

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 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Organ Transplants

Medicaid coverage of transplant services falls into two groups. Group I includes corneal and kidney transplants. Group II includes matched bone marrow, mismatched bone marrow, pancreas, heart, liver, small bowel, liver/small bowel, liver/pancreas, liver/kidney, kidney/pancreas, lung, heart/lung and multivisceral.

Group I

Corneal and Kidney

Corneal and kidney transplants do not require prior authorization. SCDHHS will establish a quarterly post payment review process for Kidney transplants to monitor utilization and other policy guidelines. All claims are subject to review by the agency's Division of Program Integrity.

Group II

Matched Bone Marrow, Mismatched Bone Marrow, Pancreas, Heart, Liver, Small Bowel, Liver/Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung, Heart/Lung and Multivisceral

Matched bone marrow (autologous inpatient and outpatient, allogeneic related and unrelated, and cord) transplants do not require prior authorization. SCDHHS will establish a quarterly post payment review process for matched bone marrow transplants to monitor utilization and other policy guidelines. All claims are subject to review by the agency's Division of Program Integrity.

Group II (Cont'd.)

All other potential transplants, cadaver or living donor, must be authorized by SCDHHS before the services are performed. SCDHHS staff, with the assistance of their Medical Directors, will review and authorize all requests for the evaluation of Group II organ transplant candidates. SCDHHS will only support the referral of patients for an evaluation to Centers for Medicare and Medicaid Services (CMS) certified transplant centers. This will include certified facilities that are contracted with SCDHHS as well as certified facilities that are located outside of the South Carolina medical service area (> 25 miles of South Carolina borders). For a complete list of CMS approved centers, visit the CMS Web site at <http://www.cms.hhs.gov/ApprovedTransplantCenters>.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Referral requests for organ transplants to both in-state and out-of-state centers must be submitted to the Division of Physician Services before the services are rendered. The requests should include the Transplant Prior Authorization Request Form, a letter from the attending physician that describes the type of transplant needed, the patient's current medical status, course of treatment, and the name of the center to which the patient is being referred. Upon approval, SCDHHS will issue an approval letter. The approval letter will serve as authorization for pre-transplant services (72 hours pre-admission), the transplant event (hospital admission through discharge), and post-transplant services up to 90 days from the date of discharge. The letter will also contain an authorization number that must be entered in the prior authorization field of all UB-04 and the CMS-1500 claim forms submitted for reimbursement.

Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

The fax number for submitting the request is (803) 255-8255.

Once the authorization letter is received, the provider should notify the beneficiary that if transportation is needed, the beneficiary should contact the SCDHHS transportation broker in his or her region.

Inpatient Psychiatric Disorders

All acute (non-state owned) inpatient admissions with the primary diagnoses of conduct disorder (diagnoses codes 312.0 - 312.9) and oppositional defiant disorder, (diagnosis code 313.81) require prior authorization. Alliant Health Solutions, the Medicaid Quality Improvement Organization (QIO), will perform the review and will accept prior authorization review requests via facsimile. The QIO's nurse reviewers will screen the medical information provided using InterQual criteria. It is the responsibility of the attending physician to submit the Request for Prior Approval Review form and all current medical documents that support the medical necessity of the admission to the QIO.

If criteria are met, the admission will be approved and an authorization number assigned. The QIO will provide the physician's office staff with the authorization number by

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PROGRAM SERVICES

Inpatient Psychiatric Disorders (Cont'd.)

facsimile. For emergency or urgent admissions, providers must contact the QIO via facsimile for authorization within 24 hours of the date of the admission.

Hysterectomy

Medicaid requires pre-admission surgical justification for hysterectomies. InterQual criteria will be used for screening prior authorization requests. Urgent and emergent cases will be reviewed retrospectively by the QIO.

All prior approval requests for hysterectomies must be in writing. Requests are accepted via facsimile. The South Carolina Medicaid Program Surgical Justification Form for Hysterectomy and the Hysterectomy Acknowledgement Form (DHHS Form 1729) must both be completed and submitted to the QIO at least 30 days prior to scheduled surgery. Forms should be sent submitted via facsimile to Alliant Health Solutions at (803) 255-8260.

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.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hysterectomy (Cont'd.)

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.

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,

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PROGRAM SERVICES

Definitions (Cont'd.)

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.
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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Sterilization Requirements (Cont'd.)

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

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 the Forms section of this manual.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Elective Abortions (Cont'd.)

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 the Forms section of this manual.

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Billing Notes for Abortions (Cont'd.)

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.

Back/Spinal Surgery and Other Back Procedures

Back/spinal surgery and other back procedures require prior authorization. Alliant Health Solutions is responsible for reviewing and approving prior authorization requests using InterQual criteria.

Reduction Mammoplasty

Reduction mammoplasty for large, pendulous breasts on a female may be considered medically necessary and not a cosmetic procedure when InterQual screening criteria is met. Prior authorization is required for all ages.

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.

Repeat Female Reduction Mammoplasty

Repeat Female Reduction Mammoplasty may be considered when supporting documentation meets InterQual screening criteria.

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. Reimbursement is also allowed for the reconstruction of both breasts following a bilateral mastectomy when

SECTION 2 POLICIES AND PROCEDURES**PROGRAM SERVICES****Reconstructive Breast Surgery (Cont'd.)**

medical evidence supports the removal of both breasts because of the high incidence for the development of cancer in the unaffected breast.

Prior authorization must be obtained. Alliant Health Solutions is responsible for prior authorization requests. InterQual screening criteria applies.

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, see "Procedure Codes Requiring Prior Authorization" in Section 4.

Gynecomastia

Although unilateral or bilateral mastectomy in a male is rarely indicated, this procedure may be allowed when medically necessary. Prior authorization must be obtained by the attending physician. The South Carolina Medicaid Program Request for Prior Approval form and all necessary documentation should be submitted via facsimile to Alliant Health Solutions at (803) 255-8260. InterQual screening criteria applies.

Adolescent Male Gynecomastia

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

Repeat Male Gynecomastia

Repeat Male Gynecomastia may be considered when supporting documentation meets InterQual screening criteria.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Obesity (Cont'd.)

for one of these illnesses. The following services are not covered by Medicaid:

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

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 may 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.

Prior authorization is required from Alliant Health Solutions. InterQual screening criteria applies.

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 that was caused by the pannus or aggravated by the pannus.

Prior authorization is required and requests may be submitted to Alliant Health Solutions via facsimile at (803) 255-8260. InterQual screening criteria applies.

Positron Emission Tomography (PET) Scans

SCDHHS will reimburse for certain Positron Emission Tomography (PET) scans. PET scan reimbursement is limited to one per twelve (12) months. PET scans will be

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Positron Emission Tomography (PET) Scans (Cont'd.)

covered only for the staging and restaging of cancer malignancies. They should not be utilized for screening purposes. The use of PET scans to monitor tumor response during a planned course of therapy is not covered.

Restaging only occurs after a course of treatment is completed. The clinical applications for coverage include services relating to Brain Cancer, Breast Cancer, Colorectal Cancer, Esophageal Cancer, Head and Neck Cancers, Lung Cancer, Lymphoma, Melanoma, Refractory Seizures, Solitary Pulmonary Nodule, and Thyroid Cancer.

PET scans will be subject to retrospective review to include paid inpatient/outpatient hospital claims and physician claims. Documentation must be maintained in the beneficiary's medical records to support the medical necessity of the procedure.

Dental Services

Adults

Beneficiaries over the age of 21 may be eligible for dental services only if the services are delivered in preparation for or during the course of treatment for one or more of the following conditions:

- Organ transplants
- Chemotherapy for cancer treatments
- Radiation of the head and/or neck for cancer treatments
- Total joint replacement
- Heart valve replacement
- Treatment of trauma related injuries administered in a hospital or outpatient facility

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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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 Representative
Post Office Box 8206
Columbia, SC 29202-8206

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Outpatient Dialysis (Cont'd.)

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 the Forms section 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.

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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Covered Conditions (Cont'd.)

- 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 seeks the source of the pain as well as work to relieve and resolve the pain. 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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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. InterQual screening criteria applies.

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-Spasmotic Drugs for Severe Spasticity — An implantable infusion pump is covered when used to administer anti-spasmotic 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:

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PROGRAM SERVICES

Implantable Infusion Pumps (Cont'd.)

- 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.
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

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Implantable Infusion Pumps (Cont'd.)

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.

SPECIAL COVERAGE GROUPS

Family Planning Services

Family planning services are defined as those services that prevent or delay unwanted or unintended pregnancies. These services include pregnancy prevention services for males (vasectomies) or females of reproductive age (typically between the ages of 10-55 years).

Family planning services do not require a referral or prior authorization for beneficiaries in Medicaid's managed care programs. All services rendered to dually eligible, both Medicare and Medicaid, patients should be filed to Medicare first. Some family planning services which are non-covered by Medicare are reimbursed by Medicaid.

For billing procedures, contact Physician Services at (803) 898-2660.

Covered Services

Family planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as Medicaid providers. They include family planning examinations, counseling services related to pregnancy prevention, contraceptives, family planning related laboratory services, etc., and sterilizations (including vasectomies) with a completed sterilization consent form (located in the Forms section of this manual). All family planning services must be billed using the appropriate CPT or HCPCS code with the FP modifier and/or appropriate family planning diagnosis code. Hospital claims for family planning services are not required to report the FP modifier.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services

Services required to manage or treat medical conditions and/or diseases, whether or not such procedures are also related to preventing or delaying pregnancy, are not eligible as family planning. Services to address side effects or complications associated with various family planning methods requiring medical interventions other than changing the birth control method (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) should not be billed using the FP modifier and/or family planning diagnosis code.

The following are also not considered family planning services:

- Routine gynecological exams (diagnosis code V72.3) in which contraceptive management is not provided
- Services normally rendered for pregnancy prevention that are rendered for other medical purposes (*e.g.*, administering Depo-Provera for endometriosis)

Many procedures that are performed for “medical” reasons also have family planning implications. When services other than family planning are provided during a family planning visit, these services must be **billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable**. Some examples of these include:

- Sterilization by hysterectomy
- Abortions
- Hospital charges incurred when a beneficiary enters the hospital for sterilization purposes, but then opts out of the procedure
- Removal of an IUD due to a uterine or pelvic infection
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions
- Diagnostic or screening mammograms
- Medical complications requiring treatment (for example, perforated bowel or bladder tear) caused by, or following, a family planning procedure
- Any procedure or service provided to a woman who

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services (Cont'd.)

is known to be pregnant

- Removal of contraceptive implants due to medical complications
- Services to a woman who has been previously sterilized

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Family Planning Waiver

The South Carolina Department of Health and Human Services (SCDHHS) has received approval from the Centers for Medicare & Medicaid Services (CMS) to continue the Family Planning Waiver (FPW) Expansion of Medicaid Benefits for women for an additional three years (January 1, 2008 through December 31, 2010). It is an optional eligibility category providing **outpatient** family planning services along with testing for Sexually Transmitted Infections (STIs), and initial antibiotic treatment of six STIs. It is limited to **females** of childbearing age (typically 10-55) who do not qualify for an eligibility category with the full range of Medicaid benefits. These women are at or below 185% of the Federal Poverty Level (FPL). An application is necessary to determine if the woman qualifies for this eligibility category or the full array of services under another eligibility category. If the beneficiary becomes eligible for full coverage of Medicaid benefits, she will have the option of being terminated from the FPW and transferred to the appropriate eligibility category that will enable her to receive the full range of Medicaid-covered services as well as Family Planning services.

Although only outpatient pregnancy prevention services along with testing and initial antibiotic treatment for six sexually transmitted infections are covered for women sponsored by the FPW, the Medicaid program promotes the increased use of primary medical care. Services provided to women sponsored by the FPW that are not pregnancy prevention are the responsibility of the patient.

Note: If a medical condition/problem is identified and the provider is unable to offer free or affordable care, the provider should refer the beneficiary to her local health department for a listing of primary care providers or call the Department of Medical Support Services at (803) 898-4614 for a listing of primary care providers who will

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Family Planning Waiver (Cont'd.)

provide services based on the woman's income.

The South Carolina Breast and Cervical Cancer Early Detection Program (Best Chance Network) provides coverage to women under the age 65 who have been diagnosed and found in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). For further information, providers or beneficiaries may call 1-888-549-0820 (toll-free).

Family planning services provided to women under the FPW category are billed using the appropriate CPT code or HCPCS code with an FP modifier and/or family planning diagnosis code. **Hospital claims for Family Planning services are not required to report the FP modifier.** When a Pap smear is sent to an outside lab for screening, the lab staff must be notified that the patient is an FPW recipient so they can bill using an appropriate diagnosis code and an FP modifier to ensure proper payment.

For approved codes covered under the FPW see Section 4 of this manual.

Note: This list will be updated periodically as codes are approved and/or deleted. All family planning services **must** be billed using a family planning modifier (FP) and family planning diagnosis code.

Covered Services Under Family Planning Waiver

Family planning services are defined as those services that prevent or delay unwanted or unintended pregnancies. Family planning services may be prescribed and rendered by physicians, clinics, or other Medicaid providers recognized by state and federal laws and enrolled as Medicaid providers to eligible women of childbearing age (typically ages 10-55). These include family planning examinations, counseling services related to pregnancy prevention, contraceptives, family-planning-related laboratory services, and sterilizations with a completed sterilization consent form (located in the Forms section of this manual). Family planning services should be billed using the appropriate CPT or HCPCS code with an FP modifier and appropriate family planning diagnosis code.

Note: Pregnancy testing (when the test result is negative) is a reimbursable family-planning-related service in two situations:

1. The test is provided at the time family planning

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PROGRAM SERVICES

Covered Services Under Family Planning Waiver (Cont'd.)

services are initiated for an individual.

2. The test is provided after the initiation of family planning services, when the patient may not have used the method properly, or when the patient is having an unusual response to the family planning method.

Effective January 1, 2008, if, during an initial or annual family planning evaluation/management visit, any of six specific sexually transmitted infections (STIs) is identified, one course of antibiotic treatment from the approved drug list (see Section 4) will be allowed per calendar year under the FPW. The six covered STIs are syphilis, chlamydia, gonorrhea, herpes, candidiasis, and trichomoniasis. Any co-pays for the medications will be the responsibility of the patient.

Neither STI testing nor STI treatment are covered during any visit other than initial and/or annual visits.

Non-Covered Services Under Family Planning Waiver

Services required to manage or to treat medical conditions/diseases, whether or not such procedures are also related to preventing or delaying pregnancy, are not covered as family planning. Services to address side effects or complications (*e.g.*, blood clots, strokes, abnormal Pap smears, etc.) associated with various family planning methods requiring medical interventions other than changing the birth control method should not be billed using an FP modifier and/or family planning diagnosis code.

The following are also not considered family planning services and should not be billed with an FP modifier and and/or family diagnosis code:

- Routine gynecological exams (diagnosis code V72.3) in which contraceptive management is not provided
- Services normally rendered for pregnancy prevention that are rendered for other medical purposes (*e.g.*, administering Depo-Provera for endometriosis)

Many procedures that are performed for “medical” reasons also have family planning implications. When services other than family planning are provided during a family planning waiver visit, these services **are the responsibility**

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Non-Covered Services Under Family Planning Waiver (Cont'd.)

of the patient and are not billable under the FPW. Some examples of these include:

- Sterilization by hysterectomy
- Abortions
- Charges incurred when a recipient enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure
- Inpatient hospital services
- Removal of an IUD due to a uterine or pelvic infection
- Colposcopy and biopsy of cervix/vagina
- Diagnostic or screening mammograms
- Medical complications requiring treatment (*e.g.*, perforated bowel or bladder tear) caused by or following a family planning procedure
- Any procedure or service provided to a woman who is known to be pregnant
- Removal of contraceptive implants due to medical complications
- Services to a woman who has been previously sterilized
- Routine gynecological exams (diagnosis code V72.3) in which contraceptive management is not provided

Note: Beneficiaries are allowed one permanent sterilization procedure per lifetime.

Hospice

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

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

Hospice services are provided to the beneficiary according

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

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:

- 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:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Hospice (Cont'd.)

- o Provided (either directly or under arrangement) by the designated hospice
- o Provided by another hospice under arrangements made by the designated hospice
- o 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
- Occupational Therapy
- Ambulatory Surgery Clinics
- Medical Rehabilitation Services
- School-Based Services
- Physical Therapy
- Private Duty Nursing
- Podiatry

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

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

- 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-04. 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.

Qualified Medicare Beneficiary (QMB)

Medicaid beneficiaries who are also Qualified Medicare Beneficiaries (QMBs) are eligible for payment of the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid. Reimbursement for these services will be consistent with the SC State Medicaid Plan.

Please refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries.

Please refer to the Medicaid Web-Based Claims Submission Tool, in Section 1, for instructions on how to access beneficiary information, including QMB status.

MEDICAID MANAGED CARE

Medical Homes Network (MHN)

MHN 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.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Managed Care Organizations (MCOs)

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 eligibility to see if the beneficiary is enrolled in a Medicaid MCO. Services rendered to a beneficiary who is enrolled in a Medicaid MCO require the rendering provider 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 MCO's scope of service.
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.