

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



CLINIC SERVICES PROVIDER MANUAL

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South Carolina Department of Health and Human Services

CONTENTS

- 1. Program Overview 1
 - Requirements for Participation 1
 - Pre- and Post-Payment Review..... 1
 - Medical Records 1
 - Treatment Rendered Outside the South Carolina Medical Service Area..... 2
- 2. Covered Populations..... 3
 - Eligibility/Special Populations 3
- 3. Eligible Providers 5
 - Provider Qualifications 5
- 4. Covered Services and Definitions 9
 - Injections 9
 - Orphan Drugs..... 9
 - Family Planning Services 10
 - Opioid Treatment Programs (OTP)..... 22
 - Non-Covered Services 24
- 5. Utilization Management..... 28
 - Prior Authorization..... 28
- 6. Billing Guidance 29
 - End Stage Renal Disease Program 29
 - Ambulatory Surgical Centers 31
 - Outpatient Pediatric AIDS Clinics 36

- Opioid Treatment Programs (OTP).....40

1

PROGRAM OVERVIEW

REQUIREMENTS FOR PARTICIPATION

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

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

The South Carolina Medicaid Program will reimburse for services provided in the following clinics/centers: End Stage Renal Disease (ESRD) Clinics, Ambulatory Surgery Centers (ASC), Outpatient Pediatric AIDS Clinics (OPAC), and Infusion Centers. Policies and procedures that govern reimbursement for services provided in these facilities are outlined in this section.

PRE- AND POST-PAYMENT REVIEW

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

MEDICAL RECORDS

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

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

TREATMENT RENDERED OUTSIDE THE SOUTH CAROLINA 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. Clinics in Charlotte, Augusta, and Savannah are also considered within the service area and would not require prior authorization.

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

- A beneficiary traveling outside the SCMSA needs emergency medical services and the beneficiary’s health would be endangered if necessary care were postponed until his or her return to South Carolina.
- A physician makes an out-of-state referral because needed services are not available within the SCMSA.

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

Note: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)
- [Procedure Codes](#)

2

COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Breast and Cervical Cancer Early Detection Program (Best Chance Network)

The South Carolina Breast and Cervical Cancer Early Detection Program (Best Chance Network) provides coverage for women under the age of 65 who have been diagnosed and found to be 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 toll free +1 888 549 0820.

End Stage Renal Disease Program

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

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

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

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

Medicaid Claims Receipt
Post Office Box 1412
Columbia, SC 29202-1412

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

Outpatient Pediatric AIDS Clinics

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

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

- Proper care for infected infants and children, (i.e., pneumocystis carinii prophylaxis or specific treatment for HIV infection).
- Coordinate primary care services with the family's primary care provider (when one is available and identified).
- Coordinate required laboratory evaluations when clinical evaluations are not needed. Laboratory evaluations may be arranged at local facilities if this is more convenient for the patient/family and if the tests are available locally. These evaluations may be coordinated with the primary care provider and often with the assistance of local health department personnel.
- Management decisions and regularly see the child(ren) and parents when HIV-infected children are hospitalized at a Level III hospital. When HIV-infected children are hospitalized at regional or local hospitals with less severe illnesses, staff must provide consultation to assist in the management of their care.

Clinic personnel must provide case coordination and social work services to the families to assure specialty and primary care follow-up and to assist in obtaining needed services for the child and family.

3

ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

Ambulatory Surgical Centers

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

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

Outpatient Pediatric AIDs Clinics

Provision of Personnel

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

Pediatric Infectious Disease Specialist

The pediatric infectious disease specialist will see all patients. His or her role is to perform a medical assessment by history and physical examination and to assess the results of all laboratory studies. The physician makes all decisions regarding therapeutic intervention and communicates results of the clinic assessments and therapeutic plan to the primary care physician. The pediatric infectious disease specialist consults with clinic staff regarding appropriate interval follow-up care, consults with the primary care provider regarding both the ongoing care of the children and management of acute problems, and maintains current knowledge related to HIV care through medical literature and continuing medical education.

Case Coordinator

The case coordinator is responsible for scheduling the patient for clinic appointments, taking into account both the medical needs of the patient and the scheduling concerns of the parents. The case coordinator coordinates and facilitates patient flow among various providers, meets individually with

each family to provide counseling and education regarding HIV infection and the health and social issues related to the infection, follows up all laboratory studies performed during the clinic visits, conducts and chairs staff meetings for the multidisciplinary clinic providers, serves as liaison to all community-based services involved in the care of the patient/family, and assesses the ability of the family to meet the health care needs of the child and to comply with the recommended treatment plan.

Nutritionist

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

Social Worker

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

Child Life Specialist

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

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

Infusion Centers

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

- Centers must be enrolled by SCDHHS and provide cost report information upon request.
- Centers must be freestanding and have a non-physician-type office setting.

- Centers owned by or affiliated with a hospital must work independently from the hospital, and costs associated with the center must not be included in the hospital's inpatient or outpatient cost reporting.
- Professional staff must be licensed and meet South Carolina state laws governing the practice for the services they provide.
- Centers must have the ability to perform the following therapy services:
 - Chemotherapy
 - Hydration
 - Immune globulin intravenous (IGIV)
 - Blood and blood products
 - Antibiotics
 - Intrathecal/lumbar puncture
 - Inhalation
 - Therapeutic phlebotomy

A physician, nurse practitioner (NP), or physician assistant (PA) must provide direct supervision in the infusion center setting. The clinician providing direct supervision must be permitted by the South Carolina Code of Laws to perform and supervise the services or procedures. The clinician must be available to furnish assistance and direction throughout the performance of the procedure. Also the clinician providing supervision must have sufficient knowledge and training to administer medication and lifesaving procedures during a medical emergency.

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

Opioid Treatment Programs (OTP)

Provider Requirements

Eligible OTPs must meet all the standards required of an OTP as described in 42 CFR 8.12 and maintain the following provider requirements:

- Be an enrolled Medicaid provider
- Be licensed by the South Carolina Department of Health and Environmental Control (DHEC) as a Narcotic Treatment Program (NTP)
- Be registered with the Drug Enforcement Agency (DEA)
- Hold a current and active certification from the Substance Abuse and Mental Health Services Administration (SAMHSA) as an Opioid Treatment Program
- Be accredited by CARF, JCAHO, or other SAMHSA approved OTP-accrediting body
- Hold a permit with the South Carolina Board of Pharmacy

Provision of Personnel

Each OTP must be staffed with personnel in accordance with CFR 8.2. Staff providing direct client services must meet licensing as specified by the South Carolina Department of Health and Environmental Control (DHEC) Psychoactive Substance Abuse or Dependence (PSAD) standards.

4

COVERED SERVICES AND DEFINITIONS

INJECTIONS

Injectable drugs are covered if the following criteria are met:

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

Drugs and biologicals that have not received final marketing approval by the FDA are not covered unless CMS advises otherwise. For a list of injectable drugs, see the procedure code information available on the provider portal.

Unlisted Injections

The name of the drug (including the dosage given and the National Drug Code [NDC] number) must be attached to the claim with an invoice indicating the cost of the drug. Medical necessity must also be documented; the provider should attach a copy of the physician's order and the flow sheet to the claim.

Claims billing chemotherapy drugs or "other drugs" without documentation will be rejected.

A list of injection codes for each program is provided on the provider portal. Separate reimbursement for supplies is not allowed.

ORPHAN DRUGS

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

- Liletta®
- Mirena®
- Paragard®
- Skyla®
- Implanon®/Nexaplanon®
- Kyleena®

Sterilization

For all elective sterilizations, SCDHHS requires the provider and beneficiary to complete a Consent for Sterilization form located on the provider portal. The Consent for Sterilization form (DHHS Form 687) has been designed to meet all federal requirements associated with elective sterilizations. The physician should submit a properly completed consent form with his or her claim so all providers including clinics and hospitals may also be reimbursed.

*****The sterilization consent form is codified in federal regulations as an Appendix to 42 CFR 441 Subpart F. Because the form is codified in federal regulation it never expires and must be used regardless of whether there is a current OMB date. For Medicaid purposes the form does not require an expiration date to be valid. This is the only form that can be used, and it may not be altered in any way. The lack of a current form is not a valid reason to deny a claim providing the form has not been altered and is compliant with regulations. *****

Definitions as described in the Code of Federal Regulation:

- **Sterilization** — Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.
- Institutionalized Individual — An individual who is:
 - 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.
 - Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.
- **Mentally Incompetent Individual** — Means an individual who has been declared mentally incompetent by a federal, state, or local court. All sections of the Consent for Sterilization form must be completed when submitted with the claim for payment. Each sterilization claim and consent form is reviewed for compliance with federal regulations.

Requirements

In order for Medicaid to reimburse for an elective sterilization, the following requirements must be met:

- The Consent for Sterilization form must be signed at least 30 days prior to, but no more than 180 days prior to, the scheduled date of sterilization.
- The individual must be at least 21 years old at the time the consent form is signed.
- The beneficiary cannot be institutionalized or mentally incompetent. If the physician questions the mental competency of the individual, he or she should contact the Provider Service Center (PSC) at (888) 289-0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.
- The individual must voluntarily give consent. All questions must be answered and all topics in the consent form discussed. (A witness of the beneficiary's choice may be present during the consent interview.) The FP counseling or FP education/instruction procedure code may be billed when this service is rendered and documented.
- A copy of the consent form must be given to the beneficiary after Parts I, II, and III are completed.
- At least 30 days, but not more than 180 days, must pass 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). No one can sign the form for the individual.

Exceptions to the 30-day waiting period are:

- **Premature Delivery** — The informed consent must have been signed at least 30 days prior to the expected date of delivery. In cases involving a Cesarean section (C--section), the scheduled date of the C--section is considered the expected date of delivery. At least 72 hours must have elapsed since the informed consent was given.
- **Emergency Abdominal Surgery** — The emergency does not include the operation to sterilize the beneficiary. At least 72 hours must have elapsed since the informed consent was given. An explanation must accompany the consent form.

Note: If the beneficiary is pregnant, premature delivery is the only exception to the 30-day waiting period. Informed consent may not be obtained while the beneficiary to be sterilized is:

- In labor or childbirth.
- Seeking or obtaining an abortion.

- Under the influence of alcohol, controlled substances, or other substances which may affect the beneficiary's judgment.

Consent for Sterilization Form

If the consent form was correctly completed and meets all federal regulations, the claim will be approved for payment. If the consent form does not meet the federal regulations, the claim will be rejected and a letter sent to the physician explaining the rejection.

If the consent form is not attached to the claim, the claim will be rejected and a new claim will need to be filed with the Consent for Sterilization form attached.

Listed below are explanations of each field that must be completed on the consent form and whether it is a correctable error.

Consent to Sterilization

- Name of the physician or group scheduled to do the sterilization procedure. (If the physician or group is unknown, put the phrase "OB on Call"): Correctable Error.
- Name of the sterilization procedure (e.g., bilateral tubal ligation): Correctable Error.
- Birth date of the beneficiary. (The beneficiary must be at least 21 years old when he or she gives consent by signing the consent form 30 days prior to the procedure being performed.): Correctable Error.
- Beneficiary's name. (Name must match name on CMS-1500 form): Correctable Error.
- Name of the physician or group scheduled to perform the sterilization or the phrase "OB on call"; Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Beneficiary's signature. (If the beneficiary signs with an "X," an explanation must accompany the consent form.): Non--correctable error.
- Date of Signature: Non--correctable error without detailed medical record documentation.
- Beneficiary's Medicaid ID number (10 digits): Correctable Error.

Interpreter's Statement

If the beneficiary had an interpreter translate the consent form information into a foreign language (e.g., Spanish, French, etc.), the interpreter must complete this section. If an interpreter was not necessary, put "N/A" in these fields: Correctable Error.

Statement of Person Obtaining Consent

- Beneficiary's name: Correctable Error.

- Name of the sterilization procedure: Correctable Error.
- Signature and date of the person who counseled the beneficiary on the sterilization procedure.: This date must be the same date of the beneficiary's signature date.
 - Signature is not a correctable error.
 - Date is not a correctable error without detailed medical record documentation.
 - If the beneficiary signs with an "X," an explanation must accompany the consent form: Not a correctable error without detailed medical record documentation.
- A complete facility address: An address stamp is acceptable if legible.

Physician's Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure. (This date must match the date of service physician is billing for on the CMS-1500.): Correctable Error.
- Name of the sterilization procedure: Correctable Error.
- Estimated Date of Confinement is required if sterilization is performed within the 30-day waiting period and the beneficiary was pregnant. At least 72 hours are required to pass before the sterilization procedure may be done: Correctable Error.
- An explanation must be attached if emergency abdominal surgery was performed within the 30-day waiting period. At least 72 hours are required to pass before the sterilization, and the sterilization procedure may not be the reason for the emergency surgery.
- Physician signature and date: a physician's stamp is acceptable.

The rendering or attending physician must sign the consent form and bill for the service. The Consent form must be dated on the same date as the sterilization or after. The date is **not a correctable error** if the date is prior to the sterilization without detailed medical record documentation. In the license number field, put the rendering physician's Medicaid legacy Provider ID or National Provider Identifier (NPI) number. Either the group or individual Medicaid legacy Provider ID or NPI is acceptable.

Billing Notes for Sterilization and Other Related Procedures

Under the following circumstances, bill the corresponding sterilization procedure codes:

Essure® Sterilization Procedure

SCDHHS will reimburse for the Essure® Sterilization procedure only when certain criteria are met. This procedure is available to women who have risk factors that prevent a physician from

performing a safe and effective laparoscopic tubal ligation. Reimbursement will be provided for any of the following criteria:

- Morbid obesity (BMI of 35 or greater).
- Abdominal mesh that mechanically interferes with the laparoscopic tubal ligation.
- Permanent colostomy.
- Multiple abdominal/pelvic surgeries with documented severe adhesions.
- Artificial heart valve requiring continuous anticoagulation.
- Any severe medical problems that would contraindicate laparoscopy because of anesthesia considerations. (This must be attested in the request for prior approval that general anesthesia would pose a substantial threat to beneficiary's life.)

SCDHHS removed the prior authorization and criteria requirements for the Essure® sterilization procedure. The procedure will be covered when performed in an inpatient or outpatient hospital setting or in a physician's office. SCDHHS will reimburse for the implantable device by utilizing the appropriate code with the FP modifier appended, and the professional service will be reimbursed utilizing the appropriate CPT code must also have the FP modifier appended. Hysterosalpingogram and Radiological supervision and interpretation should be billed as follow--up procedures 90 days after the sterilization. Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a Consent for Sterilization form with the claim.

Sterilization Codes and Services:

- Tubal ligation following a vaginal delivery by a method except laparoscope
- Tubal ligation following C--section or other intra-abdominal (tubal ligation as the minor procedure) surgery
- Ligation, transection of fallopian tubes; abdominal or vaginal approach
- Occlusion of fallopian tubes by device
- Laparoscopic sterilization by fulguration or cauterization
- Laparoscopic sterilization by occlusion by device
- Vasectomy

Provision of the services listed above should always be billed via hardcopy with a copy of the Consent for Sterilization form attached.

ESRD Program

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

- Technical Component — Policies and procedures are outlined in this section.
- Professional Services (Nephrology) — Policies and procedures can be found in the Physicians, Laboratories, and Other Medical Professionals Medicaid Provider Manual.

Procedure codes for ESRD services can be found on the provider portal.

The Composite Rate — Medicaid Only

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

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

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

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

Hospital Outpatient Dialysis

Medicaid will sponsor outpatient services related to ESRD treatment under the same guidelines outlined for ESRD clinics and if the hospital is certified as a hospita-l-based ESRD clinic. Hospitals presently certified are Palmetto Richland Memorial Hospital, St. Francis Hospital, the Medical University of South Carolina, Hampton Regional Medical Center, Charlotte Memorial Hospital,

Medical College of Georgia, and Carolinas Hospital System. Hospital outpatient dialysis services are billed on the Uniform Billing (UB) claim form and reimbursed under the Outpatient fee schedule.

Hospital Inpatient Dialysis

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

Guidelines for Hepatitis B Vaccine

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

- First dose.
- Second dose — One month after first dose.
- Third dose — Six months after first dose.
- One month after the third dose the patient should be tested for Hepatitis B Surface Antibody to determine whether he or she has responded to the vaccine. If the vaccine was successful, the patient should be tested annually for Hepatitis B Surface Antibody to confirm immunity.
- Patients who received the Hepatitis B vaccine but did not develop an immunity to Hepatitis B should be tested (Hepatitis B Surface Antigen Test) once a month.

Blood Products and Transfusion

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

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

Ambulatory Surgical Centers

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

- Facility Services — Policies and procedures are outlined in this section.
- Physician's Professional Fee — Reimbursement for professional services can be found in the Physicians, Laboratories, and Other Medical Professionals Medicaid Provider Manual.

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

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

Facility Services

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

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

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

Nursing Services, Services of Technical Personnel and Other Related Services

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

Use by the Patient of the ASC's Facilities

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

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

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

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

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

Blood and Blood Products

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

Diagnostic or Therapeutic Items and Services

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

Administrative, Record Keeping, and Housekeeping Items and Services

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

Material for Anesthesia

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

Intraocular Lenses

ASC facility services include IOLs approved by the FDA for insertion during or subsequent to cataract surgery.

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

- Anterior chamber angle fixation lenses

- Iris fixation lenses
- Irido-capsular fixation lenses
- Posterior chamber lenses

Dental Services

South Carolina Medicaid will allow for the reimbursement of dental services performed in an ASC setting that are approved and listed on the Ambulatory Surgery Fee Schedule on the provider portal.

Laboratory and X-Ray Services

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

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

The South Carolina Medicaid Program requires that all independent laboratories meet Clinical Laboratory Improvement Amendments regulations and enroll with SCDHHS. For enrollment information, providers should write to Medicaid Provider Enrollment, Post Office Box 8809, Columbia, SC, 29202, or contact Medicaid Provider Enrollment via the SCDHHS Provider Service Center at +1 888 289 0709.

Prosthetics

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

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

The ASC must provide sufficient documentation to justify reimbursement for the item, as well as the charged rate for the item (i.e., the invoice). If Medicaid has knowledge the device could have been purchased from another source at a more reasonable rate, reimbursement may be considered on the basis of reasonable charge rather than actual cost.

Elective Sterilization

For policy, documentation, and billing guidance related to sterilizations please refer to the [Family Planning](#) section under the *Covered Services and Definitions* of this manual.

Hospice

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

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

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

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by a social worker who has at least a bachelor's degree and is working under the direction of a physician.
- Physicians' services provided by the hospice medical director or physician member of the interdisciplinary group.
- Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient care.
- Medical appliances and supplies, including drugs and biologicals. Only those supplies used for the relief of pain and symptom control related to the terminal illness are covered.
- Home health aide services and homemaker services.
- Physical therapy, occupational therapy, and speech/-language pathology services.
- Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home.

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

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

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

SCDHHS will require prior authorization for hospice services to Medicaid--only beneficiaries. The hospice provider must submit requests for prior authorization along with medical documentation to KEPRO. All hospice services except General Inpatient care will be pre-authorized for up to six months. If a beneficiary is in need of hospice services beyond the initial six months, the hospice provider must submit a new request to KEPRO.

Outpatient Pediatric AIDS Clinics

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

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

Zidovudine (AZT)

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

OPIOID TREATMENT PROGRAMS (OTP)

Introduction

Opioid Treatment Programs (OTPs) provide evidence-based medication assisted treatment (MAT) for persons with Opioid Use Disorder. OTPs employ multidisciplinary staff who provide services utilizing pharmacological, physiological and psychotherapeutic interventions to stabilize, prevent withdrawal, and help improve the overall functioning and health of beneficiaries with an OUD diagnosis.

Medical Necessity/Admission Guidelines

To qualify for admission into an OTP a beneficiary must meet one of the following requirements:

- Have a current DSM/ICD diagnosis of Opioid Use Disorder (OUD) and a history of physiological dependence for at least one year prior to admission OR
- If clinically appropriate, the program Physician or APRN may waive the requirement of a one-year history for:
 - Beneficiaries who have been previously treated for OUD and are at risk of relapse OR
 - Pregnant beneficiaries
 - Beneficiaries who have been released from a correctional setting within the last six months

Medical necessity must be confirmed at time of admission by Physician or APRN who is employed by the OTP and must be documented in the medical record.

OTP Service Guidelines

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

- A comprehensive medical history, physical examination, and lab screening.
- Intake activities for medication assisted treatment.
- Periodic assessment for medication assisted treatment. (up to four times per 12 month treatment period)
- An individual plan of care (IPOC) with short-term and measurable treatment goals at the onset of treatment and reformulation annually.
- Assessment, ordering, administration, and regulation of medication to levels that are appropriate for the individual and supervise withdrawal management.
- Urine drug screenings at a minimum of once (1) per month.
- 90-day progress summaries documenting the evaluation of a beneficiary's progress toward the achievement of goals and objectives, overall response to treatment, appropriateness of services rendered. The progress summary shall be completed at least every 90-calendar days from the signature date on the initial IPOC and maintained in the medical record.
- Medical counseling as needed on health topics such as HIV/AIDS and Hepatitis.
- Case management as needed to include medical monitoring, coordination of care, and referral to ancillary services (e.g. treatment for psychiatric illness, and primary health care).
- If pregnant, the beneficiary must meet with the physician at least once monthly.

Continuation of Care Guidelines

Medical necessity should be re-established on an annual basis as confirmed by the persistence of a diagnosis of Opioid Use Disorder and meet the following:

- If services are discontinued the beneficiary would be at risk of hospitalization or relapse of drug dependency.
- Another level of care is not clinically indicated at the time of assessment/reassessment.
- The beneficiary continues to make progress on established goals or continues to actively participate in treatment

Discharge Guidelines

Beneficiaries must be considered for discharge from treatment or transferred to another level of care when they meet any of the following criteria:

- The beneficiary no longer meets medical necessity
- The beneficiary successfully completes the treatment program
- The beneficiary requires either a higher or lower level of care
- Administrative discharge due to behavior that is inconsistent with treatment program standards or lack of participation in treatment.

Note: The reason for discharge must be documented in the beneficiary's medical record.

NON-COVERED SERVICES

Services beyond those outlined in this section that are required to manage or to treat medical conditions and/or diseases, whether or not such procedures are also related to FP, are not covered under the FP Program. Services to address side effects or complications (e.g., blood clots, strokes, abnormal Pap smears, etc.) associated with various FP methods requiring medical interventions (e.g., blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should not be billed using an FP modifier or FP diagnosis code. When services other than FP are provided during an FP visit, these services must be billed separately using the appropriate CPT/HCPCS codes and modifiers if applicable. Examples of these services include:

- Sterilization by hysterectomy.
- Abortions.
- Hospital charges incurred when a beneficiary enters an outpatient hospital/facility for sterilization purposes, but then opts out of the procedure.
- Inpatient hospital services.

- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions.
- Treatment of medical complications (for example, perforated bowel or bladder tear) caused by or following a FP procedure.
- Any procedure or service provided to a woman who is known to be pregnant.

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

FP Services

Examinations, Visits, Biennial Physical Examinations, FP Counseling, and screenings are not covered in the ASC, ESRD, and Infusion Center Clinic Settings.

Hospice

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

Services that require prior authorization are:

- ASCs
- Audiology
- County Health Departments
- Drug, Alcohol, and Substance Abuse Services
- Durable Medical Equipment (DME)
- Emergency Room
- Health Clinics
- Home- and Community -Based Services
- Home Health
- Hospital
- Medical Rehabilitation Services
- Mental Health

- Occupational Therapy
- Pharmacy
- Physical Therapy
- Podiatry
- Private Duty Nursing
- Psychologist Services
- School--Based Services
- Speech Therapy

If billing issues cannot be resolved with the hospice, contact the SCDHHS Provider Service Center (PSC) at +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

End Stage Renal Disease Program

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

Ambulatory Surgical Centers

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

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

These items and services should be billed to SCDHHS by the participating provider. The ASC will not receive separate reimbursement for these services. For example, items such as ace bandages, elastic stockings, and pressure garments are generally used as secondary coverings and would not be considered "primary" surgical dressings. Reimbursement for these items is available through the

Medicaid DME program and should be obtained from a DME provider enrolled in the South Carolina Medicaid Program.

5

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Ambulatory Surgical Centers

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

A complete list of approved procedure codes, including supplemental codes for dental services, is available on the provider portal.

6

BILLING GUIDANCE

END STAGE RENAL DISEASE PROGRAM

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

Vitamins and Supplements

For dually eligible beneficiaries, the Medicaid program is the primary sponsor for payment of the following list of vitamins and supplements. ESRD clinics may be reimbursed for the actual cost of distributing these vitamins and supplements.

- Multivitamins
- Vitamin D
- Nutritional Supplements
- Calcium
- Calcium Acetate
- Antacids (Phosphate Binders)
- Iron Salts
- Iron with Vitamins
- Iron Complex

Nephrology Services

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

Laboratory Services Included Under Composite Rate

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

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

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

Included in the composite rate:

- Per treatment: All hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments
- Weekly: Prothrombin time for patients on anticoagulant therapy and Serum Creatinine
- Weekly or 13 per quarter: BUN
- Monthly: Serum Calcium, Serum Potassium, Serum Chloride, CBC, Serum Bicarbonate, Serum Phosphorous, Total Protein, Serum Albumin, Alkaline Phosphatase, aspartate amino transferase (AST) (SGOT) and LDH
- Automated battery of tests: If an automated battery of tests such as the SMA-12 is performed, and contains most of the tests listed in monthly category, it is not necessary to separately identify any tests in the battery that are not listed above

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

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

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

Laboratory Tests for CAPD

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

- Monthly: Potassium, CO2, Calcium, Chloride, Total Protein, Albumin, Alkaline Phosphatase, Phosphorus, LDH, AST (SGOT), Creatinine, Sodium, and Urea Nitrogen (BUN)
- Separately billable laboratory tests:
 - WBC, RBC, and Platelet Count every three months
 - Residual Renal Function and 24-hour Urine Volume every six months

AMBULATORY SURGICAL CENTERS

For current ACS rates, please refer to the Ambulatory Surgery Fee Schedule which is found on the SCDHHS website: <http://www.scdhhs.gov>.

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

Certain codes covered in the ASC are considered medical, as highlighted in the codes information and will pay at 100% of the allowed rate or the charged rate, whichever is lower.

Dental Services

When multiple dental services are performed at the same operative session, it is imperative that providers bill for the procedure with the highest payment grouping (primary code group) to be reimbursed at 100%. This primary procedure should not be billed with a modifier. All second and subsequent dental services performed during the same surgical operative session will be reimbursed at 50% of the established rate and must be billed using the U9 modifier.

All claims will be subject to post--payment review by Program Integrity (PI).

Hospital Acquired Conditions

SCDHHS will make zero payments to providers for Other Provider Preventable Conditions which includes Never Events. The reporting requirements for Never Events include ASCs and Practitioners. These providers will be required to report Never Events on the CMS-1500 claim form or the 837-P claim transaction. Avoidable errors that fall under this policy include:

- Wrong surgical or other invasive procedure performed on a patient
- Surgery or other invasive procedure on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

ASCs are required to follow the following procedures for reporting avoidable errors (Never Events):

Claims submitted using the CMS-1500 claim form or 837-P claim transaction, must include the appropriate modifier appended to all lines that relate to the erroneous surgery(s) or procedure(s) using one of the following applicable National Coverage Determination modifiers:

- PA — Surgery wrong body part
- PB — Surgery wrong patient
- PC — Wrong surgery on patient

The non-covered claim must also include one of the following ICD-10-CM diagnosis codes reported:

- Y65.51 — Performance of wrong procedure (operation) on correct patient
- Y65.52 — Performance of procedure (operation) on patient not scheduled for surgery
- Y65.53 — Performance of correct procedure (operation) on wrong side or body part

Related Claims

Within 30 days of receiving a claim for a surgical error, SCDHHS shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, the PI Division or its designee will audit all claims for the recipient to determine if they relate to or have the potential to be related to the original Never Event claim. When PI or its designee identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, PI or its designee will continue to review recipient history for related claims and take appropriate action as necessary. Related services do not include performance of the correct procedure.

General Provisions

Medicaid will not pay any claims for “provider -preventable conditions” for any member who is Medicare/Medicaid eligible.

No reduction in payment will be imposed on a provider for a provider preventable condition, when the condition defined as a PPC for the particular member existed prior to the initiation of the treatment for that member by that provider.

Reductions in provider payments may be limited to the extent that the following apply:

- The identified PPC would otherwise result in an increase in payment.
- The SCDHHS can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

To review the complete Health Acquired Conditions policy you may go to:

<http://www.cms.gov/HospitalAcqCond>.

Multiple Surgery Guidelines

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

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

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

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

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

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

- Tonsillectomy and adenoidectomy.
- Two endoscopic surgical procedures on the same anatomical site, or two like procedures through the same incision. When a surgical procedure is performed through an endoscope, the diagnostic endoscopy is inclusive in the reimbursement. The facility may be reimbursed either for the endoscopic procedure or the diagnostic endoscopy, but not for both.

- Incidental procedures (i.e., appendectomy, lysis of adhesions during other abdominal procedure). If a procedure is carried out through the laparotomy incision, the facility may choose to bill for the laparotomy or the actual procedure performed during the surgery. Most likely, it will be the code that reimburses the higher rate. In any case, Medicaid will sponsor payment for one or the other, but not for both.
- Bilateral procedures (through same incision).
- Application of a splint or cast following surgical fracture repair.

Payment Guidelines

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

No reimbursement will be made for subsequent procedures which 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 (i.e., laparoscopy with lysis of adhesions and laparoscopy with fulguration of oviducts [with or without transection] or laparoscopy with occlusion of oviducts by device).

Modifiers

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

Billing Guidelines

Claims for surgery must be filed using the CPT code that most closely describes the surgical procedure that was performed.

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

- On a single CMS claim form

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

- Only subsequent procedures that add significantly to the major surgery (not services incidental to the major surgery (e.g., incidental appendectomy, incidental scar excision, puncture of ovarian cyst, simple lysis of adhesions, simple repair of hiatal hernia)

- In order of complexity with the most complex procedure first
- Using the appropriate modifier; Medicaid will key the first modifier indicated for each procedure only
- With charges listed separately for each procedure
- With appropriate number of units, if applicable, according to procedure code description

When identical procedures (not bilateral) are billed for the same day, the first should be billed without a modifier, and the second with modifier LT or RT. If the same procedure is billed a third time, the claim must be filed hard copy with supporting documentation. Failure to include documentation will result in an 892 edit. The provider must submit a new claim with appropriate documentation indicating a repeat service.

Separate Procedures Performed on the Same Date of Service

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

78 — Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period.

79 — Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period

Bilateral Surgery

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

If the description for a procedure notes the service is a “bilateral” or “unilateral or bilateral” procedure, do not report modifier 50 with the procedure code. Examples of bilateral procedures include lengthening of hamstring tendon; multiple, bilateral and Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral.

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

OUTPATIENT PEDIATRIC AIDS CLINICS

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

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

Infusion Centers

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

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

Injectable drugs may be billed in addition to the therapy codes. A complete list of these drug codes can be found on the provider portal. The Injectable Drug Fee schedule can be found on the SCDHHS website at <https://www.scdhhs.gov/resource/fee-schedules>.

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

Medical Record Documentation Requirements

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

Drugs and/or Blood Service Sponsored or Donated

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

Drugs and services sponsored, donated, or otherwise paid for by outside sources are not reimbursed by Medicaid and should not be billed. Billing these services to SCDHHS will result in recoupment. It is recommended that the infusion center have internal measures to identify which

services are provided at no expense to the center. This information must be available to SCDHHS upon request.

Therapy Administration Guidelines

Chemotherapy Infusion Therapy

Chemotherapy infusion therapy refers to the administration and management of a patient who is receiving a regimen of chemotherapy agents. Regardless of the number of agents and/or medications administered either simultaneously or sequentially, only charges for one method of chemotherapy infusion (regardless if more than one method is administered) should be billed per session.

Providers must use the appropriate codes to bill for the intravenous chemotherapy administration, intra-arterial chemotherapy administration, and chemotherapy administration requiring use of a portable or implantable pump.

Routine maintenance of an access device is considered part of the service and is not to be billed separately.

1. Chemotherapy Administration IV Push Technique and Chemotherapy Administration Intra-Arterial Push Technique:

An IV push is defined as the administration of a chemotherapy agent via the port nearest to the point of vascular or arterial access. This technique is performed by a provider using a syringe.

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

2. Pump Refills/Maintenance:

These codes should be used when refilling portable and implanted pumps or reservoirs with chemotherapy agents. They are not to be used for the routine maintenance of an access device.

Inhalation Therapy

Inhalation therapy services include the administration of gases or drugs in gaseous, vapor, or aerosol form by drawing them into the lungs along with inhaled air for local or systemic effect. The cost of the inhalation agent is included in the Under Pulmonary Diagnostic Testing and Therapies service.

Antibiotic Infusion Therapy

Antibiotic infusion therapy services include the intravenous administration of antibiotics for systemic effect. It is correct to bill the appropriate drug "J" code in addition to this administration code.

Antibiotics administered via the infusion method must be billed referencing the correct

Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis (Specify Substance or Drug) services. This also applies to infusions of Amphotericin B.

Antibiotics administered via an IV push technique **when infusion services are not rendered** should be billed using the appropriate drug “J” code only.

Blood/Blood Products Infusion Therapy

Blood and blood product infusion therapies include the cost of the type and antibody and A, B, O, or Rh typing tests that **are inclusive** charges per patient per blood transfusion **treatment session. Blood transfusions may be billed one time per session regardless of the number of blood products infused. The appropriate blood product code and number of units should be billed with the infusion therapy code.**

For each unit of Blood (whole), for Transfusion infused, the appropriate unit(s) should be placed in the column for units. Other blood products should be billed accordingly:

- Cryoprecipitate, each unit
- Red blood cells, leukocytes reduced, each unit
- Platelets, each unit
- Red blood cells, each unit
- Platelets, pheresis, each unit
- Platelets, pheresis, leukocytes reduced, each unit
- Platelets, pheresis, irradiated, each unit
- Platelets, pheresis, leukocytes reduced, irradiated, each unit
- Infusion, Albumin (Human), 5%, 250 m1
- Infusion, Albumin (Human), 25%, 20 m1/Infusion, Albumin (Human), 25%, 50 m1
- Platelets, pheresis, pathogen -reduced, each unit
- Pathogen(s) test for platelets

The Blood Transfusion service code may also be used when therapeutic phlebotomy is performed in the course of exchange transfusions.

Note: Medicaid does not reimburse for certain factor products (Factor VIII and IX) supplied by DHEC. Medicaid beneficiaries with hemophilia must be enrolled in the State’s hemophilia program, which is administered by DHEC. The hemophilia program furnishes a clotting factor to enrolled Medicaid beneficiaries. If a Medicaid beneficiary chooses to have this factor product administered

by an infusion center, the infusion center may bill Medicaid for the infusion using the Blood Transfusion service code. It is incorrect to bill for the factor drug using any code.

Hydration Therapy

Hydration therapy is the administration of replacement solutions alone or in conjunction with other drugs to maintain fluid and electrolyte balance in a patient. Hydration therapy is only allowed when the services are administered as a separate procedure. The medical record should clearly indicate the medical necessity for hydration therapy. The appropriate drug “J” code should also be billed.

Payment of hydration therapy is considered bundled into the payment for Chemotherapy Infusion Therapy when administered simultaneously as part of the chemotherapy treatment regimen and cannot be separately billed.

IGIV Infusion Therapy

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

Therapeutic Phlebotomy

Therapeutic phlebotomy is the removal of blood for purposes of treating certain diseases such as polycythemia and disorders of iron metabolism, etc. Therapeutic Phlebotomy may be billed with the Blood Transfusion service code when therapeutic phlebotomy is performed in the course of an exchange transfusion. Therapeutic Phlebotomy should not be billed for phlebotomies when blood is withdrawn and a reciprocal replacement blood transfusion exchange does not occur during the session.

Routine venipuncture is not a covered infusion center service and should not be billed using the Therapeutic Phlebotomy service.

Routine Maintenance/Declotting

Routine maintenance (flushing with heparin or saline) of an access device is included in the infusion therapy service and cannot be billed separately. If this is the only service rendered, Heparin Sodium, Heparin Lock Flush may be billed. Bill the Urokinase 5,000 IU Vial service when declotting an access device and this is the only service provided.

Unclassified/Unlisted Drug Injections

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

Synagis®

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

RSV prophylaxis should be initiated at the onset of the RSV season and terminated at the end of the RSV season. Payment for Synagis® administration will be limited to five doses per season given on or after October 15 and no later than March 31. Prior approval will not be required for up to six doses as long as they are given at least 30 days apart and meet the guidelines of the American Academy of Pediatrics (AAP) for Synagis® administration. Any dose over the limit of six or administered after the RSV season (October–March) will require prior approval.

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

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

Physicians Billing for Additional Services

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

Prolonged Services

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

Critical Care Services

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

OPIOID TREATMENT PROGRAMS (OTP)

Reimbursement Policy

OTPs are reimbursed with five all-inclusive procedures and two assessment code whose rates are established in the SCDHHS fee schedule. The procedures are as follows:

Intake Activities for Medication Assisted Treatment
Periodic assessment for Medication Assisted Treatment**Medication Assisted Treatment**

Methadone; weekly bundle.

Medication Assisted Treatment

Buprenorphine; oral, weekly bundle.

Medication Assisted Treatment

Buprenorphine, injectable, monthly bundle.

Medication Assisted Treatment

Naltrexone; monthly bundle.

Medication Assisted Treatment

No medication administered; weekly bundle.

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

*MAT Intake activities/periodic assessment MAT codes may be billed during the same time period.

*If a beneficiary is in long-term recovery and does not require weekly/daily OTP visits, the weekly MAT code may be billed but the beneficiary's medical record must reflect their phase of treatment, days of attendance, and service notes for any required services.

*If a beneficiary is receiving monthly MAT, the code including the medication should be billed on the week it is administered. The other weeks the code without medication (G2074) should be billed.