SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

HOSPITAL SERVICES PROVIDER MANUAL

SEPTEMBER 1, 2021

South Carolina Department of Health and Human Services

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PROGRAM OVERVIEW

A Hospital is defined as a general acute care institution licensed as a Hospital by the applicable State of South Carolina (South Carolina or State) 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 the Provider Administrative and Billing Manual, 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 (SCMSA) 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 manual for more information.

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

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 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 the *Billing Guidance* section for specific billing instructions.

OUT-OF-STATE SERVICES

The term 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. For additional guidance, including necessary prior approval and billing considerations for Out-of-State services, see *Section 5 Utilization Management* of this manual.

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
- Section 4 - Procedure Codes

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Medicare/Medicaid (Dually Eligible)

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

Medicare has two parts:

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

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 the *Special Coverage* section for billing guidelines for LRD.

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 co-insurance for these non-covered charges. The notice of non-coverage by Medicare to notify patients that the service(s) is not covered may also serve as the notification to the patient that Medicaid will not cover the service. If the patient is given advance notice of non-coverage, then the patient may be billed for the non-covered charges.

All services rendered to dually eligible Medicare/Medicaid patients should be filed to Medicare first. Refer to *Section 8 Billing Guidance* in this manual for billing guidelines.

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ELIGIBLE PROVIDERS

PROVIDER MEDICAID ENROLLMENT AND LICENSING

Certification, Licensing, Contracts and Enrollment

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:

- **Personnel:** All patients must be treated by or under the direct supervision of a Physician licensed to practice medicine in the State. 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.

- **Emergency Service Personnel:** A Physician must screen all patients who arrive for treatment in the Emergency Room (ER) to assess level of care as mandated by COBRA/OBRA legislation.

- **Supervision:** South Carolina Medicaid requires a supervising entity (Physician, Dentist or any program that has a supervising health professional component) to be physically located in South Carolina or within the 25-mile radius of the South Carolina border.

For Hospital Certification and Licensing contact:

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

For Medicaid Contract Negotiation contact:

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

To request a Medicaid enrollment packet, please contact Medicaid Provider Enrollment via the SCDHHS Provider Service Center (PSC) at +1 888 289 0709, submit an online request at http://www.scdhhs.gov/contact-us, or you may submit a request in writing to:

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

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, Clinical Laboratory Improvement Act (CLIA) Certification, and End Stage Renal Disease (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.

Out-of-State Hospitals

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

Out-of-State Hospital claims should be sent in hard copy to:

Medicaid Claims Receipt
Post Office Box 1458
Columbia, SC 29202-1458

For assistance with out-of-State Hospital claims, please contact the PSC at +1 888 289 0709 or submit an online inquiry at https://www.scdhhs.gov/Contact-Info.

For policies regarding organ transplants, please refer to the *Organ Transplants* subsection in *Section 7 Special Coverage*.

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.

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COVERED SERVICES AND DEFINITIONS

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 Quality Improvement Organization (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 with the procedure code information associated with this manual.

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

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.

Managed Care Organization (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 Bureau of Managed Care at +1 803 898 4614.

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 post payment review and may be paid as two separate admissions unless the post payment 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.

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 ID number. The SCDHHS county office listing is located on the website at https://www.scdhhs.gov/site-page/where-go-help.

Exception
In an effort to ensure timely access to critical Zidovudine (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 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.

For Dates of Service on or before September 30, 2015:

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

For Dates of Service on or after October 1, 2015:

When billing for the administration of the Hepatitis B vaccine the appropriate procedure code is 3E0134Z, Introduction of Serum, Toxoid and Vaccine into Subcutaneous Tissue, Percutaneous Approach or 3E0234Z Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach. Administration of the Hepatitis B vaccine to infants 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 week's supply of AZT syrup to be billed by the Hospital or pharmacy provider. The AZT syrup can only be billed under the mother's Medicaid ID number when the newborn does not have an assigned Medicaid ID number at the time of discharge.

Supplies, Appliances and Equipment

Items furnished by the Hospital for the care and treatment of the patient during his or her inpatient stay are covered inpatient Hospital services and are included in the DRG payment. Under certain

circumstances, supplies, appliances and equipment used during the inpatient stay are covered even though they are taken with the patient when he or she is discharged. These are circumstances in which it would be unreasonable or impossible from a 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.

Transportation of Self-Administered Oxygen Dependent Beneficiaries

Effective June 1, 2014, SCDHHS will amend the non-emergency transportation policy for self-administered oxygen dependent beneficiaries discharged from inpatient Hospitals or ERs. The policy applies to beneficiaries who are admitted, as an inpatient of a Hospital or Hospital ER, are oxygen dependent and currently do not have their portable oxygen system in their possession, and do not require transportation via ambulance for their return trip to their residence for any other reason. The Hospital is responsible for arranging and acquiring a portable oxygen system complete with all medically necessary accessories, upon discharge. Hospitals and Ambulance providers will no longer receive reimbursement for non-essential, non-medically necessary ambulance transportation for self-administered oxygen dependent beneficiaries. All provider types and services are subject to post payment review by the Division of Program Integrity.

It is the responsibility of both the Hospital and Durable Medical Equipment (DME) provider to coordinate and dispense oxygen to the Medicaid beneficiary who is currently admitted to the Hospital or Hospital ER in order for the appropriate mode of non-emergent transportation to be arranged with the transportation broker upon discharge. The dispensing DME provider will be responsible for arranging the return of the portable oxygen system dispensed by their company at the time of discharge from the admitting Hospital facility.

SCDHHS will reimburse for a portable oxygen system, E0443 billed with a U1 modifier, and the dispensing DME provider will be reimbursed at a rate of $20.00 per occurrence. SCDHHS will limit the number of occurrences per patient to no more than three occurrences per calendar month. Services that exceed three occurrences per calendar month will not be reimbursed.

It is the responsibility of Emergency Medical Services providers whenever possible to transport oxygen dependent beneficiaries with the beneficiary's personal portable oxygen system in anticipation of the beneficiary's medical/health needs.

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, please call the PSC or submit an online inquiry at: http://www.scdhhs.gov/contact-us.

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 Observation

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

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

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

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 8 Billing Guidance* 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 8 Billing Guidance* for specific billing instructions.

Drugs

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

Self-Administered Drugs

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

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

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

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

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 ER 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 the Centers for Medicare & Medicaid Services (CMS), will be updated yearly based on the Medicare Fee Schedule rates. The Medicaid Management Information Systems (MMIS) will identify Clinical Lab Panels and Individual Automated Tests and reimburse the amount based on the Automated Test Panel 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 Current Procedural Terminology (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 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 South Carolina Medicaid for these services, (2) the arrangement will result in no additional cost to the South Carolina 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.

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 Treatment/Therapy/Testing (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 Healthcare Common Procedure Coding System (HCPCS) codes:

- Depo-Provera®, HCPCS code J1050
- Vitrasert®, HCPCS code J7310
- SYNAGIS®, HCPCS code 90378
- IMPLANON®, HCPCS code J7307

Long Acting Reversible Contraceptives (LARCs)
LARCs provided in an inpatient Hospital setting are considered an add-on benefit to the DRG reimbursement. SCDHHS will reimburse providers for LARCs through a gross level credit adjustment. In order to process the LARC payment, Hospitals are required to utilize the HCPCS code that represents the device, along with the appropriate ICD-PCS Surgical Code and the ICD-CM Diagnosis Code that best describe the services delivered. The LARC reimbursement will process as a gross level credit adjustment and will appear on a future remittance advice. Providers will receive a letter of notice and reconciliation report quarterly identifying the credit adjustment along with pertinent patient information to apply the credit to the correct patient account. The letter of notice will identify the Adjustment Reference Number and will be identified by the prefix LARC.

Covered LARCs:

- Levonorgestrel-releasing intrauterine contraceptive system (Kyleena®), 19.5 mg
- Levonorgestrel-releasing intrauterine contraceptive system (Liletta®), 52 mg
- Levonorgestrel-releasing intrauterine contraceptive system (Mirena®), 52 mg
- Intrauterine (IU) copper contraceptive (Paragard®)

- Levonorgestrel-releasing intrauterine contraceptive system (Skyla®), 13.5 mg
- Etonogestrel (contraceptive) implant system, including implant and supplies (IMPLANON®/ Nexplanon®)
- Permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure). This requires a sterilization request form to be signed 30 days prior to the procedure.

Physician Services

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

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

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

Adult Nutritional Counseling

Effective August 1, 2015, SCDHHS will implement the Obesity initiative. This policy currently targets those obese individuals who do not meet the criteria for bariatric surgery or related services. Obesity is defined for this program as an adult patient with a body mass index (BMI) of 30 or greater.

Currently, this program will exclude the following categories of beneficiaries:

- Pregnant women.
- Patients, for whom medication use has significantly contributed to the beneficiary's obesity as determined by the treating Physician, are not eligible to participate in the obesity program.
- Beneficiaries who have had or scheduled to have bariatric surgery.
- Beneficiaries actively being treated with bariatric surgery.

There is an exhaustive list of medications that could contribute to obesity. Here are examples of medications that may cause weight gain:

- Atypical antipsychotics (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)
- Long-term use of oral corticosteroids (prednisone, prednisolone)
- Certain anticonvulsant medications (valproic acid, carbamazepine)
- Tricyclic antidepressants (amitriptyline)

Note: For Healthy Connections Medicaid members who receive Medicare benefits, SCDHHS will only pay secondary payments to Medicare.

The program consists of intensive behavioral therapy for obesity and includes three factors:

- Screening for obesity in adults using measurement of BMI calculated by dividing the patient's weight in kilograms by the square of height in meters.
- Dietary (nutritional) assessment.
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

All services must be rendered within the South Carolina Medicaid Service Area (SCMSA). SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

The following billing instructions apply to fee-for-service only. For instructions on submitting claims to MCOs, please refer to the provider contract with the appropriate MCO.

Hospitals will not be reimbursed separately for the Physicians or Dietitian services on an UB-04 claim form. Hospitals may enroll dietitians with their professional clinics and bill for their dietitian's services on the CMS-1500 form. Please note that the appropriate revenue code for Hospitals to bill for Obesity Services is 942 Other Therapeutic Services – Education and Training, which is not a covered service with SCDHHS. Therefore, it is imperative that Hospitals link the licensed dietitians to their professional clinic group for payment of services.

Children's Nutritional Counseling

All services must be rendered within the SCMSA. The SCMSA is defined as South Carolina and adjacent areas within 25 miles of its borders.

Hospitals will not be reimbursed separately for the Physicians or dietitian services on an UB-04 claim form. Hospitals may enroll dietitians with their professional clinics and bill for their dietitian's services on the CMS-1500 form. Please note that the appropriate revenue code for Hospitals to bill for Obesity Services is 942 Other Therapeutic Services – Education and Training which is not a covered service with SCDHHS. Therefore, it is imperative that Hospitals link the licensed dietitians to their professional clinic group for payment of services.

Please refer to the Physicians Laboratories and Other Medical Professionals Manual for the complete obesity policy (adults and children) for providers and dietitians.

Professional Services

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

Hospital-Salaried/Hospital-Based Physician

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

Physician's Assistant

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

Certified Registered Nurse Anesthetist/Anesthetist Assistant

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

Certified Nurse Midwife

A Certified Nurse Midwife (CNM) must be licensed to practice as a Registered Nurse and as a CNM 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 NP or CNS. The NP/CNS practices under a Physician preceptor according to mutually agreed-upon protocol. The

NP/CNS may be reimbursed under their individual Medicaid provider number or the supervising Physician's Medicaid number.

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

Teaching Physician Policy

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

- **Resident:** A Resident is either an individual who participates in an approved graduate medical education (GME) program or a Physician who is not in an approved GME program but who is authorized to practice only in a Hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.

- **Medical Student:** A medical student is an individual who is enrolled in a program culminating in a degree in medicine. Any contribution of a medical student to the performance of a billable service or procedure must be performed in the physical presence of a teaching Physician or jointly with a Resident in a service meeting the requirements set forth for teaching Physician billing.

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

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

Subsection I

Accessibility of the teaching Physician while the Resident is providing services is defined as follows:

- **Ambulatory:** Accessibility of the teaching Physician for supervision of ambulatory services requires the teaching Physician to be present in the clinic or office setting while the Resident is treating patients. The Physician is thus immediately available to review the patient's history, personally examine the patient as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

- **Inpatient:** Accessibility of the teaching Physician for supervision of non-procedural inpatient services requires that the teaching Physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching Physician must review the patient's history, personally examine the patient as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses and determine the course of treatment.

- **Procedures:**

  – **Minor Procedures:** For supervision of procedures that take only a few minutes to complete or involve relatively little decision-making once the need for the procedure is determined, the definition of accessibility requires that the teaching Physician be on the premises and immediately available to provide services during the entire procedure.

  – **All Other Procedures:** Accessibility for supervision of all other procedures requires that the teaching Physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

Subsection II

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

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

NON-COVERED SERVICES

Convenience Items

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

Incidental Procedures

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

complexity of the major surgery or are rendered incidentally and performed at the same time as the major surgery. Incidental procedures should not be shown on the claim.

Cosmetic Procedures

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

Repair of the following birth defects is not considered cosmetic surgery: cleft lip, cleft palate, webbed fingers and toes, congenital ptosis and other birth defects 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 are non-covered by Medicaid.

Hospital Acquired Conditions (HACs), Other Provider Preventable Conditions (OPPCs), and Never Events (NEs)

Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPCs).

PPCs are clearly defined into two separate categories: Healthcare Acquired Conditions and OPPCs or NEs.

Healthcare Acquired Conditions include HACs. OPPCs refer to OPPCs and NEs (surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient, etc.).

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

Reductions in provider payment(s) may be limited to the extent that the identified PPCs would otherwise result in an increase in payment(s).

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries. The Medicaid participant should never be billed for these events.

By definition, PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought, and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate elements of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Inpatient Acute Care Hospitals, Ambulatory Surgery Centers (ASCs), Physicians and Other Practitioners are held accountable for NEs while Inpatient Acute Care Hospitals are also held accountable for HACs and OPPCs.

The non-payment policy includes the following NEs and OPPCs:

NEs:

- Surgery on a wrong body part or site.
- Wrong surgery on a patient.
- Surgery on the wrong patient.

OPPCs:

- Post-operative death in normal healthy patient.
- Death/disability associated with use of contaminated drugs, devices or biologics.

- Death/disability associated with use of device other than as intended.
- Death/disability associated to medication error.
- Maternal death/disability with low-risk delivery.
- Death/disability associated with hypoglycemia.
- Death/disability associated with hyperbilirubinemia in neonates.
- Death/disability due to wrong oxygen or gas.

Providers should view the Appendix I HACs List on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html.

The All Patient Refined (APR)-DRG software will identify diagnoses that meet the definition of a HAC, OPPC or NE. The grouper software will then ignore the HAC, OPPC, or NE and assign a DRG as if it were not present. The proposed regulation also extends the non-payment policy to Medicaid contracts. Therefore, the Managed Care plans will not be required to pay for HACs, OPPCs and NEs.

As referenced earlier in the policy, no reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider (Present on Admission).

5
UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Quality Improvement Organization (QIO)

SCDHHS contracts for external utilization review services with a QIO. Keystone Peer Review Organization, Inc. (KEPRO) is the current QIO contractor. The QIO review consists of:

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

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

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

Pre-Surgical Justification for Elective Hysterectomies

Long Term Living (LTL) clients are required to choose a service provider from a Client Choice of Provider(s) Form, which lists available providers of each service for the client's waiver of participation. The Client Choice of Provider(s) Form will identify the referring entity and LTL provider(s) already involved in the care of the client. Any service requiring a preferred provider to participate in a bid process is excluded from this policy. For bid process services, the provider submitting the lowest bid will be awarded the referral. If the provider submitting the lowest bid cannot provide the service, the referral will be awarded to the next lowest bidder.

Prior Authorization

SCDHHS contracts with a QIO, KEPRO, to perform pre-surgical review of select surgical procedures. Providers must submit all appropriate clinical information along with the Request for Prior Approval Review to KEPRO.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
For Provider Issues Email: atrezzoissues@kepro.com

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

Requesting providers 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 the QIO can be found on the provider portal.

Medicaid Managed Care

Medically Complex Children's Waiver (MCCW) 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 Primary Care Provider (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.

Instructions for Obtaining Prior Authorization

The responsibility for obtaining pre-admission/pre-procedure review rests with either the attending Physician or the Hospital. The requesting provider must submit all necessary documents including the Request for Prior Approval Review to KEPRO.

The QIO 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 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. The QIO review personnel will notify the attending Physician's office of the denial.

Procedure for Reconsideration of Denial of Prior Approval

- The Physician may request a reconsideration of the initial denial decision by submitting a written request outlining the rationale for recommending the procedure. Reconsideration may be requested whether the case was a pre-procedure or post-procedure review. The request should be in writing to KEPRO.

- If a case is denied upon reconsideration, the determination is final and binding upon all parties (CFR 473.38).

Out-of-State Services

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 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 via the PSC at: +1 888 289 0709, an online inquiry at http://www.scdhhs.gov/contact-us, or by fax at: +1 803 255 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.
- 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 at an otherwise avoidable risk of non-payment or delayed payment.

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 via the

PSC at +1 888 289 0709 or by submitting an online inquire at http://www.scdhhs.gov/contact-us for two reasons:

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

Ancillary and Other Out-of-State Services
Other health care services are compensable under the South Carolina Medicaid Out-of-State Program. For specific out-of-State referrals, please contact the PSC or submit an online inquiry.

Prior Authorizations for Inpatient Admissions

All acute care Hospital admissions, except deliveries and births, must be prior authorized by the QIO, KEPRO. Requests for emergency admissions must be made within five business days of the admission. KEPRO will use McKesson's InterQual criteria for medical necessity and will provide a determination within 24 hours of the request for non-emergency situations. If a second level consultant's review is required, a determination will be made by the QIO within two business days of the initial request. The prior authorization request may be initiated by either the Physician or the Hospital. The prior authorization number, however, must be shared with all providers involved with the admission.

Patients with Medicare as primary payer are only required to obtain a prior authorization if Medicare does not make a payment or the service is not covered by Medicare and Medicaid then becomes primary. Please note that MCOs will continue to authorize services according to their specific plans for enrolled beneficiaries (members).

Requests for prior authorizations from KEPRO may be submitted using one of the following methods.

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
For Provider Issues Email: atrezzoissues@kepro.com

Outpatient Therapies

For recipients age 21 and over, physical, occupational and speech therapies (PT/OT/ST) performed in an outpatient Hospital setting must be pre-authorized by the QIO, KEPRO. At a minimum, physical therapy services must improve or restore physical functioning as well as prevent injury, impairments, functional limitations, and disability following disease, injury or loss of a body part. Occupational therapy must prevent, improve or restore physical and/or cognitive impairment following disease or injury. Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.

InterQual criteria for outpatient rehabilitation will be used to support medical necessity. The list of therapy codes that requires prior authorization is located on the provider portal. KEPRO authorizes the initial evaluation and the first four weeks of therapy upon request. At four weeks, a concurrent review is performed to re-evaluate the patient's condition and response to treatment. At that time the provider may request up to an additional eight weeks of therapy.

For claims with dates of service on or after June 1, 2012, Hospital providers are required to submit the revenue code and the applicable CPT procedure code as defined in the CPT reference guide for the specified therapy. For therapy procedures defined in 15-minute sessions, SCDHHS will define 15 minutes as one unit of service. Therapy sessions are limited to four units per date of service.

Patients with Medicare as primary payor are only required to obtain a prior authorization if Medicare does not make a payment or the service is not covered by Medicare and Medicaid then becomes primary. Please note that MCOs will continue to authorize services according to their specific plans for enrolled beneficiaries (members).

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
For Provider Issues Email: atrezzoissues@kepro.com

Back/Spinal Surgery and Other Back Procedures

Back/spinal surgery and other back procedures require prior authorization. The QIO, KEPRO, is responsible for reviewing and approving prior authorization requests using InterQual criteria.

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
- ER
- 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
- Health Clinics
- County Health Departments
- Home Health
- Home- and Community-Based Services
- DME

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 PSC at: +1 888 289 0709 or submit an online inquiry at: http://www.scdhhs.gov/contact-us for assistance.

6
REPORTING/DOCUMENTATION

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 the Provider Administrative and Billing Manual and in Medical Record and Documentation Requirements in this section.

7
SPECIAL COVERAGE

SPECIAL COVERAGE ISSUES

Administrative Days

SCDHHS 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 LRD 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

LTL 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. Community Long Term Care (CLTC) will determine a level of care or tentative level of care. The tentative level of care is reserved for those beneficiaries who are expected to be admitted to a nursing facility within 14 days. level of care determinations will be documented on either a Level of Care Certification Letter (DHHS Form 185) or Community Long Term Care Notification Form (DHHS Form 171). Either of these forms can be used when billing administrative days.

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

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

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

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

Retroactive Certification

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

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

Hospital-Issued Notification Letters

When the Hospital 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.

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 LRD must be exhausted before administrative days can be approved. If Medicare grace days are provided, administrative days cannot be billed for these days.

Medical Record Requirements

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

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

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:

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

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

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

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

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

Administrative days claims must meet the Medicaid policy on time limits for submitting claims. Please refer to the Provider Administrative and Billing Manual 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.

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. Providers should reference the CPT guide for the applicable CPT codes.

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. Visits must be medically necessary. Additional visits may be allowed if medical justification is submitted. Please refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Provider Manual for billing instructions.

Organ Transplants

All potential transplants, cadaver or living donor, must be authorized by the QIO, KEPRO, before the services are performed. SCDHHS will only support the referral of patients for an evaluation to 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 SCMSA (> 25 miles of South Carolina borders). For a complete list of CMS approved centers, visit the CMS website at:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Transplant.html

Referral requests for organ transplants to both in-State and out-of-State centers must be submitted to the QIO, KEPRO, 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, KEPRO 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. For managed care members, transplants remain the responsibility of the MCO with the exception of 72 hours prior to inpatient Hospital admission through discharge.

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

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
For Provider Issues Email: atrezzoissues@kepro.com

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.

Hysterectomy

Medicaid requires pre-admission surgical justification for hysterectomies by KEPRO. Prior authorization must be obtained even if the surgery follows a delivery. Providers should use the Request for Surgical Justification for Hysterectomy Form and the Consent for Sterilization Form with each request. There is a 30-day wait period from the date the Consent for Sterilization Form is signed before the surgery is performed. InterQual criteria will be used for screening prior authorization requests. For urgent and emergent hysterectomy cases, the 30-day wait is not required, however the reason for the emergency must be provided by the Physician. The claim will be reviewed retrospectively.

Requests for prior authorizations from KEPRO may be submitted using one of the following methods:

KEPRO Customer Service: +1 855 326 5219
KEPRO Fax: +1 855 300 0082
For Provider Issues Email: atrezzoissues@kepro.com

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 Consent for Sterilization Form, DHHS 687, prior to the hysterectomy.

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

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

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

- The individual was informed before the surgery that the hysterectomy would make her permanently incapable of reproducing.
- The individual was already sterile before the hysterectomy and the Physician who performs the hysterectomy certifies in writing that the individual was sterile at the time of the hysterectomy. The certification must state the cause of the sterility.
- The individual required a hysterectomy because of a life-threatening emergency situation and the Physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening situation in which the Physician determined that prior

acknowledgement was not possible. The certification must include a diagnosis and description of the nature of the emergency.

Elective Sterilization

For all elective sterilizations, SCDHHS requires the provider and beneficiary to complete a Consent for Sterilization Form located with the Forms information associated with this manual. 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 that all providers including Clinics and Hospitals may also be reimbursed.

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, or
- 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 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 PSC at: +1 888 289 0709 or submit an online inquiry at: https://www.scdhhs.gov/Contact-Info.
- 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 Family Planning counseling or Family Planning 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

- 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, 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, then the claim will be approved for payment. If the Consent Form does not meet the federal regulations, the claim will reject and a letter sent to the Physician explaining the rejection.

If the Consent Form is not submitted attached to the claim, the claim will be rejected and a new claim will need to be filed complete 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 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.

Physicians Statement

- Beneficiary's name: Correctable Error.
- Date of the sterilization procedure (This date must match the date of service that you are 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 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 interferers 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 beneficiaries' 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 HCPCS code with the FP modifier (service provided as part of Family Planning program) 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. A Consent for Sterilization Form must be completed and submitted with the claim. Federal guidelines for sterilization procedures will remain a requirement which includes completing and submitting a Consent for Sterilization Form.

Sterilization 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.

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 Family Planning, are not covered under the Family Planning Program. 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 (e.g., blood clots, strokes, abnormal Pap smears, etc.) other than changing the birth control method should not be billed using an FP modifier (service provided as part of Family Planning program) or Family Planning diagnosis code. 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. 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 Family Planning 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.

Abortions

Non-Elective Abortions

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

Therapeutic Abortions

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

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

The Abortion Statement is required and must contain the name and address of the patient, the reason for the abortion, and the Physician's signature and date. The patient's certification statement is only required in cases of rape or incest. A blank Abortion Statement can be found with the Forms information associated with 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.

- Non-elective abortion procedure codes should be used for spontaneous, incomplete, inevitable, missed, septic, hydatidiform mole, or other non-elective abortions with appropriate diagnosis code. Refer to *Section 4 Covered Services and Definitions* of this manual for non-elective abortion procedures.
- For dates of service on or before September 30, 2015, ICD-9-CM diagnosis codes for elective therapeutic abortions are located on the SCDHHS website on the webpage.
- For dates of services on or after October 1, 2015, elective therapeutic abortions must ONLY be billed with ICD-10-CM diagnosis O04 range and Z33.2.
- Refer to procedure code information on the provider portal for elective therapeutic abortion procedure codes.
- 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.
- For dates of service on or before September 30, 2015, ICD-9-CM diagnosis codes that do not require documentation are located on the SCDHHS website on the webpage.

For dates of service on or after October 1, 2015, the following ICD-10-CM diagnosis codes that do not require documentation:

ICD-10 CODE	DESCRIPTION
O01.0	CLASSICAL HYDATIDIFORM MOLE
O01.1	INCOMPLETE AND PARTIAL HYDATIDIFORM MOLE
O01.9	HYDATIDIFORM MOLE, UNSPECIFIED
O02.81	INAPPROPRIATE CHANGE IN QUANTITATIVE HUMAN CHORIONIC GONADOTROPIN (HCG) IN EARLY PREGNANCY
O02.0	BLIGHTED OVUM AND NONHYDATIDIFORM MOLE
O02.89	OTHER ABNORMAL PRODUCTS OF CONCEPTION
O02.9	ABNORMAL PRODUCT OF CONCEPTION, UNSPECIFIED
O02.1	MISSED ABORTION

ICD-10 CODE	DESCRIPTION
O36.4XX0	MATERNAL CARE FOR INTRAUTERINE DEATH, NOT APPLICABLE OR UNSPECIFIED
O36.4XX1	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 1
O36.4XX2	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 2
O36.4XX3	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 3
O36.4XX4	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 4
O36.4XX5	MATERNAL CARE FOR INTRAUTERINE DEATH, FETUS 5
O36.4XX9	MATERNAL CARE FOR INTRAUTERINE DEATH, OTHER FETUS
O42.00	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.019	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, UNSPECIFIED TRIMESTER
O42.90	PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED WEEKS OF GESTATION
O42.919	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, UNSPECIFIED TRIMESTER
O42.011	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, FIRST TRIMESTER
O42.012	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, SECOND TRIMESTER
O42.013	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE, THIRD TRIMESTER
O42.02	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR WITHIN 24 HOURS OF RUPTURE
O42.911	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, FIRST TRIMESTER
O42.912	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, SECOND TRIMESTER
O42.913	PRETERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR, THIRD TRIMESTER
O42.92	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, UNSPECIFIED AS TO LENGTH OF TIME BETWEEN RUPTURE AND ONSET OF LABOR

ICD-10 CODE	DESCRIPTION
O42.10	PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED WEEKS OF GESTATION
O42.111	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, FIRST TRIMESTER
O42.112	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, SECOND TRIMESTER
O42.113	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, THIRD TRIMESTER
O42.119	PRETERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE, UNSPECIFIED TRIMESTER
O42.12	FULL-TERM PREMATURE RUPTURE OF MEMBRANES, ONSET OF LABOR MORE THAN 24 HOURS FOLLOWING RUPTURE

Questions or difficulty with the processing of claims for abortion services should be directed to the PSC at: +1 888 289 0709 or you may submit an online inquiry at: http://www.scdhhs.gov/contact-us.

Reduction Mammaplasty

Reduction mammaplasty 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 Mammaplasty

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 Mammaplasty

Repeat Female Reduction Mammaplasty 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 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. The QIO, KEPRO, 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 DME program for women who have undergone any type of mastectomy.

For a list of codes requiring Prior Authorization, see “Procedure Codes Requiring Prior Authorization” in *Section 4 Covered Services and Definitions*.

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 to the QIO, KEPRO. 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 for one of these illnesses. The following services are not covered by Medicaid:

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

Bariatric Surgery

Bariatric surgery is a covered service for members who meet InterQual guidelines for medical necessity.

Prior authorization for bariatric surgery procedures is required from the QIO, KEPRO. InterQual screening criteria applies.

Panniculectomy

Panniculectomy is the surgical excision of the abdominal apron containing superficial fat in obese individuals. The Panniculectomy procedure includes a Lipectomy. An Abdominoplasty is the excision of excessive skin and subcutaneous tissue. The Abdominoplasty is considered an add-on procedure to the Panniculectomy and also includes a Lipectomy.

The following conditions must be met for coverage by Medicaid:

- 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 the QIO, KEPRO. InterQual screening criteria applies.

Positron Emission Tomography (PET) Scans

SCDHHS will reimburse for certain PET scans. PET scan reimbursement is limited to two per 12 months. PET scans will be covered only for the staging and restaging of cancer malignances. 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, please contact the PSC at: +1 888 289 0709 or submit an online inquiry at: http://www.scdhhs.gov/contact-us.

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 PSC at: +1 888 289 0709 or submit an online inquiry at: https://www.scdhhs.gov/Contact-Info.

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. The facility is responsible for ESRD enrollment of the patient with Medicare and Medicaid. See the ESRD Enrollment Medicaid Recipient, DHHS Form 218, located with the Forms associated with 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

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

- 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.

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
While a member is an inpatient in a Hospital 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:

- 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:
  - The disease is unresectable.
  - The patient refuses surgical excision of the tumor.
- Anti-Spasmodic Drugs for Severe Spasticity — An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., Baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:
  - 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.
  - Prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.
- 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:

- Medical documentation must reflect the coordination and treatment of the cause of pain.
- 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).
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary catheter to monitor acceptable pain relief and an acceptable degree of side effects (including effects on the activities of daily living).

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

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

Non-Reimbursable Services

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

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 is a limited benefit program available to men and women who meet the appropriate federal poverty level percentage in order to be eligible. Family Planning provides coverage for physical examinations, Family Planning services, Family Planning-related services, and some preventative health screenings. Family Planning promotes the increased use of primary medical care; however, beneficiaries enrolled in this program only receive coverage for a limited set of services. Services provided to men and women enrolled in Family Planning that are not specifically outlined below are the sole responsibility of the beneficiary.

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

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 the PSC at +1 888 289 0709, submit an online inquiry, https://www.scdhhs.gov/Contact-Info, or refer to the Physicians Services Provider Manual.

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. All Family Planning services must be billed using the appropriate CPT or HCPCS code with the FP modifier (service provided as part of Family Planning program) and/or appropriate Family Planning diagnosis code. Hospital claims for Family Planning services are not required to report the FP modifier.

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 (service provided as part of Family Planning program) and/or Family Planning diagnosis code.

The following are also not considered Family Planning services:

- For dates of service on or before September 30, 2015, routine gynecological exams (diagnosis code V72.3) in which contraceptive management is not provided.
- For dates of service on or after October 1, 2015, routine gynecological exams (diagnosis codes Z01.411, Z01.419, and Z01.42) 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 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.

Long Acting Reversible Contraceptives (LARCs)
Any LARC billed to SCDHHS by a pharmacy will be shipped directly to the provider’s office for insertion. Providers should take extra care to ensure that they bill Medicaid only for reimbursement of the insertion of the device, and not the device itself, when it is obtained and billed through the pharmacy benefit.

Providers ordering LARCs through the pharmacy benefit must order them through the following specialty pharmacies:

- Paragard® — Direct +1 877 727 2427
- Mirena®/Skyla® — CVS +1 803 551 1030
- IMPLANON®/Nexaplanon® — CVS +1 800 571 2767

The option for providers to purchase these devices directly and bill them via the traditional buy and bill mechanism will continue. All Family Planning services should be billed using the appropriate CPT or HCPCS code with an FP modifier (service provided as part of Family Planning program) and/or appropriate diagnosis code.

Note: Pregnancy testing (when the test result is negative) is a reimbursable Family Planning service in two situations:

1. The test is provided at the time Family Planning 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.

Covered LARCs:

- Kyleena® J7296
- Liletta® J7297
- Mirena® J7298
- ParaGuard® J7300
- Skyla® J7301
- IMPLANON® J7307

Sterilization
For policy, documentation and billing guidance related to sterilizations please refer to the *Elective Sterilization within Section 7 Special Coverage Issues* 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.

8
BILLING GUIDANCE

OUTLIERS

A cost outlier occurs if a Hospital's estimated costs exceed a specified amount above the DRG base payment; the 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: +1 803 898 1040.

DEPO-PROVERA

When revenue code 636 and J1050 are listed on an inpatient claim an add-on payment for Depo-Provera will be added to the DRG payment.

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
- TTT 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 on the SCDHHS website.

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 website. 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
- Vitrasert® implant
- Depo-Provera®
- SYNAGIS®
- Kyleena®
- Liletta®
- Mirena®
- Paragard®
- Skyla®
- IMPLANON®/Nexplanon®
- Essure, permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure)

  This add-on service requires a Consent for Sterilization form to be signed 30 days prior to the procedure.

Outpatient Non-Surgical Services — Reimbursement Type 5

An outpatient claim is classified as non-surgical, Reimbursement Type 5, when the claim shows an ER, clinic visit, or treatment room 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 additional services. Reimbursement Type 5 with an ER 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 website. 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 ER, 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
- Vitrasert® implant
- Depo-Provera®
- SYNAGIS®
- IMPLANON®
- Kyleena®
- Liletta®
- Mirena®
- Paragard®
- Skyla®
- Essure, permanent implantable contraceptive intra-tubal occlusion device(s) and delivery system (Essure)

This add-on service requires a Consent for Sterilization Form to be signed 30 days prior to the procedure.

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

An outpatient claim falls into the 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.

The payment amounts for TTT services include all related non-Physician services.

Pre-Admission Services (72-hour Rule)

Outpatient services rendered to a beneficiary within the three days prior to the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient 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.

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.

MEDICAID MANAGED CARE

MCO Program Billing Notes

- 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.

- 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.

- A beneficiary's program status on date of admission to the Hospital will determine which program requirements the Hospital will follow.

When reporting inpatient and outpatient data to the Office of Research and Statistics for Medicaid MCO program members, the payer carrier code (item 50A-C) should list the carrier code assigned to the MCO.