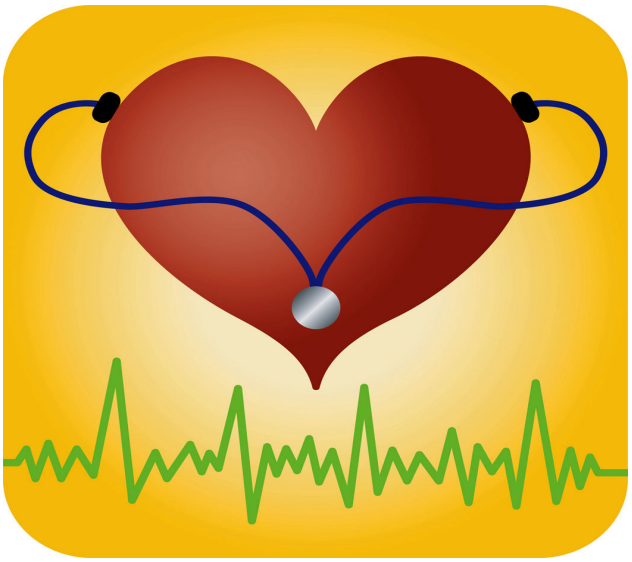
South Carolina Medicaid Managed Care Program

Policy and Procedure Guide
for
Managed Care Organizations



April 2008

TABLE OF CONTENTS

MANAGED CARE ORGANIZATIONS

INTRODUCTION

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency in South Carolina responsible for the administration of a program of medical assistance under Title XIX of the Social Security Act known as the Medicaid Program. The United States Department of Health and Human Services allocated funds under Title XIX to the SCDHHS for the provision of medical services for eligible persons in accordance with the South Carolina State Plan for Medical Assistance.

The SCDHHS has defined its mission as providing statewide leadership to most effectively utilize resources to promote the health and well being of South Carolinians. The State intends to promote and further its mission by defining measurable results that will improve member access and satisfaction, maximize program efficiency, effectiveness, and responsiveness, and reduce operational and service costs. The following methods are intended to support the achievement of this mission:

- Provide a medical home for Medicaid beneficiaries to promote continuity of care.
- Emphasize prevention and self-management to improve quality of life.
- Supply providers and members with evidence-based information and resources to support optimal health management.
- Utilize data management and feedback to improve health outcomes for the state.

The establishment of a medical home for all Medicaid eligible recipients has been a priority/goal of the SCDHHS for a number of years. The goals of a medical home include:

- Accessible, comprehensive, family centered, coordinated care.
- A medical home with a provider to manage the patient's health care, to perform primary and preventive care services and to arrange for any additional needed care.
- Patient access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care.
- Patient education regarding preventive and primary health care, utilization of the medical home and appropriate use of the emergency room.

The purpose of this guide is to document the medical and program policies and requirements implemented by the SCDHHS for Managed Care Organizations (MCO) wishing to conduct business in South Carolina.

The Department of Managed Care, located within the Division of Care Management, Bureau of Care Management and Medical Support Services, is responsible for the formulation of medical and program policy, interpretation of these policies and oversight of quality and utilization management requirements set forth in this chapter. Contractors in need of assistance to locate, clarify, or interpret medical or program policy should contact the Department of Managed Care at the following address:

Department of Managed Care
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: (803) 255-8232
Phone: (803) 898-4614

Requests to add, modify or delete standards, criteria or requirements related to current medical or program policy should be forwarded to the Department of Managed Care.

THE CONTRACT PROCESS

This section of the guide is designed to provide the information necessary for preparing to initiate an MCO contract with SCDHHS. SCDHHS will furnish potential contractors with a copy of the model MCO contract upon request. This contract may also be found on the SCDHHS website at www.scdhhs.gov. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a risk-based contract with any qualified MCO that has been issued a Certificate of Authority to operate as a domestic insurer in state by the South Carolina Department of Insurance (DOI). Potential contractors who are not currently licensed as domestic insurers in the state of South Carolina should contact the DOI, the office of Company Licensing to begin that process. Licensing information may be obtained by calling 803-737-6221 or through the DOI website, www.doi.sc.gov

The potential contractor should enclose a copy of the Certificate of Authority with a letter requesting inclusion/participation/enrollment in the MCO program and should indicate if the program wishes to operate under the Standard or Ethical Limitations contract. If the MCO wishes to operate under the Ethical Limitations contract, the letter must include a copy of the company's Ethical Limitations statement/policy. The letter should be addressed to

Director, Division of Care Management
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Upon receipt of this letter and the Certificate of Authority, SCDHHS will verify the license and date of issue with the DOI. Upon confirmation, SCDHHS will mail an Enrollment Package to the potential contractor/vendor. The Enrollment package will contain the following:

1. Two (2) copies of the formal standard/ethical limitations contract
2. Enrollment Form (DHHS Form 219-HMO)
3. Minority Business Form
4. Disclosure of Ownership and Controlling Interest Statement
5. Form W-9, Taxpayer Identification Number and Certification
6. Drug Free Workplace Form
7. EFT Authorization Form
8. Certification Relating to Restrictions on Lobbying
9. Copy of the MCO Policy and Procedures Guide

The potential contractor should then sign and date both copies of the Contract and submit to SCDHHS, along with three (3) copies of the MCO's Required Submissions . The Department of Managed Care will review the Required Submissions internally.

SCDHHS will notify the MCO of any changes or re-submissions that must be made prior to approval. Concurrent to this review process, the MCO will coordinate with the SCDHHS Division of MMIS to establish connectivity with SCDHHS information systems. Upon approval of all required submissions and the establishment of connectivity, SCDHHS will authorize its External Quality Review Organization (EQRO) to begin the Readiness Review of the MCO's South Carolina operation. If deficiencies are noted during the Readiness Review, the MCO must submit a Plan of Correction (PoC) to SCDHHS. The time frames given for correcting the deficiencies will be based on the severity and scope of the deficiencies. The SCDHHS staff will monitor the MCO's progress with its PoC.

Once the Readiness Review has been completed, the EQRO has submitted its final report to SCDHHS and SCDHHS finds the MCO to be in compliance with all requirements, the contract is submitted to CMS for approval. Upon receiving approval from CMS, the Managed Care staff will review county networks submitted by the MCO and determine network adequacy. Along with the county network submission, the MCO will provide an attestation that all provider contracts are in compliance with the following state requirements:

- All contracts and amendments have been approved by SCDHHS,
- All contracts have been properly signed,
- All contract include approved hold harmless language,
- All contracts cover the services specified in the county network submission,
- All contracts (as appropriate) contain suitable documentation regarding hospital privileges, credentialing information and a listing of group practice members

The MCO will be able to begin enrolling members within ten (10) business days following the approval of the network.

Activities and Potential Time Frames

- Review of Required Submissions — Up to 120 days
- Readiness Review (not including scheduling time) — 2 to 3 days
- Readiness Review Report Completed — Within 30 days of site visit
- Review of Contract by CMS — Up to 45 days
- Network Adequacy Desk Review — Submitted upon passing of Readiness Review
- Network Approval — ASAP
- Sign-up/assignment of members — Within 10 days following Network Approval
- Enrollment of members — See Enrollment Process

Required Submissions

The following items/documents must be submitted by the MCO with the signed Signature Pages of the official contract. The contract sections indicated are intended as a guide only and may not be the only contract requirements related to the required submission listed. This information is being provided as a guide only and does not

relieve the contractor from complying with **all** appropriate contract requirements for each required submission.

A. Organizational Requirements

1. A Certificate of Authority as approved and licensed by the South Carolina Department of Insurance to operate as a domestically licensed Managed Care Organization (MCO). (CONTRACT SECTION 2.14)

2. A copy of Ownership and Controlling Interest Statement. Organizational documents (partnerships, incorporations, etc.) Form CMS 1513. (CONTRACT SECTION 10.14 -Included with Enrollment Packet)

3. Certification statements. (Included with Enrollment Packet)

4. A copy of any current or pending administrative legal action or grievance filed by subcontractor/member, including the dates of initiation and resolution. (CONTRACT SECTION 5.1.33)

5. A copy of any current or pending administrative legal action or grievance of person(s) convicted of criminal offense, including the dates of initiation and resolution. (CONTRACT SECTION 10.16)

6. A list of staff Liaisons. Please include the Name, Title, and Telephone Number of the designated individual for the following: (CONTRACT SECTION 3.4)

   Liaison Staff Contact
   Medical Director Contact
   Senior Management Contact
   QA Contact
   Reporting Contact

B. Provider Requirements (Provider Network List)

7. A listing of network provider/subcontractors. (This should only include executed contracts). (CONTRACT SECTION 4.11.2) .

8. A copy of any Notice of Intent of Subcontractors Termination. (CONTRACT SECTION 5.1.28)

9. A copy of model subcontracts for each health-care provider type. (CONTRACT SECTION 5)

C. Service Delivery Requirements

10. A description of expanded services, if any, offered for Medicaid members. (CONTRACT SECTION 4.8)

11. A listing of the service area(s) as approved by SCDOI & Medicaid service area (if different). (CONTRACT SECTION 4.11.1)

12. A copy of the referral/monitoring process, policies and procedures, as well as forms, process for in/out of plan services to include Medicaid fee-for-service referrals. (4.9.1, 4.1, 4.9.8)

13. A copy of written emergency room service policies, procedures, protocols, definitions, criteria for authorization/denial of emergency room services and triage system. (CONTRACT SECTION 4.3, and see Quality Assurance and Utilization Review section of this document)

14. A copy of PCP selection procedures and forms. (CONTRACT SECTION 4.11)

D. Quality Assessment and Performance Improvement

15. A copy of Quality Assessment and Performance Improvement (QAPI) Program per 42 CFR 438 requirements. (Written description, credentialing, disciplining, and recredentialing policies and procedures). (Reference most current Contract and P/P Guidelines)

E. Marketing

16. The Contractor's maximum Medicaid member enrollment (projected) levels. (CONTRACT SECTION 6.10)

17. A copy of the Contractor's written marketing plan and materials, including evidence of coverage and enrollment materials, recipient education materials, member handbook, grievance materials, a sample or copy of the member ID card(s) and advertising materials. (CONTRACT SECTION 7.2 and See Marketing, Member Education and Enrollment section of this document)

F. Reporting

18. Proof of data transfer capabilities verified in writing by SCDHHS and the Contractor. Proof shall constitute the successful transfer of test files via EDI and meet SCDHHS file format requirements.

Readiness Review

The Readiness Review for MCOs is conducted after the Required Submissions and associated MMIS activities have been approved by the SCDHHS. The MCO is scored against a set of nationally recognized standards that represent SCDHHS' expectations for successful operation within the South Carolina Medicaid Program. SCDHHS will supply a copy of the most current version of the Readiness Review Standards upon request. The Review is conducted at the MCO's South Carolina location. It includes a desk review of the various policies and procedures, committee minutes, etc., as well as interviews with key staff members. The MCO will be expected to have a number of materials available during the Review: The External Quality Review Organization (EQRO) will coordinate with the MCO to schedule the Review and to communicate the EQRO's expectations.

Provider Network Adequacy Determination Process

Medicaid enrolled MCOs are responsible for providing all core services specified in the contract between DHHS and the MCO. The MCO may provide the services directly or may enter into subcontracts with Providers who will provide services to the members in exchange for payment by the MCO. Subcontracts are required with all providers of service unless otherwise approved by SCDHHS. Examples of exceptions include ambulance providers and other common out-of-network specialist providers.

The MCO and its network providers/subcontractors shall ensure access to health care services in accordance with the Medicaid contract and prevailing medical community standards in the provision of services under the Contract. Such factors as distance traveled, waiting time, length of time to obtain an appointment, after-hours care must meet established guidelines. The MCO shall provide available, accessible and adequate numbers of facilities, service locations, service sites, professional, allied and para-medical personnel for the provision of core services, including all emergency services, on a 24-hour-a-day, 7-days-a-week basis. Provider Network requirements are listed in this section of the Guide. At a minimum, there must be at least one primary care physician per every 2,500 MCO members.

Services must be accessible as described in the Proximity Guidelines. Generally, this is within a thirty (30) mile radius from a member's residence for PCPs. Specialty care arrangements must meet normal service patterns as determined by SCDHHS. Exceptions may be made if the travel distance for medical care exceeds the mileage guidelines.

Provider County Network Approval Process

The following guidelines are used in the review and approval of an MCO's provider networks. Any changes (terminations/additions) to an MCO's network in any county are evaluated by the Department of Managed Care using the same criteria.

1. The MCO submits its network listing for a specific county to the Department of Managed Care, requesting approval to commence Medicaid member enrollment in that county.

The MCO is responsible for ensuring that all enrolled providers are eligible to participate in the Medicaid Program. SCDHHS will transmit to the Contractor, on a regular basis, information regarding individuals prohibited from receiving Federal funds who appear on the OIG electronic database. However, the Contractor should also check the GSA and other applicable federal reporting sources to ensure compliance with section 3.10 of the MCO contract.

2. Using the Provider Network Listing Spreadsheet and other appropriate provider listings the Department of Managed Care examines the listing for the inclusion & availability of provider types for the following categories of service: Ancillary, Hospital, Primary Care and Specialists.

3. The adequacy of each of these provider types is evaluated based on the MCO's projected maximum member enrollment for that county, proximity guidelines and the following network criteria: There are four categories of provider types noted on the Provider Network Listing Spreadsheet in the "status" column. Those listed as a status "1" are required and a contract with the provider must be completed. Status "2" services are optional. For status "3" services a contract is not required but the MCO must provide a signed statement attesting the service will be arranged and provided through any necessary means, including the use of out-of-network providers. Status "4" services are those that are not mandated by Medicaid but are optional services provided by the MCO. If they are offered and a contract does not exist, there must be a statement of attestation as described for status "3" services. .

4. As appropriate, SCDHHS staff and physician consultants are utilized to determine access-to-care trends and Medicaid/non-Medicaid provider type availability for each county. The goal is to ensure the approval of a network that will guarantee appropriate access to care for Medicaid MCO members.

5. SCDHHS reports are analyzed to determine normal fee-for-service patterns for specific groupings of providers.

6. If the submitted provider network is determined not to be adequate by the Department of Managed Care, the submitted provider network, documentation and reasons for denial of the county by the Department of Managed Care is shared with management at the division, bureau and executive levels.

7. If SCDHHS finds that a network is not adequate, the MCO will be notified in writing that the network is not approved and the specific reasons for that decision.

8. If SCDHHS determines that the MCO has submitted an adequate network for that county, the Department of Managed Care will approve the network, set the effective date for enrollment and notify the MCO in writing. SCDHHS will also notify the MMIS system to modify the "counties served" indicator in the provider file to allow member enrollments to be processed. Also, both the enrollment and transportation brokers are informed of the addition of approved counties.

9. SCDHHS reserves the right to perform a site review at the MCO to review provider subcontracts, including any applicable approved amendments, and Hold Harmless Agreements. Should SCDHHS exercise its right to review, subcontracts and Hold Harmless Agreements are reviewed to determine whether the language in the subcontracts has been previously approved by SCDHHS and to ensure that **all** agreements are properly executed.

11. In the event that an MCO submits a county network that uses existing (approved) providers, SCDHHS does not require that the provider contract/hold harmless agreement be physically examined during the review process, if the provider contract/hold harmless agreement has been reviewed and approved within 60 days prior to the current examination.

Provider Network Listing Spreadsheet

Service	Status	DHHS Comments
ANCILLARY SERVICES:		
Ambulance Services	3	
Durable Medical Equipment	1	
Orthotics/Prostetics	1	
Home Health	1	
Infusion Therapy	1	See Proximity Guidelines for Specialty Care Services
Laboratory/X-Ray	1	
Pharmacies	1	See Proximity Guidelines for Primary Care Provider Services
HOSPITALS	1	See Proximity Guidelines for Specialty Care Services
PRIMARY CARE PROVIDERS:		
Family/Gen. Practice	1	
Internal Medicine	1	
RHC's/FQHC's	2	Not required but may be utilized as PCP provider
Pediatrics	1	May function as PCP (30 miles) or Specialty Provider (50 miles)
OB/GYN	1	May function as PCP (30 miles) or Specialty Provider (50 miles)

SPECIALISTS		
Allergy/Immunology	1	
Anesthesiology	3	
Audiology	3	
Cardiology	1	
Chiropractic	4	
Dental	4	
Dermatology	1	
Emergency Medical	3	
Endocrinology and Metab	1	
Gastroenterology	1	
Hematology/Oncology	1	
Infectious Diseases	1	
Neonatology	1	
Nephrology	1	
Neurology	1	
Nuclear Medicine	3	
Ophthalmology	1	
Optician/Optometry	4	
Orthopedics	1	
Otorhinolryngology	1	
Pathology	3	
Pediatrics, Allergy	3	South Carolina Medical Service Area (SCMSA)*
Pediatrics, Cardiology	3	SCMSA
Psychiatry (private)	3	
Pulmonary Medicine	1	
Radiology, Diagnostic	3	
Radiology, Therapeutic	3	
Rheumatology	1	
Surgery - General	1	
Surgery - Thoracic	3	
Surgery - Cardiovascular	3	
Surgery - Colon and Rectal	3	
Surgery - Neurological	3	
Surgery - Pediatric	3	
Surgery - Plastic	3	
Urology	1	
Speech Therapy	1	
Physical/Occupational Therapy	1	
Long Term Care	3	MCO has at least 30 days responsibility up to the earliest opportunity for disenrollment
	1 = Required **2 = Optional** **3 = Attestation** **4 = Attest, if offered**	Attestation – The MCO attests that the service will be arranged and provided through any necessary means, including out-of-network providers.

Proximity Guidelines		
Primary Care Physicians should be within 30 miles		
Specialty Care Physicians should be within 50 miles		
In reviewing networks, SCDHHS considers both the above-listed "Proximity Guidelines", and utilization trends of the regular Medicaid Fee-For-Service system. SCDHHS may grant exceptions to these criteria on a case-by-case basis.		
*The term South Carolina Medical Service Area (SCMSA) refers to the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border. Charlotte, Augusta, and Savannah are considered within the service area.		

BENEFICIARY ENROLLMENT

Who is Eligible to Enter an MCO?

This program is limited to certain Medicaid eligibles who:

- do not also have Medicare;
- are not age 65 or older;
- are not in a nursing home;
- do not have limited benefits such as, Family Planning Waiver recipients, Specified Low Income Beneficiaries, etc.;
- are not Home and Community Based Waiver recipients;
- are not enrolled in the Medically Fragile Children's' Program;
- are not Hospice recipients;
- do not have an MCO through third party coverage; or
- are not enrolled in another Medicaid managed care plan.

How Is Eligibility Determined

Individuals who meet financial and categorical requirements may qualify for Partners for Health (Medicaid).

The South Carolina Department of Health and Human Services determines eligibility for Medicaid. An individual applying for Medicaid as an SSI recipient must apply at the local Social Security office. Generally, an individual who is approved for SSI will automatically receive Medicaid. Applications for all other coverage groups may be filed in person or by mail. Applications may be filed at out-stationed locations such as the county health departments, federally qualified rural health centers, most hospitals and the county Department of Social Services. Applications may be mailed to:

South Carolina Department of Health and Human Services
Division of Central Eligibility Processing
Post Office Box 100101
Columbia, South Carolina 29202-3101

Persons who are approved for Partners for Health (Medicaid) receive a permanent, plastic Partners for Health (Medicaid) card. They are instructed to take the card with them when they receive a medical service.

Coverage Groups

A. Low Income Families (LIF)

- At least one child in the home is under age 18 (19 if in a secondary school) and lives in a family with low income.

- Four Month Extended - These are individuals who lost their LIF benefit due to increased child or spousal support. Their Medicaid continues for four (4) months after they become ineligible for LIF.

- Extended/Transitional Medicaid - Up to twenty-four months of Medicaid benefits is available after the loss of LIF eligibility if:

  1) Earnings or hours of employment of the caretaker relative or loss of earned income disregard caused LIF ineligibility; and

  2) the family has received benefits in the month prior to the loss of eligibility.

- **Title IV-E** - These are children who were or would have been eligible for LIF at the time they were placed for adoption or in foster care. These children are automatically entitled to Medicaid.

- **Ribicoff Children** - These are children whose family income is below 50% of poverty. They can be eligible even if they live with both parents. South Carolina provides Partners for Health (Medicaid) to these children up to age 18.

B. Supplemental Security Income (SSI) - A cash payment through the Social Security Administration and Medicaid benefits are available to aged, blind and disabled individuals who meet income and resource requirements.

Some individuals who have lost their eligibility for SSI are still entitled to Medicaid. They are:

- **1977 Pass Alongs** - These are individuals who would still be eligible for SSI "but for" Social Security cost of living increases they received since 1977.

- **Disabled Widows and Widowers** - These are individuals who would still be eligible for SSI "but for" a 1983 change in the actuarial reduction formula and subsequent cost of living increases.

- **Disabled Adult Children** - These are individuals who would still be eligible for SSI "but for" entitlement to or an increase in Social Security Disabled Adult Child benefits.

C. Qualified Medicare Beneficiaries (QMB's) - These are individuals who have Medicare Part A hospital insurance and have income at or below 100% of poverty and meet the resource requirements.

D. **Specified Low Income Medicare Beneficiaries (SLMBs)** - These are individuals who have Medicare Part A hospital insurance and meet income and resource requirements. For these individuals, the Medicaid Program is required to pay the Medicare Part B premium only. These individuals **are not** entitled to any other Medicaid benefits.

The Balanced Budget Act of 1997 provides 100% of federal funding for the full payment of the Medicare Part B premium for a limited number of individuals with family income between 120% and 135% of poverty.

E. **Pregnant Women and Infants With Income Under 185% of Poverty** - Partners for Health (Medicaid) is provided to pregnant women and infants who have monthly income at or below 185 percent of the federal poverty level. There is no resource test for this group.

F. **Partners for Healthy Children (PHC) ages 1 to19** - These are children who live in families at certain income limits. In South Carolina this group is a mixture of mandatory and optional coverage. The mandatory group is children between 1 and 6, who are at or below 133% of the federal poverty level, and children older than 6, who were born on or after September 1983, who are at or below 100% of the federal poverty level. The optional group is children aged 1 to 19 whose family's income is over the level of the mandatory groups but at or below 150% of the federal poverty level.

G. **Institutionalized/Home and Community-Based Services** - These are individuals who reside in a medical institution or receive home and community-based services and who would be eligible for LIF or SSI if they were not in an institution. This group also includes individuals whose eligibility is determined using a special income level.

H. **Optional State Supplementation** - These are aged, blind or disabled individuals who have countable resources less than $2,000 and who have monthly countable income at or below the established level and who reside in Community Residential Care Facilities (CRCF). The optional supplement payment is made through the SCDHHS.

I. **Children For Whom a State Adoption Assistance Agreement is in Effect** - These are special needs children for whom there is a State Adoption Assistance Agreement in place and for whom the State Adoption Assistance Agency has determined a placement could not be made without medical assistance.

J. **Children Under 21 With Special Living Arrangements** - These are children under age 21 who reside in a foster home or a group home. Their board payment is fully or partially sponsored by public funds. If the child's income is below FI standards, they can qualify for Medicaid.

K. Aged, Blind and Disabled – These are individuals with countable income at or below 100% of poverty and who meet the resource requirements.

L. TEFRA Children - These are children age 18 or younger who live at home and meet the SSI definition of disability for a child, and meet the level of care required for Medicaid sponsorship in either a Nursing Home, ICF/MR or an acute care hospital. Parent's income and resources are not considered in determining eligibility. Individuals eligible under this group must meet income and resource requirements.

M. Working Disabled - These are individuals who meet the Social Security definition of disabled and are working, and who earn more than $800 per month. Eligibility is determined using a two-step process. In the first step, the family's income, after allowable deductions, must be less than 250% of the federal poverty guidelines. If the family income meets this test, the individual's own unearned income must be below the Supplemental Security Income limit for an individual .

N. SC's Medicaid Breast and Cervical Cancer Program (MBCCP) – Women under the age of 65 diagnosed, and in need of treatment for either

- Breast Cancer
- Cervical Cancer
- Pre-Cancerous Lesions (CIN 2/3 or atypical hyperplasia)

can be eligible for Medicaid coverage

Breast and Cervical Cancer Basic Eligibility Criteria:

- The applicant has been diagnosed and found in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia),
- She is an adult under age 65,
- She does not have other insurance coverage that would cover treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including Medicare Part A or B,
- Her family income meets Best Chance Network (BCN) guidelines (at or below 200% of the Federal Poverty Level), and
- She is not eligible for another Medicaid eligibility group.
- Coverage for women diagnosed by BCN is limited to women age 47 – 64.

Infants

Infants who are born to a Medicaid eligible pregnant woman are "deemed" to be eligible for Medicaid simply because the mother is Medicaid eligible. They continue to be eligible for Medicaid for one year after delivery as long as the child is a member of the mother's household and remains a resident of the state. Eligibility continues without regard to income. A separate Medicaid application is not required. Infants born to women eligible for Emergency Services Only may not be deemed. A separate application and eligibility determination must be completed. SCDHHS cannot produce the infant's Medicaid card without the child's official name and correct birth date.

"Non-deemed Infants" refers to infants who were not born to a Medicaid eligible pregnant woman. An application and eligibility determination must be completed for these infants. If an infant has siblings in the home who receive Medicaid under the Partners for Healthy Children or Low Income Families Program, the infant may be added to the case with the siblings. If the infant's eligibility is determined under the Infants Program, the budget group consists of the infant and parents in the home and may also include the siblings, but only the infant is eligible. Once the infant is determined eligible, Medicaid benefits continue for one year regardless of changes in circumstances and the infant continues to meet non-financial criteria.

Should a child be hospitalized on his first birthday, Medicaid benefits continue until the last day of the month in which the hospital stay ended provided the following conditions are met:

- eligibility would have ended because the child reached the maximum age for that category of assistance;
- the child is otherwise eligible; and
- inpatient hospital services were received on the day the child reached the maximum age.

Annual Review

Sixty (60) days prior to the annual review date, the beneficiary is sent a review form to complete.

(1) If the beneficiary does not return the review form at all, the case is closed and the beneficiary's eligibility is terminated.

(2) If the beneficiary returns the form incomplete, the form is returned to the beneficiary with a checklist indicating what is missing and how to correct the problem. If the missing information is not received by the next review date, the case is closed 60 days after the original review form was mailed, usually on the next review date.

(3) If the beneficiary returns the form complete, the date the form was received is entered in MEDS. The worker performs the review. Data from the review form is verified as necessary and a re-determination is made on the case. The case is either approved or closed.

(4) If the beneficiary returns the form after the case has been closed, the date the form was received will be compared to the closure date. If the received date is

less than 30 days after the closure date, the case is reopened and the review is processed as if it had been received on time.

(5) If the beneficiary returns the form more than 30 days after the case has been closed, the review form is treated like a new application. If any additional verification is needed, a checklist is forwarded to the beneficiary. Policy allows up to 45 days to make an eligibility determination on a new application. At this point, the case is either approved or denied.

For further information on eligibility or income and resource requirements, please see the DHHS website at www.scdhhs.gov

Enrollment Process

SCDHHS has instituted a new enrollment process for Medicaid managed care called South Carolina Healthy Connections Choices (SCHCC). It is currently operated under contract with MAXIMUS Inc. SCHCC is being implemented by region with a target of May 2008 for statewide implementation. Additional details on SCHCC may be found at www.scchoices.com. Newly eligible Medicaid beneficiaries and beneficiaries going through the yearly eligibility re-determination process who also meet the criteria for Medicaid managed care participation will be informed of their various managed care choices. Before being assigned to a plan by SCHCC, beneficiaries who are eligible for plan assignment are given at least thirty (30) days to choose a plan or decide to remain in the fee-for-service Medicaid program. Beneficiaries not eligible for plan assignment may proactively enroll in a managed care plan (see Payment Categories chart below for a listing of eligibility types and assignment status).

Since South Carolina operates a voluntary managed care system, current Medicaid recipients may enroll at any time with a managed care option. Also, once a person has joined or been assigned to a managed care plan, they have ninety (90) days in which they may transfer to another plan or to fee-for-service Medicaid without cause. After the 90-day choice period has expired, members must remain in their health plan until their one year anniversary date unless they have a special reason to make a change (see disenrollment section for details).

Contractors may not generate enrollment forms in any SCHCC implemented region. After May 1, 2008, Contractors will not be allowed to generate enrollment forms in any part of the state and enrollment activities will be performed by Healthy Connections Choices (for the purposes of this manual, Contractors will be allowed to enroll members in the Pee Dee region during April 2008.)

Payment Category Chart

PCAT	PAYMENT CATEGORY	Major Group	MCO participation	MHN participation	Assign	Outreach Only
	Regular Medicaid					
10	MAO (Nursing Home)	Elderly/Disabled			N	N
11	MAO (Extended/Transitional)	Low Income Families	X	X	N	Y
12	OCWI (Infants)	Pregnant Women and Infants	X	X	Y	N
13	MAO (Fostercare/Adoption)	Low Income Families	X	X	N	**Y**
14	MAO (General Hospital)	Elderly/Disabled	X	X	N	N
15	MAO (Waivers - Home & Community)	Elderly/Disabled		X	N	**Y**
16	Pass Along Eligibles	Elderly/Disabled	X	X	Y	N
17	Early Widows/Widowers	Elderly/Disabled	X	X	Y	N
18	Disabled Widows/Widowers	Elderly/Disabled	X	X	Y	N
19	Disabled Adult Children	Elderly/Disabled	X	X	Y	N
20	Pass Along Children	Elderly/Disabled	X	X	N	**Y**
31	Title IV-E Foster Care	Low Income Families	X	X	N	**Y**
32	Aged, Blind, Disabled (ABD)	Elderly/Disabled	X	X	Y	N
33	ABD Nursing Home	Elderly/Disabled			N	N
40	Working Disabled	Elderly/Disabled	X	X	Y	N
51	Title IV-E Adoption Assistance	Low Income Families	X	X	N	**Y**
54	SSI Nursing Home	Elderly/Disabled			N	N
57	Katie Beckett/TEFRA	Elderly/Disabled	X	X	Y	N
58	Family Independent Sanctioned	Low Income Families	X	X	N	**Y**
59	Low Income Families	Low Income Families	X	X	Y	N
60	Regular Foster Care	Low Income Families	X	X	N	**Y**
68	Family Independent Work Supp.	Low Income Families	X	X	N	**Y**
70	Refuge Entrant	Low Income Families			N	N
71	Breast and Cervical Cancer	Elderly/Disabled	X	X	Y	N
80	SSI	Elderly/Disabled	X	X	Y	N
81	SSI With Essential Spouse	Elderly/Disabled	X	X	Y	N
85	Optional Supplement	Elderly/Disabled	X	X	N	**Y**
86	Optional Supplement & SSI	Elderly/Disabled	X	X	N	**Y**
87	OCWI Pregnant Women /Infants	Pregnant Women and Infants	X	X	Y	N
88	OCWI Partners For Healthy Children	Children	X	X	Y	N
91	Ribicoff Children	Low Income Families	X	X	Y	N
	Others					
55	Family Planning Waiver	Low Income Families			N	N
56	ISCEDC/COSY Children	Elderly/Disabled			N	N
90	Qualified Medicare Beneficiary	Elderly/Disabled			N	N
92	Silver Card	Elderly/Disabled			N	N
E	Emergency Services				N	N
I	Inmate Services				N	N
C	Emergency/Inmate Services				N	N

Enrollment of Newborns

All newborns of Medicaid MCO Program members are the responsibility of the Contractor, unless the mother has specified otherwise prior to delivery. To assure continuity of care in the crucial first months of the newborn's life, every effort shall be made by the Contractor to expedite enrollment of newborns into the Contractor's Plan. For Medicaid MCO Program members, the SCDHHS will enroll newborns into the same managed care plan as the mother, for the first ninety (90) calendar days from birth unless otherwise specified by the mother. The newborn will be enrolled in the same managed care plan as the mother through the end of the month in which the ninetieth (90th) day falls. The newborn's effective date will be the first day of the month of birth.

The enrollment form contains a statement that the member understands that a child born into the family unit will be enrolled in the same MCO as the mother unless otherwise specified by the mother. The newborn shall continue to be enrolled with the mother's MCO unless the mother/guardian changes the enrollment. For retro newborns, a break in a newborn's enrollment could occur between the end of the required 90 days and the next period of enrollment in the Managed Care Plan. This break in enrollment is determined by the date of notification of the newborn to SCDHHS or the date of the creation of the newborn's eligibility record in MEDS.

Enrollment Period

MCO Program members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The member may request disenrollment without cause at any time during the 90 days following the date of the member's initial enrollment with the MCO. A member shall remain in the Contractor's plan unless the member submits a written request to disenroll, to change managed care plans for cause or unless the member becomes ineligible for Medicaid and/or MCO enrollment. The following are considered cause for disenrollment by the member:

- The member moves out of the MCO's service area;
- The plan does not, because of moral or religious objections, cover the service the member seeks;
- The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time **and** not all related services are available within the network; **and** the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; and
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

Annually, SCDHHS will mail a re-enrollment offer to Medicaid MCO members to determine if they wish to continue to be enrolled with the Contractor's plan. Unless the member becomes ineligible for the Medicaid MCO Program or provides written notification that they no longer wish to be enrolled in the Contractor's plan, the member will remain enrolled with the Contractor.

Disenrollment

Disenrollments may be initiated by (1) the member, (2) SCDHHS or (3) the Contractor. Member-initiated disenrollment is addressed above in the section entitled **Enrollment Period.** The Contractor may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. The Contractor may contact the member upon receipt of the monthly member listing file. However, follow up must be within the guidelines outlined in this guide.

Recipients wishing to disenroll from a managed care plan and either return to the fee-for-service system or enroll with another managed care plan must use the SCDHHS Form 280-2 Managed Care Plan Change Form to disenroll from the original plan prior to being enrolled in an MCO. This form is available on the SCDHHS website and may be used to disenroll from any SC Medicaid Managed Care option. If a recipient wishes to disenroll from one option and enroll in the MCO at the same time, the recipient may do so by checking the appropriate box on the Change Plan form or by going to www.scchoices.com and following the directions to change plans. If the recipient is within the first 90 days of enrollment with the original plan, no documentation is necessary to support the change in plans. If the recipient is in his/her lock-in period, he/she must submit documentation in order for SCDHHS to process the request. Prior to approving the member's request, SCDHHS will refer the request to the Contractor to explore the member's concerns and attempt to resolve them. The Contractor will notify SCDHHS within 30 calendar days of the result of their intervention. The final decision on whether to allow the member's disenrollment rests with SCDHHS, not the Contractor. If a decision has not been reached within sixty (60) days, the member's request to disenroll shall be honored. The recipient shall be disenrolled from the first plan effective the last day of the month (depending upon the cut-off cycle) and will be enrolled in the new plan effective the first of the following month.

The SCDHHS will notify the Contractor of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of Medicaid MCO program eligibility;
- Death of a Member;
- Intentional Submission of Fraudulent Information;
- Becomes an inmate of a Public Institution;
- Moves out of State;
- Elects Hospice;
- Medicare Eligibility;
- Becomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Elects Home and Community Based Waiver Programs;

- ♦ Enrollment in the Medically Fragile Children's Program;
- ♦ Loss of Contractor's Participation;
- ♦ Becomes age 65 or older;
- ♦ Member admitted to a DJJ Community Facility;
- ♦ Enrollment in another MCO through third party coverage; and
- ♦ Enrollment in another Medicaid managed care plan.

The Contractor shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MCO Program member whose enrollment should be terminated prior to SCDHHS' knowledge.

The Contractor shall have the right to contact MCO members who have been disenrolled when the reason for disenrollment is "ineligible for Medicaid". This means that Medicaid eligibility has been terminated.

The Contractor may request to disenroll a Medicaid MCO Program member based upon the following reasons:

- Contractor ceases participation in the Medicaid MCO program or in the Medicaid MCO Program member's service area;
- Medicaid MCO Program member dies;
- Becomes an inmate of a Public Institution;
- Moves out of State or Contractor's service area;
- Elects Hospice;
- Becomes Institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Elects Home and Community Based Waiver Programs;
- Becomes enrolled in the Medically Fragile Children's Program;
- Member admitted to a DJJ Community Facility;
- Contractor determines recipient has Medicare coverage;
- Becomes age 65 or older; and
- Fails to follow the rules of the managed care plan.
- Member's behavior is disruptive, unruly, abusive or uncooperative.
- Member has access to care issues.
- Fraudulent use of Medicaid card or Plan card
- Member placed out of home.

The Contractor's request for member disenrollment must be made in writing to SCDHHS using the SCDHHS Form 280-2 Managed Care Plan Change Form or, when appropriate, utilizing the Plan Initiated Disenrollment Request Form provided by Health Connections Choices and the request must state the detailed reason for disenrollment. The request must also include documentation verifying any change in the member's status. SCDHHS will determine if the Contractor has shown good cause to disenroll the member and SCDHHS will give written notification to the Contractor and the member of its decision. The Contractor and the member shall have the right to appeal any adverse decision.

The Contractor shall not terminate a member's enrollment because of any adverse change in the member's health except when the member's continued enrollment in the MCO would seriously impair the Plan's ability to furnish services to either this particular member or other members.

The same time frames that apply to enrollment shall be used for changes in enrollment and disenrollment. If a member's request to be disenrolled or change MCO plans is received and processed by SCDHHS by of the internal cutoff date for the month, the change will be effective on the last day of the month. If the member's request is received after the internal cutoff date, the effective date of the change will be no later than the last day of the month following the month the disenrollment form is received. A Member's disenrollment is contingent upon their "lock-in" status (see Enrollment Period Section).

Guidelines for Involuntary Member Disenrollment	
Reason for Involuntary Disenrollment	**Disenrollment Effective Date**
Loss of Medicaid eligibility	Member will be auto-disenrolled during next processing cycles.
Death of Member	Leave enrollment through the month of death. Member will be disenrolled at the end of the month of death. Any premiums for months following the month of death will be recouped.
Intentional submission of fraudulent information	Member will be disenrolled at the earliest effective date allowed.
Member becomes inmate* of public institution	Leave enrollment through the month of incarceration. Member will be disenrolled at the end of the month of incarceration. Any premiums for months following the month of incarceration will be recouped.
Member moves out of state	Leave enrollment through the month the member moves out of state. Member will be disenrolled at the end of the month of the move. Any premiums for months following the month of the move will be recouped.
Member elects hospice	Member will be disenrolled at the end of the month immediately preceding hospice enrollment. Any premiums paid for months following the month of disenrollment will be recouped.
Member becomes Medicare eligible	Member will be auto-disenrolled during next processing cycles. (no retro-disenrollment or recoupment from MCO.)
Member in LTC/NH >30 days	Member will be disenrolled at the earliest effective date allowed by system edits.
Member elects CLTC/Waivers	Member will be disenrolled at the earliest effective date allowed by system edits.
Member enters Medically Fragile Children's Program (MFCP)	Member will be disenrolled at the earliest effective date allowed by system edits.
Loss of Contractor's participation	Member will be disenrolled based on MCO's termination date
Member becomes 65 or older	Member will be disenrolled in normal processing cycles.
Member enrolled in another MCO through third party liability	Leave enrollment until the month of private MCO coverage. Member will be disenrolled at the end of the month of new enrollment. Any premiums for months following the month of enrollment in private MCO or other Medicaid managed care plan coverage will be recouped.
Recipient on Inconsistent County Report	Member will be disenrolled at the earliest effective date allowed by system edits following verification of new address.
Member fails to follow rules of managed care plan.	Member will be disenrolled at the earliest effective date allowed by system edits.
Member admitted to a DJJ Community Facility	Member will be disenrolled beginning the first day of the month they entered the Facility. Any premiums that were paid will be recouped. The MCO will receive a credit adjustment for any services provided during the months in question.
Member status changes to family planning only	If the status of the member changes while in the hospital to a category where the hospital and physician charges would not be paid under FFS, the patient would be responsible for both the facility and physician charges for the uncovered portion of the stay (from the date that their status changes to FP services only).
Member terminates with one MCO and joins another while in hospital (disenrollment/enrollment date occurs	The insurance plan that covers a member on the day of admission to a hospital will be responsible for the entire

while in hospital)	stay (facility charge), even if their insurance carrier changes while they are inpatient. The date of service will dictate the responsible party for physician charges.
All disenrollments are subject to the MMIS cutoff date. **Inmate is defined as a person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.*	

PAYMENTS/ADJUSTMENTS

The MCO will be paid through a capitated payment to provide services to the Medicaid members. The monthly capitated payment is equal to the monthly number of members in each member category multiplied by the established rate for each group as detailed in **Appendix B, Capitation Rate(s) and Rate Methodology** of the contract.

Some payments, however, may be paid to the MCO through an adjustment. If the adjustment processed by the SCDHHS Department of Managed Care is a "Gross Level" adjustment, information on the MCO's remittance advice form will not be member specific. However, the MCO will receive detailed documentation from their SCDHHS Program Manager for each of these adjustments. From the time this documentation is mailed to the MCO, there may be up to a six week turn-around time to process an adjustment request.

The following will be paid through adjustment, rather than through capitation:

Maternity Kicker Payment

The Maternity Kicker Payment (MKP) includes all facility and professional claims associated with deliveries. The facility charges for deliveries that include sterilization are included in the MKP for the standard rates only.

The MCO should request monthly payment for all deliveries in the preceding month. The MCO should complete the Monthly Maternity Notification Log (see "MCO Reports to SCDHHS" section). Target date for submission of these payment requests should be the 15th of each month. These reports should be submitted to the MCO's SCDHHS Program Manager in Excel. This may be sent on a CD or via the SCDHHS Extranet. Based on the information in the payment request an adjustment will be prepared. Once prepared, a copy of documentation will be sent to the MCO indicating a 4 to 6 week turn-around time for payment. MCOs will only be paid the MKP for stillborns, not the Newborn Kicker Payment.

Newborn Kicker Payment

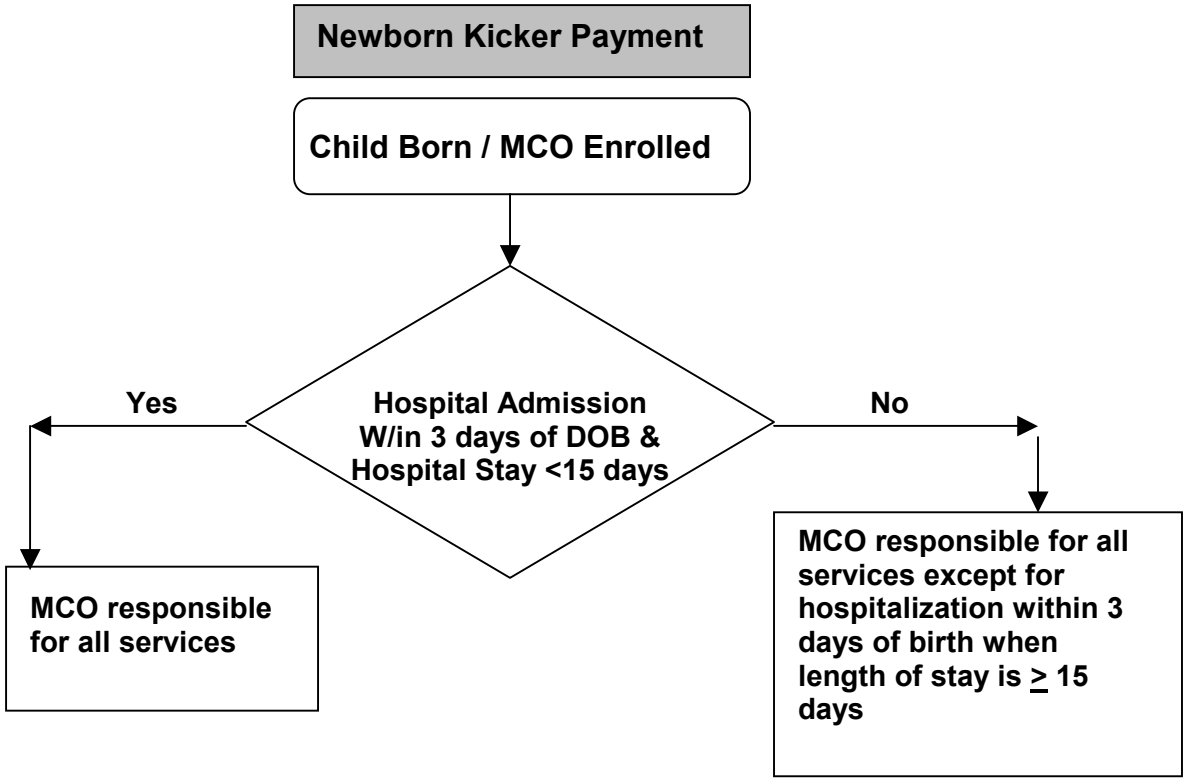
The Newborn Kicker Payment (NKP) is the only payment the MCO will receive for the month a baby is born. The NKP is priced to cover the costs for the month of birth. Newborns must be enrolled in the MCO for the month of birth in order for the MCO to receive the NKP. The NKP includes all hospital claims associated with the newborns where the hospital length of stay is less than 15 days. The NKP also includes all physician and pharmacy claims for the birth month, **regardless of the length of the hospital stay**. The MCO should complete the Monthly Newborn Notification Log (see "MCO Reports to SCDHHS" section) and submit it to the Program Manager. Newborns submitted more than 3 months past the birth date will not be processed for payment without SCDHHS approval.

Hospital claims associated with newborns where the hospital length of stay is equal to or greater than 15 days will be paid through Newborn Reinsurance (Fee-For-Service). The MCO is not eligible to receive a Newborn Kicker Payment when there is only one inpatient hospital claim with a begin date of service within the first three days of life and the claim is eligible for re-insurance. The cost of all birth month services (including physician, drugs, all other in-the-rate costs associated with reinsured newborns except the reinsured hospital stay) is included in the newborn kicker payments that are paid to the HMO for newborns who are not reinsured.

Newborn Reinsurance

The Newborn Reinsurance covers hospital services of newborns whose length of stay is 15 or more days and their admission is within 3 days of birth. Each hospital stay during the first month of life is counted as a separate stay. Therefore a transfer is counted as two stays, not one. The reinsurance covers only the hospital cost of the entire inpatient stay, not doctor charges, and not charges after discharge.

Please see Newborn Kicker Payment flowchart below.



The following adjustments will be utilized to remediate any payment discrepancies:

Retro Newborn Adjustment

The purpose of this adjustment is to reimburse SCDHHS for all MCO-covered services delivered to retro-enrolled newborn MCO members and paid by the Medicaid Fee-For Service system. No action is required by the MCO. SCDHHS will manually generate this information and prepare adjustments.

Rate Change Adjustments

In the event that CMS approves a rate change and authorizes the new rate be implemented retroactively, the SCDHHS staff will calculate any appropriate credit/debit adjustments due to/from the MCO.

Sanctions

The preferred method for enforcing monetary sanctions imposed by SCDHHS is via the debit adjustment process. Reasons for sanctions are defined in the Sanction section of the Contract.

Capitation/Premium Payment Adjustment

When it is determined by SCDHHS that a capitated premium payment should have (or have not) been paid for a specific member, an adjustment will be processed to correct the discrepancy. The MCO should contact the appropriate SCDHHS Program Manager to report any possible discrepancies.

CORE BENEFITS

The following list of services and benefits are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. MCO plans are required to provide Medicaid MCO Program members "medically necessary" care, at the very least, at current limitations for the following services. Unless otherwise specified, service limitations are based on the State Fiscal Year (July 1 - June 30). While appropriate and necessary care must be provided, the MCOs are not bound by the current variety of service settings. More detailed information on Medicaid policy for services and benefits may be found in the corresponding Provider Manual. These manuals are available electronically on the SCDHHS website at http://www.scdhhs.gov.

MCO plans may offer expanded services to Medicaid MCO Program members. Additions, deletions or modifications to the expanded services made during the contract year must be submitted to SCDHHS for approval. These expanded services may include medical services which are currently non-covered and/or which are above current Medicaid limitations. If the Contractor elects not to provide, reimburse for, or provide coverage of a service because of an objection on moral or religious grounds, the Contractor must furnish information about the services it does not cover as follows:

- To the State with its application for a Medicaid contract or whenever it adopts the policy during the term of the contract.
- The information must be provided to potential enrollees before and during enrollment.
- The information must be provided to enrollees within ninety (90) days after adopting the policy.

Inpatient Hospital Services

Inpatient hospital services are those items and services, provided under the direction of a physician, furnished to a patient who is admitted to a general acute care medical facility for facility and professional services on a continuous basis that is expected to last for a period greater than 24 hours. An admission occurs when the Severity of Illness/Intensity of Services criteria set forth by the review contractor and approved by SCDHHS is met. Among other services, inpatient hospital services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological and rehabilitative services in emergency or non-emergency conditions. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment.

> ***Current Medicaid Service Limitations:*** *Coverage of inpatient hospital services is limited to general acute care hospital services. Inpatient rehabilitative services provided in a separate medical rehabilitation facility or a separately licensed specialty hospital are not reimbursable. Rehabilitation services which are rendered to Medicaid recipients on an inpatient or outpatient basis at a general acute care hospital are reimbursable.*

Ancillary Medical Services

Ancillary services, such as pathology, radiology, emergency medicine and anesthesiology are included in the managed care rate and covered under hospital inpatient and outpatient services. These services are to be reimbursed by the MCO when authorized by a contracted provider or, when emergency services are rendered, by both contracted and non-contracted providers. In the event the provider (physician) does not receive prior approval from the MCO, the MCO is still responsible for payment for ancillary medical services rendered.

Current Medicaid Service Limitations: *Consult the SCDHHS provider manuals for Physician Services, Hospitals and other manuals, as appropriate, for definitions, limitations and billing issues.*

Transplant-Related Services

The following services are **not** considered to be transplant services and remain the responsibility of the Contractor:

- Corneal Transplants,
- Pre Transplant services up to 72 hours preadmission,
- Post Transplant services after discharged by Medical University Hospital Authority (MUHA). (see Physicians Provider Manual).
- Post-Transplant pharmaceutical services.

Maternity Services

The MCO is responsible for all claims except in cases where the newborn hospital claim is eligible for reinsurance. Newborn hospital claims are eligible for reinsurance when all three (3) of the following conditions are met:

- The child is born to a mother enrolled in a SC Medicaid MCO, and
- The hospital admission is within three (3) days of the child's date of birth, and
- The length of stay in the hospital is greater than or equal to fifteen (15) days.

For cases that qualify for reinsurance, only hospital facility claims meeting the criteria above will be paid through Fee-For-Service. Physician claims remain the responsibility of the MCO. (*See Newborn Kicker Payment flowchart.)*

Newborn Hearing Screenings

Newborn Hearing Screenings are included in the core benefits when they are rendered to newborns in an inpatient hospital setting. This procedure is **not** included in the DRG. Therefore the MCO should work with providers to insure

payment. The MCO is responsible for payment for this screening. The MCO rate includes payment for this service.

Outpatient Services

Outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, and emergency services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient/ambulatory care facilities include Hospital Outpatient Departments, Diagnostic/Treatment Centers, Ambulatory Surgical Centers, Emergency Rooms, End Stage Renal Disease Clinics (ESRD) and Outpatient Pediatric AIDS Clinics (OPAC). Included in these services are assessments for mental health and substance abuse and treatment of renal disease. Additional outpatient services would include emergency services for treatment of a medical emergency or accidental injury. Comprehensive neurodevelopmental and/or psychological developmental assessment and testing services shall be provided to eligible children under the age of 21 who have, or are suspected to have, a developmental disability, significant developmental delay, behavioral or learning disorder or other disabling condition. Such medically necessary diagnostic services, treatment and other measures, are for the purpose of correcting or ameliorating physical and/or mental illnesses and conditions which left untreated, would negatively impact the health and quality of life of the child. Therapeutic and rehabilitative services include, but are not limited to, physical therapy, occupational therapy, and speech therapy rendered in an outpatient hospital setting. Services performed in an outpatient hospital setting are considered to be Family Planning services only when the primary diagnosis is “Family Planning.”

Current Medicaid Service Limitations: *None*

Outpatient Pediatric Aids Clinic Services (OPAC)

An Outpatient Pediatric AIDS Clinic (OPAC) is a distinct entity that operates exclusively for the purpose of providing specialty care, consultation and counseling services for Human Immunodeficiency Virus (HIV) infected and exposed Medicaid eligible children and their families. Children who are born to HIV positive mothers, but do not test positive, are seen every three months in the clinic until they are two years old. Those children that do test positive, are seen twice a week for eight weeks and then once a month until they are two years old. Children who do not improve stay in the OPAC Program.

OPAC is designed to be a multidisciplinary clinic. The mission of OPAC is to follow children who have been exposed to HIV perinatally as children born to women infected with HIV. The following activities shall be considered the key aspects of OPAC and may be provided by OPAC or an alternate MCO network provider:

- All exposed children will be followed with frequent clinical and laboratory evaluations to allow early identification of those children who are infected.

- Provide proper care for infected infants and children, i.e., pneumocystis carinii prophylaxis or specific treatment for HIV infection.

- Coordinate primary care services with the family's primary care provider (when one is available and identified).

- Coordinate required laboratory evaluations that occur when clinical evaluations are not needed. These should be arranged at local facilities if this is more convenient and the tests are available locally. May be coordinated with the primary care provider and often with the assistance of local health department personnel.

- Provide management decisions and regularly see the children and parents when HIV infected children are hospitalized at the Level III Hospitals. When HIV infected children are hospitalized at regional or local hospitals with less severe illnesses, provide consultation to assist in the management of their care.

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

Psychiatric Assessment Services

The Contractor is required to pay for psychiatric assessment services as follows:

90801 Psychiatric Diagnostic Interview Exam (All Providers)
90802 Interactive Psychiatric Interview (Private Psychiatrist only)

Service Requirements: a maximum of 1 Assessment per member every six months. The Contractor may authorize additional assessments at their discretion, based on medical necessity. This applies to adults and children.

Physician Services

Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics,

skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

Current Medicaid Service Limitations: *12 visits per member per state fiscal year for adults, unlimited visits for children under the age of (21).*

Early & Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child

The EPSDT program provides comprehensive and preventive health services to children through the month of their 21st birthday. The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid recipients and their patents or guardians effectively use these resources.

The MCO will assure that the EPSDT program contains the following benefits:

- Comprehensive Health and Developmental History
- Comprehensive Unclothed Physical Exam
- Appropriate Immunizations
- Laboratory Tests
- Lead Toxicity Screening
- Health Education
- Vision Services
- Dental Services
- Hearing Services

The MCO is responsible for assuring that children through the month of their 21st birthday are screened according to the American Academy of Pediatrics (AAP) periodicity schedule. (http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf).

Current Medicaid Service Limitations: *None*

Maternity Services

Maternity services include high levels of quality care for pregnant members. Maternity care service benefits include prenatal, delivery, postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. All pregnant members and their infants should receive risk appropriate medical and referral services. Hospital claims with both a cesarean section and sterilization are not reimbursed through Family Planning funding sources. Therefore, MCOs operating under either the Standard or Ethical contract are responsible for these inpatient hospital claims. MCOs operating under the Standard contract will be responsible for any associated sterilization professional fees. MCOs operating under the Ethical contract will not be responsible for

any associated sterilization professional fees. This will be reimbursed by the fee-for-service system.

Current Medicaid Service Limitation: *None*

Communicable Disease Services

An array of communicable disease services are available to help control and prevent diseases such as TB, syphilis, and other sexually transmitted diseases (STD's) and HIV/AIDS. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, according to the Centers for Disease Control (CDC) standards. In addition, specialized outreach services are provided such as Directly Observed Therapy (DOT) for TB cases.

Eligible recipients should be encouraged to receive TB, STD, and HIV/AIDS services through their primary care provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. Eligible recipients have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions to services.

If the member receives these services through the MCO primary care provider, the MCO is responsible for reimbursement for the services. If the member receives these services outside the MCO network, providers will be reimbursed through the Fee-For-Service system.

Current Medicaid Service Limitations: *None*

Family Planning

An array of family planning services is available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies. Covered services include traditional contraceptive drugs and supplies and preventive contraceptive methods. Family planning services are also available through special teen pregnancy prevention programs. Services performed in an outpatient hospital setting are considered to be Family Planning services only when the primary diagnosis is "Family Planning."

Eligible recipients should be encouraged to receive family planning services through their primary care provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. However, eligible recipients have the freedom to receive family planning services from any appropriate Medicaid providers without any restrictions.

Standard Contracted MCO: If the member receives these services through the MCO primary care provider, the MCO is responsible for reimbursement for the services. If the member receives these services outside the MCO network, providers will be reimbursed through the Fee-For-Service system.
Ethical Contracted MCO: If the member receives these services through the MCO primary care provider or outside the MCO network, providers will be reimbursed through the Fee-For-Service system.

Current Medicaid Service Limitations: *None*

Independent Laboratory And X-Ray Services

Benefits cover laboratory and x-ray services ordered by a physician and provided by independent laboratories and portable x-ray facilities. An independent laboratory and x-ray facility is defined as a facility licensed by the appropriate State authority and not part of a hospital, clinic, or physician's office.

Current Medicaid Service Limitations: *None*

Durable Medical Equipment

Durable medical equipment is equipment that provides therapeutic benefits or enables a recipient to perform certain tasks that he or she would be unable to undertake otherwise due to certain medical conditions and/or illnesses. Durable medical equipment is equipment that can withstand repeated use and is primarily and customarily used for medical reasons and is appropriate and suitable for use in the home. This includes medical products; surgical supplies; and equipment such as wheelchairs, traction equipment, walkers, canes, crutches, ventilators, prosthetic and orthotic devices, oxygen, hearing aide services (provided by contractor only), and other medically needed items when ordered by a physician as medically necessary in the treatment of a specific medical condition. The attending physician has the responsibility of determining the type or model of equipment needed and length of time the equipment is needed through a written necessity statement. The member's prognosis is a deciding factor in approving equipment rental versus purchase. The MCO is responsible for informing members and providers of their policy regarding rental and/or purchase of equipment. Luxury and deluxe models are restricted if standard models would be appropriate. Repairs to medical equipment are covered if reasonable.

Current Medicaid Service Limitations: *None*

Hearing Aids and Hearing Aid Accessories

The Contractor is responsible for providing the following for members under age 21:

L8614 through L8619 V5030 through V5266

plus

L8699 and L9900

Prescription Drugs

Pharmaceutical services include providing eligible recipients with needed pharmaceuticals as ordered by valid prescriptions from licensed prescribers for the purpose of saving lives in emergency situations or during short term illness, sustaining life in chronic or long term illness, or limiting the need for hospitalization

Current Service Limitations:

Routinely covered pharmaceutical services include most rebated legend (i.e. prescription) and most rebated over-the-counter (OTC) products. Medicaid sponsors reimbursement for unlimited prescriptions or refills for eligibles to the date of their 21st birthday. Eligibles age 21 and above are allowed up to four (4) Medicaid-covered prescriptions per month. However, certain items are routinely exempt from the monthly prescription limit. The exemptions to the monthly prescription limit are the following: insulin syringes used in the administration of home injectable therapies; home-administered injectables (insulin products, however, count toward the monthly limit); aerosolized pentamidine; clozapine therapy; and family planning pharmaceuticals and devices. .A prescription limit override process allows for adult beneficiaries' monthly prescription limit to be exceeded if the prescription limit has already been reached *and* the prescription meets stipulated override criteria. SCDHHS provides prescription coverage for a maximum 34-day supply of medication per prescription (31 days' supply for Schedule II drugs) or refill. At least 75% of the current non-controlled substance prescription must be used (as directed on the prescription) before Medicaid pays for a refill of the prescription. Medicaid reimburses for most rebated generic products; many brand name products for which generics are available require prior authorization (PA). Prior authorization is also required for certain other products as well as for quantities exceeding established per month limitations. Approval for Medicaid coverage of products requiring prior authorization is patient-specific and is determined according to certain established medical criteria and conditions.
If the beneficiary is responsible for co-payments, the current prescription co-payment for Medicaid beneficiaries is $3.00 per prescription or refill. In those cases where an MCO plan utilizes a formulary, the formulary and any updates/changes must be provided to Medicaid members and providers in a timely manner. The formulary must allow for coverage of any non-formulary products currently reimbursable as fee-for-service by South Carolina Medicaid. Information regarding coverage allowance for a non-formulary product must be disseminated to Medicaid members and providers.

Emergency and Other Ambulance Transportation

Emergency transportation is defined as transportation related to an emergency or acute care situation where normal transportation would potentially endanger the life of the patient. Medical necessity for ambulance transport is established when the recipient's condition warrants the use of ambulance transportation and the use of any other

method is not appropriate. Types of services include ambulance, non-emergency medical vehicles, and air ambulances.

Ambulance transportation services for individuals to receive necessary medical care services, even in a non-emergent situation (e.g., transporting a patient from one level of care to another, i.e., from a hospital to a nursing home, from a Level III hospital to a Level I hospital) is included in the MCO rate. A patient is considered transferred when moved from one acute inpatient facility to another acute inpatient facility based on the physician's order and provided the patient meets the level of care criteria for inpatient stay. SCDHHS will consider a transfer for social reasons (e.g., so patient can be closer to family support system, etc.) provided the medical records justify the need for the transfer and the patient still requires acute hospital care.

Current Medicaid Service Limitations: *None*

Home Health Services

Home Health services are health care services delivered in a person's place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies.

Current Medicaid Service Limitations: *75 visits per member, per state fiscal year*

Institutional Long Term Care Facilities/Nursing Homes

MCO plans are required to pay for the first 30 days of confinement in a long term care facility/nursing home/hospital who provides swing bed or administrative days. Specifically, administrative days are counted as part of the hospital stay and **do not** count towards fulfilling the 30 days of MCO responsibility for long term care. Swing beds are counted in the same way as nursing home days and **do** count towards fulfilling the 30 days of MCO responsibility for long term care. Services include nursing facility and rehabilitative services at the skilled intermediary or sub acute intermediate level of care. After the first 30 days, payment for institutional long-term care services will be reimbursed fee-for-service by the Medicaid program. The member will be disenrolled at the earliest effective date allowed by system edits.

Current Medicaid Service Limitations: *None*

Hysterectomies, Sterilizations, And Abortions

The Contractor shall cover sterilizations, abortions, and hysterectomies pursuant to applicable Federal and State laws and regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the instructions with the original form maintained in the member's medical file and a copy

submitted to the contractor for retention in the event of audit. The following are applicable current policies:

**Sterilizations and Abortions are not part of the Core Benefits offered under the Ethical Limitations contract.*

1. **Hysterectomies:** The Contractor must cover hysterectomies when they are non-elective and medically necessary. Non-elective, medically necessary hysterectomies must meet the following requirements:

   (a) The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.

   (b) The individual or her representative, if any, must sign and date an acknowledgment of receipt of hysterectomy information form (see Forms section) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

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

   The acknowledgment form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances , a physician statement is required.

   (c) Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

   (d) Hysterectomy shall 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.

2. **Sterilizations*:** Non-therapeutic sterilization must be documented with a completed Consent Form (See Forms section) which will satisfy federal and state regulations. Sterilization requirements include the following:

   (a) Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

   (b) The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of

premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affects the patient's state of awareness.

(c) The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.

(d) The individual to be sterilized is mentally competent.

(e) The individual to be sterilized is not institutionalized: i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.

(f) The individual has voluntarily given informed consent on the approved Sterilization for Medicaid Recipients Form, SCDHHS Form 1723 (see Forms section).

**Sterilizations are not part of the Core Benefits offered under the Ethical Limitations contract.*

3. **Abortions*:** Abortions and services associated with the abortion procedure shall be covered only when the life of the mother is or would be endangered if the fetus were carried to term and must be documented in the medical record by the attending physician stating why the abortion is necessary; or if the pregnancy is the result of an act of rape or incest. Abortions must be documented with a completed Abortion Statement Form (see Forms section) which will satisfy federal and state regulations.

   The following guidelines are to be used in reporting abortions. Diagnosis codes in the 635 range should be used ONLY to report therapeutic abortions. Spontaneous, inevitable or missed abortions should be reported with the appropriate other diagnosis codes (e.g., 630, 631, 632, 634, 636 and 637). Abortions which are reported with diagnosis and procedure codes for therapeutic abortions must be accompanied by complete medical records which substantiate life endangerment to the mother or that the pregnancy is the result of rape or incest AND the signed abortion statement.

The abortion statement 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.

The following lists identify codes which indicate therapeutic abortions:

CPT Codes for CMS-1500 & Outpatient Hospital Claims	ICD-9 Surgical Codes for Inpatient Hospital Claims	Diagnosis Codes for CMS-1500/Hospital *Must have 5th digit
59840	69.01	635.00 – 635.90
59841	69.51	636.90
59850	69.93	638.00 – 638.90
59851	74.91	
59852	75.0	
59855		
59856		
59857		

**Abortions are not part of the Core Benefits offered under the Ethical Limitations contract. Members of an MCO operating under the Ethical contract can remain with that MCO and obtain this service under the fee-for-service system.*

Preventive And Rehabilitative Services For Primary Care Enhancement (PSPCE/RSPCE)

Other services, which were previously limited to high risk women, are now available through PSPCE/RSPCE to any Medicaid recipient determined to have medical risk factors. Provision of PSPCE/RSPCE encompasses activities related to the medical/dental plan of care which: promote changes in behavior, improve the health status, develop healthier practices by building client and/or care giver self-sufficiency through structured, goal orientated individual/group interventions, enhance the practice of healthy behaviors, and promote the full and appropriate use of primary medical care **.**

The goal of PSPCE/RSPCE is maintenance/restoration of the patient at the optimal level of physical functioning. The service must include the following components:

- assessment/evaluation of health status, patient needs, knowledge level;
- identification of relevant risk factors;
- development/revision of a goal-orientated plan of care (in conjunction with the physician/dentist and patient through verbal or passive communication) that address needs identified in the assessment/evaluation and which specifies the service(s) necessary to maintain/restore the patient to the desired state of wellness/health;
- anticipatory guidance/counseling to limit the development/progression of a disease/condition to achieve the goals in the medical plan of care;
- promoting positive health outcomes;
- monitoring of health status, patient needs, skill level, and knowledge

base/readiness; and

- counseling regarding identified risk factor(s) to achieve the goals in the medical plan of care.

PSPCE/RSPCE is not intended to be offered to all Medicaid clients. It is a service that is intended to assist physicians/dentists in accepting difficult-to-treat clients into their practice. These clients may be difficult due to their diseases.

MCOs may develop utilization review protocols for this service. Protocols must be approved by SCDHHS prior to implementation.

Developmental Evaluation Services

Developmental Evaluation Services are defined as medically necessary comprehensive neurodevelopmental and psychological developmental, evaluation and treatment services for recipients between the ages of 0 – 21. These individuals have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. These services are for the purpose of facilitating correction or amelioration of physical, emotional and/or mental illnesses and other conditions which if left untreated, would negatively impact the health and quality of life of the recipient. Developmental Evaluation Services may be provided through referral to MCO network providers which may include but shall not be limited to one of the three tertiary level Developmental Evaluation Centers (DEC) located within the Departments of Pediatrics at the Greenville Hospital System, Greenville, The University School of Medicine, USC, Columbia, or the Medical University of South Carolina at Charleston. Pediatric Day Treatment, when rendered by the DECs, is considered as one of the DEC treatment services. The MCO is responsible for the following:

96111 - Initial Neurodevelopmental Assessment for Special needs Children Under Age 21.

Current Medicaid Service Limitations: 12 units per year

96111 TS Modifier - Neurodevelopmental Re-assessment for Special needs Children Under Age 21.

Current Medicaid Service Limitations: 4 units per visit

96111 SA Modifier - Initial Neurodevelopmental Assessment by a Nurse Practitioner for special needs children under age 21.

Current Medicaid Service Limitations: 12 units per year

96110 SA Modifier - Neurodevelopmental Re-assessment by a Nurse Practitioner for special needs children under age 21.

Current Medicaid Service Limitations: 4 units per visit

96101 HP Modifier - Initial Psychological Evaluation for Special Needs Children Under age 21

Current Medicaid Service Limitations: 12 units per year (Not to exceed 6 hours and cannot bill separately for psychological testing).

96101 TS Modifier - Psychological Re-evaluation for Special Needs Children Under age 21

Current Medicaid Service Limitations: 12 units per year (Not to exceed 3 hours and only 1 every 6 months)

S5105 – Pediatric Day Treatment

Current Medicaid Service Limitations: None; based on Medical Necessity criteria.

Disease Management

Disease Management is comprised of all activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management.

Audiological Services

Audiological Services include diagnostic, screening, preventive, and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts (LPHA), within the scope of his or her practice under state law, must refer individuals to receive these services. A referral occurs when the physician or other LPHA has asked another qualified health care provider to recommend, evaluate, or perform therapies, treatment or other clinical activities to or on the behalf of the beneficiary being It includes any necessary supplies and equipment. Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use.

The Contractor is responsible for providing the following audiological services:

Code/Mod	Description	Unit Length	Frequency
V5090	Dispensing Fee, unspecified hearing aid	1 handling	6 every 12 months
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	1 evaluation	1 every 12 months
92590	Hearing aid examination and selection; monaural	1 evaluation	6 every 12 months

V5011	Fitting/Orientation/Checking of Hearing Aid	1 orientation	6 every 12 months
V5275	Ear impression, each- (one)	1 ear impression one unit	6 every 12 months
V5275	Ear impression, each (both)	1 ear impression two units	6 every 12 months
92557/52	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	1 reevaluation	6 every 12 months
92592	Hearing aid check; monaural	1 analysis	6 every 12 months
92592/52	Hearing aid recheck; monaural	1 recheck	6 every 12 months
92552	Pure tone audiometry (threshold); air only	1 test	6 every 12 months
92567	Tympanometry (impedance testing)	1 test	No limit
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	1 test	No limit
92588	Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	1 test	No limit
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	1 test	No limit
92585/52	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	1 test	No limit
92584	Electrocochleography	1 test	1 per implant
92626	Evaluation of auditory rehabilitation status; first hour	1 test	10 per year

SERVICES OUTSIDE THE CORE BENEFITS

The services detailed below are those services which will continue to be provided/reimbursed by the current Medicaid program and are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. Payment for these services will remain fee-for-service. ***MCOs are expected to be responsible for the continuity of care for all Medicaid MCO Program members by ensuring appropriate referrals and linkages are made for the member to the Medicaid fee-for-service provider.***

Institutional Long Term Care Facilities/Nursing Homes

MCO plans are responsible for the first 30 days of confinement in a long term care facility/nursing home/hospital who provides swing bed or administrative days. Services include nursing facility and rehabilitative services at the intermediary or sub-acute intermediate levels of care. Specifically, administrative days are counted as part of the hospital stay and **do not** count towards fulfilling the 30 days of MCO responsibility for long term care. Swing beds are counted in the same way as nursing home days and **do** count towards fulfilling the 30 days of MCO responsibility for long term care. After the first 30 days, payment for services will be reimbursed fee-for-service by the Medicaid program for Medicaid enrolled providers. The member will be disenrolled at the earliest effective date allowed by system edits.

Mental Health And Alcohol And Other Drug Abuse Treatment Services

Mental health, alcohol and other drug abuse treatment services will be reimbursed by Medicaid fee-for-service. SCDHHS considers the following to be mental health and alcohol and other drug abuse treatment services:

Hospital Services (UB92 claims)

- Inpatient DRGs 424 through 433, 521 through 523;
- Outpatient: primary diagnosis has a class code of C

Physician/Clinic (CMS 1500 claims)

- Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS) **;**
- Services provided by the Department of Mental Health (DMH) ;

Psychiatric services except the assessment codes detailed in the Psychiatric Assessment Services section.

Should a member receive outpatient services in an emergency room setting for which the primary diagnosis is behavioral health (class code C), the emergency room visit would be paid as a fee-for-service claim (by SCDHHS). If a member presents at the emergency room with a behavioral health primary diagnosis and is admitted to the hospital, (DRG's 424-433 and 521-523) SCDHHS would be the responsible party and would not make a payment for an emergency room visit but would reimburse the hospital for an inpatient stay using a DRG payment.

For services billed by a psychiatrist, SCDHHS will pay for procedure codes 90804 – 90899 as fee-for -service. For services billed by a medical doctor (including a psychiatrist) or a para –professional, SCDHHS will pay for the following procedure codes as fee-for-service: 90804, 90806, 90847, 90853, 90882 and 99371. Both assessment codes listed in the Psychiatric Assessment Services section are the responsibility of the MCO.

The Contractor shall coordinate the referral of members for services that are outside of the required core benefits and which will continue to be provided by enrolled Medicaid providers. These services are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. These services include, but are not limited to targeted case management services, intensive family treatment services, therapeutic day services for children, out of home therapeutic placement services for children, inpatient psychiatric hospital and residential treatment facility services.

Non-Emergency Transportation

Non-emergency transportation is defined as transportation of the recipient to or from a Medicaid covered service to receive medically necessary care. Non-emergency transportation is only available to eligible recipients who cannot obtain transportation on their own through other available means, such as family, friends or community resources. The MCO may assist the member in obtaining transportation services through the SCDHHS enrollment broker system as part of its care coordination responsibilities. See Appendix 3 for enrollment broker contact information.

If the MCO authorizes out-of-state referral services and the referral service is available in-state as determined by the South Carolina Department of Health and Human Services (SCDHHS), the MCO is responsible for all Medicaid covered services related to the referral, including transportation and lodging. If the MCO authorizes out-of-state services and the service is not available in-state the MCO will only be responsible for the cost of referral services and any ambulance or medivac transportation or other services provided in core benefits.

Vision Care

All recipients, regardless of age, can receive one vision test during any 12-month period of time. For other services, if medically necessary, consult the Vision manual for the appropriate procedure code. Eyeglasses for the above recipients are limited to one pair per year. Replacements due to breakage or loss of eyewear are not authorized. However, if the prescription changes at least one half diopter during a 12 month period, the lenses can be changed to the original frame. If the patient has lost or broken the frame, the patient is financially responsible for the frame. Medicaid will supply the lenses.

Recipients between the ages of 21 and 65 years who are not in the waiver program can qualify for eyewear if the patient has had cataract surgery. If medically necessary, a replacement pair of eyeglasses will be provided for those with cataract surgery every two years thereafter.

Dental Services

Routine dental services are available to recipients under the age of 21. Routine dental services include any diagnostic, rehabilitative, or corrective procedure, supplies and preventive care furnished or administered under the supervision of a dentist.

Medicaid beneficiaries 21 and over are eligible for Emergency Dental Services only. Emergency services are defined as those necessary for the following:

- Relieving acute severe pain
- Controlling an acute infectious process
- Repairing traumatic injury
- Multiple extractions necessary due to a catastrophic medical condition(i.e. chemotherapy, organ transplant, severe heart disease,etc.) Multiple extractions must be prior authorized.

Emergency dental services for conditions that meet the above listed criteria are limited to extraction of the symptomatic tooth(teeth) and accompanying procedures (i.e.radiographs, examination and anesthesia) Preventive and Restorative dental services are not covered for beneficiaries 21 and over.

Oral surgery services are covered as a part of emergency dental services. Non-covered procedures are those that do not restore a bodily function, are frequently performed without adequate diagnosis, are not proven effective, or are experimental in nature. Services of an assistant surgeon that actively assists an operating surgeon are covered. Coverage is limited to certain major surgical procedures consistent with good medical practice.

Chiropractic Services

Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Medicaid recipients are limited to a maximum of one visit per day and up to 12 visits within a calendar year. Chiropractic visits are counted separately from the ambulatory visit limit. Also children under age 21 may have up to 12 visits during a fiscal year (July 1 through June 30).

Rehabilitative Therapies For Children -- Non-Hospital Based

The Title XIX SC State Medicaid Plan provides for a wide range or therapeutic services available to individuals under the age of twenty-one (21) who have sensory impairments, mental retardation, physical disabilities, and/or developmental disabilities or delays, as well as to individuals of any age who are in the Mental Retardation/Related Disabilities Waiver or the Head and Spinal Cord Injury Waiver programs

Rehabilitative therapy services include: speech-language pathology, audiology, physical and occupational therapies, and Nursing Services for Children under 21 years of age. These services are provided through the Local Education Authorities (LEA) or the Private Rehabilitation Services programs.

Targeted Case Management Services

Targeted Case Management (TCM) consists of services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. A systematic referral process to providers for medical education, legal and rehabilitation services with documented follow up must be included. TCM services ensure the necessary services are available and accessed for each eligible patient. TCM services are offered to alcohol and substance abuse individuals, children in foster care , chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with a head or spinal cord injury or a related disability, children and adults with Sickle Cell Disease and adults in need of protective services. Medicaid reimbursable Targeted Case Management programs available to recipients are administered by the following:

- Department of Mental Health: services for chronically mentally ill adults and children with serious emotional disturbances.
- Department of Alcohol and Other Drug Abuse Services: services for substance abusers/dependents.
- Department of Juvenile Justice: services for children 0-21 receiving community services (non-institutional level) in association with the juvenile justice system.
- Department of Social Services: a) services to emotionally disturbed children 0-21 in the custody of DSS and placed in foster care, and adults 18 and over in need of protective services and b) vulnerable adults in need of protective custody.
- Continuum of Care for Emotionally Disturbed Children: children ages 0-21 who are severely emotionally disturbed.

- Department of Disabilities and Special Needs: services to individuals with mental retardation, developmental disabilities, and head and spinal cord injuries. Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training.

- South Carolina School for the Deaf and the Blind: services to persons with sensory impairments. Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training for children 0 to 6.

- Sickle Cell Foundations and other authorized providers: services for children and adults with sickle cell disease and/or trait that enable recipients to have timely access to a full array of needed community services and programs that can best meet their needs.

- The Medical University of South Carolina provides services to children and adults with Sickle Cell.

Home And Community Based Waiver Services

Home and community-based waiver services target persons with long term care needs and provide recipients access to services that enable them to remain at home rather than in an institutional setting. An array of home and community based services provides enhanced coordination in the delivery of medical care for long term care populations. Waivers currently exist for the following special needs populations: 1) persons with HIV/AIDS, 2) persons who are elderly or disabled, 3) persons with mental retardation or related disabilities, 4) persons who are dependent upon mechanical ventilation; and 5) persons who are head or spinal cord injured. Home and community-based waiver recipients must meet all medical and financial eligibility requirements for the program in which they are enrolled. A plan of care is developed by a case manager for all enrolled waiver recipients and the services to be provided and 6) women at or below 185% of federal poverty level for Family planning services only. An array of family services is available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies. Covered services include traditional contraceptive drugs and supplies and preventive contraceptive methods. Family planning services are also available through special pregnancy prevention programs.

Pregnancy Prevention Services - Targeted Populations

The Medicaid program provides reimbursement for pregnancy prevention services for targeted populations through state and community providers. The Medicaid program will reimburse fee-for-service directly to enrolled Medicaid providers for these services.

The MCO should ensure that Medicaid MCO program members continue to have access to these programs, which include but are not limited to:

MAPPS Family Planning Services

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) provide Medicaid funded family planning services to at-risk youths. MAPPS are designed to prevent teenage pregnancy among at risk youths, promote abstinence, and educate youth to make responsible decisions about sexual activity (including postponement of sexual activity or the use of effective contraception). Services provided through this program are: assessments, service plan, counseling, and education. These services are provided in schools, office setting, homes, and other approved settings. The MCO primary care provider should contact the DHHS MAPPS Program Representative at 803-898-4614 or other approved service providers (e.g., some certain local elementary, middle, and/or high schools) to set up a system of referral to this program as needed.

Organ Transplantation

Group I – Kidney and Corneal

Kidney: Reimbursement is all-inclusive for kidney transplant. This fee includes organ procurement, donor testing, and all other services considered as the technical component to the hospital, for living, related, and cadaver donations. Refer to the Physicians Provider Manual.

Corneal: MCO is responsible for this service.

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

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

Group II – Bone Marrow (Autologous Inpatient and Outpatient, Allogenic Related and Unrelated, Cord, And Mismatched), Pancreas, Heart, Liver, Liver with Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung and Heart/Lung, Multivisceral, Small Bowel:

The MCO is responsible for all services prior to 72 hour pre-admission, post transplant services upon discharge by MUHA and post transplant pharmacy services.

All potential Group II transplants, cadaver or living donor, must be authorized by Medical University Hospital Authority (MUHA) before the services are performed.

MUHA will review all Medicaid referrals for organ transplants and issue an approval or a denial.

If the transplant is approved, the approval letter serves as authorization for pretransplant services (72 hours preadmission), the event (hospital admission through discharge), and post transplant services up to 90 days from the date of discharge.

For information concerning the referral for medical evaluation and transplant arrangements, please contact the following:

Transplant Coordinator
MUHA: 843-792-2123

BEST PRACTICES

The goal of this section is to give the MCO examples of best practices by the South Carolina Medicaid Program. These practices have addressed issues that are particularly prevalent in the South Carolina Medicaid population.

Asthma Education and Management

Development of asthma in children is influenced by interactions between genetic and environmental factors. Asthma can not be cured but can be controlled. An asthma management program will include but not limited to:

- Education program for child and parent/guardian
- Medication Education / Usage
- Prevention of Attacks
- Rescue Program
- Hospitalization Utilization / Monitoring
- Disease Management

Reference guidelines: the CDC's National Asthma Control Program – Healthy People 2010 for asthma. The goals of the program are to reduce the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activity due to asthma.

Enhanced Prenatal And Newborn Care

The problem of high infant mortality/morbidity rates has plagued South Carolina for decades. Low income women and infants are over-represented in these rates.

The South Carolina Medicaid program is committed to the concepts(s) of risk appropriate care and enhancing maternal and child health outcomes.

The following Medicaid Best Practice Guidelines are recommended:

1. Early and continuous risk screening for all pregnant women.

2. Early entry into prenatal care.

3. Care for all prenatal women by the provider level and specialty best suited to the risk of the patient (Guidelines for Perinatal Care Most Current Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists)

4. All infants should receive risk-appropriate care in a setting that is best suited to the level of risk presented at delivery. (Guidelines for Perinatal Care, Most

Current Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists)

5. Risk assessment of the infant prior to discharge from the hospital.

6. Every Medicaid eligible mother and infant should receive a postpartum/infant Home Visit (PP/HV) service.

7. Communication/Coordination regarding the perinatal plan of the care between each provider (i.e., the specialist physician should communicate pertinent information back to the community level physician).

8. A medical home for the mother-infant unit after delivery to handle the long-term health care needs.

9. Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)(otherwise known as Family Support Services) referrals when medically indicated.

For additional recommendations and guidelines for risk appropriate ambulatory perinatal care for pregnant women, *Guidelines for Perinatal Care,* Most Current Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists may be referenced. **(SCDHHS bears no responsibility for furnishing providers copies of these guidelines).**

Other Services:

Each Medicaid eligible pregnant woman should be assessed to assure that the patient receives all appropriate services available either through the local county Health Department or other providers. Such services may include Women Infants and Children (WIC), mental health services, Family Planning Services (FPS), or other appropriate health or community services to assure good birth outcomes.

Immunizations

The administration of immunizations is a required component of EPSDT screening services. An assessment of the child's immunization status will be made at each screening and immunizations administered as appropriate. If the child is due for an immunization, it must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay will be documented in the child's record. An appointment will be given to return for administration of immunization at a later date.

Immunization of children will be provided according to the guidelines recommended by the South Carolina Department of Health and Environmental Control (DHEC), the Centers for Disease Control (CDC) – Advisory Committee on Immunization Practices

(ACIP), the American Academy of Family Physicians (AAFP), The American Academy of Pediatrics (AAP), and South Carolina State Law.

If a provider does not routinely administer immunizations as part of his/her practice, he/she will refer the child to the county health department and maintain a record of the child's immunization status.

Early Childhood Immunizations

Immunization of children in the first two years of life is one of the most widely accepted strategies for improving the public's health. Conformance with guidelines is, therefore, a high priority in assuring pediatric health.

1. Childhood immunizations are to follow the current year's schedule as set by the AAP (http://www.aap.org/healthtopics/immunizations.cfm). An instant Childhood immunization scheduler is available at the following CDC website: http://www2a.cdc.gov/nip/kidstuff/newscheduler_le/

2. Performance Goals: Although the ultimate goal of an immunization effort is 100% immunization compliance, the DHHS shall adopt the goal established by South Carolina Department of Health and Environmental Control which is to appropriately immunize 90% of children by the age of 24 months.

Sickle Cell Anemia Services

To receive services recipients must be diagnosed through laboratory testing as having Sickle Cell Disease and/or Sickle Cell Trait. Recipients of all ages are eligible.

The Sickle Cell Anemia Program consists of Case Management services and Genetic Education/Family Planning services. The Case Management service includes assessment, service planning, patient monitoring and reassessment. Genetic Education/Family Planning services cover the establishment of a health, social, and genetic history record and the provision of educational services regarding family planning.

The Enhanced Maternal Services include both psycho-social and health education interventions, intended to promote favorable pregnancy outcomes.

The primary objective of the Sickle Cell Program is to enable recipients with Sickle Cell Disease and/or Trait to have timely access to a full array of needed community services and programs that can best meet their needs.

The James R. Clark Memorial Sickle Cell Foundation in Columbia, Louvenia D. Barksdale Sickle Cell Foundation in Spartanburg, The Committee on Better Racial Assurance in Charleston, and the Medical University of South Carolina in Charleston are providers of Sickle Cell Anemia Services. The Department of Health and

Environmental Control (DHEC) may be accessed for service interventions for children under the age of 48 months.

Children With Chronic/Complex Health Care Needs

Managed Care Organizations (MCOs) will address the needs of medically challenged children within the context of their family, building on the best of tradition while moving into the paradigm of best practice consistent with health care reform.

South Carolina Medicaid encourages close collaboration between all disciplines serving children with chronic conditions. The goals are to develop a service continuum that is accessible and family friendly.
As the comprehensive medical home for children with (or at risk of developing) serious disabling conditions, MCOs will include within their protocol of diagnostic and treatment services, the following services:

- Case coordination
- Social work
- Health education
- Nutrition counseling

The case coordinator is responsible for assuring that the child and family receive all needed and appropriate services either directly provided by the MCO or through the local county Health Department or appropriate specialty and/or ancillary services providers.

Two federally-funded resources for children with special needs include BabyNet and Children's Rehabilitative Services. Usually Medicaid is the "Payer of Last Resort". However BabyNet and Children's Rehabilitative Services (CRS) are federally-funded programs that require Medicaid make payment before they do.

Therefore the payment order for these two programs is:

1. Third Party Liability;
2. Medicaid; then
3. BabyNet or CRS.

Early Intervention Services offered through the Department of Disabilities and Special Needs serves as another resource for special needs children.

BabyNet

BabyNet is South Carolina's single point of entry into a system of coordinated early intervention services. (Also known as Part C of Federal Law IDEA, Individuals With Disabilities Education Act.) Appropriate referrals include infants and toddlers (birth to age 3) who are experiencing developmental delays and/or who have one of the following conditions:

- Chromosomal abnormality
- Genetic disorder
- Growth disturbance secondary to chronic illness
- Severe sensory impairment
- Developmental disorder secondary to exposure to toxic substance
- Inborn error of metabolism
- Severe attachment disorder (psychological required)
- Abnormal development of the nervous system
- Complications of prematurity (ECMO,≤ 1000 grams, or Grade III or IV intraventricular hemorrhage only)

Referral may be made to a BabyNet Service Coordinator by contacting your local DHEC Health District. The BabyNet Service Coordinator and a local multi-disciplinary team identify the most appropriate service coordinator to guide the family through procedures, agencies and services (some of which are contained in the Core Benefits required to be provided by the MCO if they are determined to be medically necessary; the MCO is considered to have the primary responsibility for all medically necessary services that are within the Core Benefits). Eligibility and service provision are established based on each child's identified developmental delay.

Children's Rehabilitative Services (CRS)

With the support of federal, state, and other funding, CRS operates a statewide network of children's medical services. By coordinating the efforts of local, regional, and state resources, CRS assures that the best possible medical services are available across the state for these special children. The CRS System of Care provides nursing intervention, social work services, nutrition services, parent-to-parent support, in and out-patient hospitalizations, braces, hearing aids, specialized medical equipment,

physical, occupational and speech therapies, and genetic services. Community based care is provided in 13 public health district sites around the state.

To participate in the CRS program, a child must be a legal resident of the United States, live in South Carolina, be under 21 years old, be diagnosed with a covered medical condition, and the family must meet certain income guidelines. Financial eligibility for program services is based on family size, income, and federal guidelines that are updated annually.

Covered Conditions and Diagnoses: CRS offers treatment and services for many disabilities, some of which are listed below:

- Bone and joint diseases;
- Hearing disorders and ear disease;
- Cleft lip and palate and other craniofacial anomalies;
- Spina Bifida and other congenital anomalies;
- Epilepsy (seizures), cerebral palsy and other central nervous system disorders;
- Rheumatic fever;
- Problems from accidents, burns, and poisoning;
- Endocrine disorders;
- Hemophilia (children and adults);
- Sickle cell disorders (children and adults);
- Developmental delays such as speech/language, motor and growth abnormalities; and
- Kidney diseases.

Covered Services

- Nursing
- Pharmacy
- Durable Medical Equipment
- Physician Services
- Social Work
- Nutrition
- Genetics
- Transition
- Parent-to-Parent Support

Services Not Covered

- Routine visits to your family doctor or pediatrician;
- Routine dental care;
- Emergency room treatment;
- Transportation; and
- Medical services not related to the CRS covered health problem.

Early Intervention (EI) Services

Early Intervention (EI) services provided by the Department of Disabilities and Special Needs (DDSN), serves children (Ages 0 to 6) and families who meet the eligibility criteria for DDSN. This criterion includes children with a diagnosis of autism, head injury, spinal cord injury and similar disabilities, and mental retardation and related disabilities.

The Disabilities and Special Needs Board in each county serves as the planning and service coordination point for the delivery of EI services. Service provision includes family training and service coordination.

Referrals may be made through BabyNet by contacting your local Disabilities and Special Needs Board.

Diabetes Education and Management

The primary objectives of any diabetes education and management interventions are to help the recipient adapt to the chronic diagnosis of Diabetes, learn self-management skills, educate the recipient and families as to the nature of diabetes, and make important behavioral changes in their lifestyle.
The MCOs will reference the American Diabetes Associated (ADA) guidelines and practices.

Prevention And Management Of Sexually Transmitted Diseases

The MCO will follow the Centers for Disease Control and Prevention (CDC) (http://wwwcdc.gov/std/program) program guidelines on the prevention, treatment and management of Sexually Transmitted Diseases (STD) and will coordinate with the local health departments (as per State and Federal laws) when members are identified as having contracted or been exposed to an STD.

Heart Disease Education and Management

Heart disease is the leading cause of death in the United States and is a major cause of disability. Heart disease is a term that includes several more specific heart conditions. Education and Management of heart disease will include but not be limited to:

- Lifestyle changes: stop smoking, diet low in fat / cholesterol and high in fiber, maintain a healthy weight and get regular exercise,
- Control Cholesterol
- Control High Blood pressure
- Control Diabetes

The MCOs will follow the CDC guidelines (http:www.cdc.gov/heart/disease/) and the American Heart Association (http://www.americanheart.org).

THIRD PARTY LIABILITY

"Third Party Liability" (or "TPL") is roughly analogous to coordination of benefits for health insurance. Medicaid, however, is secondary to all other insurance (and most but not all governmental health programs) so the savings of TPL are substantial.

Specific Areas for TPL Activity

A. Comprehensive Insurance Verification Activities

SCDHHS has a contract in place for insurance verification services. Leads from the following sources are verified by the contractor before being added to the TPL database:

- The Department of Social Services (TANF/Family Independence and IV-D)
- The Social Security Administration
- Community Long Term Care staff
- Data Matches with Employment Security, TRICARE, and the IRS
- Insurer Leads
- Leads from Claims Processing

The TPL database is an integral part of Medicaid's claims processing system. Verification includes policy and recipient effective dates, covered services, persons covered by the policy, maternity indicators, claim filing addresses and premium amounts. This data is updated continuously as new information is received.

Only verified TPL coverage data will be passed to Contractors.

Experience has shown that employers are the best source for the majority of information concerning their group health plans. Additionally, SCDHHS and its Insurance Verification Services contractor have developed over 120 employer prototypes to aid in the loading of accurate, consistent data into the TPL database.

B. Cost Avoidance

Cost Avoidance refers to the practice of denying a claim based on knowledge of an existing health insurance policy which should cover the claim. The Medicaid allowed amount for a claim which is cost-avoided is stored in a "potential action" file. It is adjusted as necessary if insurance denies payment or if insurance doesn't pay the full Medicaid allowed amount and Medicaid reimburses the difference. The resulting system-calculated totals for cost avoidance represent true savings for the Medicaid program.

C. Aggressive Benefit Recovery Activities

SCDHHS utilizes a quarterly billing cycle to recover Medicaid expenditures for claims which should be covered by other third party resources. At the end of each quarter, the Medicaid claims database is searched automatically for claims which should have been

covered by policies added during the quarter and also for claims which were not cost avoided. Automated letters are generated to providers and insurance carriers requesting reimbursement of Medicaid payments. Follow-up letters are automatically generated if refunds have not been made within a set period of time. Provider accounts may be debited if refunds are not made. Denials of payment by insurance companies may be challenged for validity and/or accuracy. Every attempt is made to satisfy plan requirements so that carriers will reimburse Medicaid.

The following types of recoveries are initiated by SCDHHS:

1. Health Insurance Recoveries. Such recovery is done on a quarterly basis for both "pay and chase" and retroactive policy accretions.

   Automated billing cycles are used for both providers and carriers. Provider accounts are debited if voluntary refunds are not received.

2. Medicare Recoveries. Billings to providers and debits to accounts are automated. (This does not apply to capitated coverage.)

3. Casualty Recoveries. A strong assignment of rights and subrogation law enables SCDHHS to maximize casualty recoveries. Accident questionnaires are generated by the Medicaid claims processing system, using automated analysis of trauma diagnosis and surgical procedure codes. Recipients are asked, “How did you get hurt?” Most injuries are the result of accidents where no party is liable to pay. For those where repayment is likely, SCDHHS contacts insurers and recipients’ attorneys to enforce its subrogation right.

PROVIDER CERTIFICATION AND LICENSING

Medical service providers must meet certification and licensing requirements for the State of South Carolina. A provider cannot be enrolled if their name appears on the Centers for Medicare and Medicaid Services (CMS) Sanction Report, or is not in good standing with their licensing board (i.e., license has been suspended or revoked). Enrolled providers are terminated upon notification of a suspension, disbarment, or termination by USHHS, Office of Inspector General. A Contractor is responsible for insuring that all persons, whether they be employees, agents, subcontractors or anyone acting on behalf of the Contractor, are properly licensed under applicable South Carolina laws and/or regulations. The Contractor shall take appropriate action to terminate any employee, agent, subcontractor, or anyone acting on behalf of the Contractor, who has failed to meet licensing or re-licensing requirements and/or who has been suspended, disbarred or terminated. All health care professionals and health care facilities used in the delivery of benefits by or through the Contractor shall be currently licensed to practice or operate in South Carolina as required and defined by the standards listed below.

The Contractor may choose to use the South Carolina Managed Care Provider Credentialing Application in the credentialing of physicians. The application may be downloaded at the following website: http://www.scalliance.org . The Contractor is also free to use its own credentialing application.

All Providers billing laboratory procedures must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate. Laboratories can only provide services that are consistent with their type of CLIA certification.

Inpatient Hospitals -Inpatient hospital providers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC), certified by the Centers for Medicare and Medicaid Services (CMS) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JACHO). Providers accredited by the Joint Commission on Accreditation of Healthcare Organizations (JACHO) only require licensing by the Department of Health and Environmental Control (DHEC).

Outpatient Hospitals - Outpatient hospital providers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC), certified by the Centers for Medicare and Medicaid Services or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Providers accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) only require licensing by the Department of Health and Environmental Control (DHEC).

Ambulatory Surgical Centers - Ambulatory surgical centers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by the Centers for Medicare and Medicaid Services (CMS) and accredited by a nationally recognized body.

End Stage Renal Disease Clinics - End stage renal disease clinics must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by the Centers for Medicare and Medicaid Services (CMS).

Laboratory Certification - In accordance with Federal regulations, all laboratory testing facilities providing services must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver or a Certificate of Registration with a CLIA identification number. Laboratories can only provide services that are consistent with their type of CLIA certification.

Infusion Centers - There are no licensing requirements or certification for infusion centers.

Medical Doctor - An individual physician must be licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Physician's Assistant - A physician assistant is defined as a health professional who performs such tasks as approved by the State Board of Medical Examiners in a dependent relationship with a supervising physician or under direct personal supervision of the attending physician.

Certified Nurse Midwife/Licensed Midwife - A certified nurse Midwife must be licensed and certified to practice as an advanced practice registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations. A licensed midwife is a layperson who has met the education and apprenticeship requirements established by the Department of Health and Environmental Control (DHEC).

Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA) - A CRNA must be licensed to practice as a Registered Nurse in the state in which he/she is rendering services **and** currently certified by the Council on Certification of Nurse Anesthetists or the Council on Re-certification of Nurse Anesthetists. An AA must be licensed to practice as an Anesthesiologist Assistant in the state in which he/she is rendering services. A CRNA is authorized to perform anesthesia services only and may work independently or under the supervision of an anesthesiologist.

Nurse Practitioner and Clinical Nurse Specialist - A registered nurse must complete an advanced formal education program and be licensed and certified by the Board of Nursing under the Department of Labor, Licensing and Regulations. Services are limited by practice protocol.

Federally Qualified Health Clinics (FQHC) - Clinics must have a Notice of Grant Award under 319, 330 or 340 of the Public Health Services Act and be certified by The Centers for Medicare and Medicaid Services (CMS). Providers billing laboratory

procedures must have a Clinical Laboratory Improvement Amendment (CLIA) certificate.

Rural Health Clinics (RHC) - Clinics must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by the Centers for Medicare and Medicaid Services (CMS). Providers billing laboratory procedures must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate. Laboratories can only provide services that are consistent with their type of CLIA certification.

Alcohol and Substance Abuse Clinics - Clinics are required to be licensed by the Department of Health and Environmental Control (DHEC).

Mental Health Clinics (DMH) - Clinics must be a Department of Mental Health (DMH) sanctioned Community Mental Health Center. Out-of-state providers must furnish proof of Medicaid participation in the State in which they are located.

Portable X-Ray - Providers must be surveyed by the Department of Health and Environmental Control (DHEC) and certified by the Centers for Medicare and Medicaid Services (CMS).

Stationary X-Ray - Equipment must be registered with DHEC.

Mobile Ultrasound - No license or certification required.

Physiology Labs - Providers must be enrolled with Medicare.

Mammography Services - Facilities providing screening and diagnostic mammography services must be certified by the US Department of Health and Human Services, Public Health Services, Food and Drug Administration (FDA).

Pharmacy - Pharmacy providers must have a permit issued by the Board of Pharmacy under the South Carolina Department of Labor, Licensing and Regulations.

Dispensing Physician - Providers must be licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Mail Order Pharmacy - Providers must be licensed by the appropriate state board. Additionally, a special non-resident South Carolina Permit Number is required of all out-of-state providers. Such permits are issued by the Board of Pharmacy, under the South Carolina Department of Labor, Licensing and regulations.

Podiatrists - Podiatrists are licensed by the Board of Podiatry Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Ambulance Transportation - Ambulance service providers are licensed by the Department of Health and Environmental Control (DHEC).

Home Health - Home health service providers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by the Centers for Medicare and Medicaid Services (CMS).

Long Term Care Facilities/Nursing Homes - Long term care facilities must be surveyed and licensed under State law and certified as meeting the Medicaid and Medicare requirements of participation by the Department of Health and Environmental Control (DHEC).

Credentialing and Re-Credentialing

The MCO may delegate the credentialing / re-credentialing process, with DHHS' approval. The MCO is responsible for ensuring that the delegated entity follows the requirements as set forth by DHHS and the National Commission for Quality Assurance (NCQA). Re-credentialing will be no less often every three (3) years.

The MCO will develop and maintain policies and procedures regarding the credentialing /re-credentialing processes, submit the policies for DHHS' approval and submit with the December submissions when changes occur. The re-credentialing process will be no less than every three (3) years, with query of the National Practitioner Databank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners (for the specific discipline) and other performance data.

An onsite review will be required of providers and subcontractors, prior to the completion of the initial credentialing process (PCP and High Volume OB/Gyn). An on-site after initial, will be completed when a complaint has been lodged against the specific provider. The MCO must document that the location has adequate facilities and the practitioner's record keeping practices are consistent with the appropriate Federal and State laws and regulations.

There will be a credentialing committee, with the MCOs Medical Director having overall responsibility for the committee's activities. The committee will represent a broad network of representation from all disciplines (including Mid-Level Practitioners) and reflect a peer review process.

The process will include, but not be limited to:

- Current Valid License / Actions
- Current DEA and / or CDS certificate / Actions
- Education / Training / Board Certification(s)
- Work History (5 years) / Justifications for Gaps
- Professional Liability / Claims History (5 years)
- Hospital Privileges / Coverage Plan
- Sanctions by Medicare / Medicaid (5 years)

- National Practitioner Databank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners (for the specific discipline)
- Disclosure by Practitioner:
  - Physical / mental stability
  - History of chemical / substance abuse
  - History of loss of license / felony convictions
  - History of loss or limitations of privileges
  - Attestation: Correctness / completeness of application

The provider has a right to review information submitted to support the credentialing application; to correct erroneous information; receive status of the credentialing (re-credentialing) application; to a non-discriminatory review and receive notification of these rights . The provider has a right to appeal the initial credentialing adverse results, but not at re-credentialing.

QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

All MCOs that contract with the SCDHHS to provide Medicaid MCO Program Services must have a Quality Assessment (QA) and Utilization Management (UM) process that meets the following standards:

1. Comply with 42 Code of Federal Regulations (CFR) 434.34 which states that the MCO must have a quality assessment system that :

   (a) Is consistent with the utilization control requirement of 42 CFR 456;
   (b) Provides for review by appropriate health professionals of the process followed in providing health services;
   (c) Provides for systematic data collection of performance and patient results;
   (d) Provides for interpretation of this data to the practitioners; and
   (e) Provides for making needed changes.

2. Maintain and operate a Quality Assessment (QA) program which includes at least the following elements :

   (a) A quality assessment plan which shall include a statement that the objective of the QA plan is to "monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. QA efforts should be health outcome oriented and rely upon data generated by the MCO as well as that developed by outside sources."

   (b) QA Staff - The QA plan developed by the MCO shall name a person who is responsible for the operation and success of the QA program. Such person shall be a registered nurse, have adequate and appropriate experience for a successful QA, and shall be accountable for QA in all of the MCOs own providers, as well as the MCOs subcontractors. The person shall spend an adequate percent of his/her time on QA activities to ensure that a successful QA program will exist. In addition, the medical director must have substantial involvement in QA activities.

   (c) QA Committee - The MCO's QA program shall be directed by a QA committee which includes membership from:

      - a variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.)
      - a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.). The QA committee shall include OB/GYN and pediatric representation; and
      - MCO management or Board of Directors.

   (d) The QA committee shall be in an organizational location within the MCO such that it can be responsible for all aspects of the QA program.

(e) The QA activities of MCO providers and subcontractors, shall be integrated into the overall MCO/QA program. The MCO QA Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QA efforts.

(f) The QA committee shall meet at least quarterly and produce written documentation of committee activities, and submit such documentation to the MCO Board and SCDHHS.

(g) QA activities and results shall be reported in writing at least quarterly to the MCO Board of Directors. Such reports shall be submitted with quarterly reports to the SCDHHS and authorized agents.

(h) The MCO shall have a written procedure for implementing the findings of QA activities, and following up on the implementation to determine the results of QA activities. Follow-up and results shall be documented in writing, go to the board, and a copy sent to the SCDHHS.

(i) The MCO shall make use of the SCDHHS utilization data or their own utilization data, if equally or more useful than the SCDHHS utilization data, as part of the QA program.

(j) Quality Assessment and Performance Improvement Program (QAPI): The Contractor shall have an ongoing quality assessment and performance improvement program for the services it furnishes to members. At a minimum, the Contractor shall:

- Conduct performance improvement projects as described in Item (l) of this Section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have favorable effect on health outcomes and enrollee satisfaction.
- Submit performance measurement data as described in Item (k) of this Section.
- Have in effect mechanisms to detect both under-utilization and over-utilization of services.
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(k) Performance Measurements: Annually the Contractor shall:

- Measure and report to SCDHHS its performance, using standard measures required by SCDHHS.
- Submit to SCDHHS data specified by SCDHHS, that enables SCDHHS to measure the performance; or

- Perform a combination of the activities described in Items k(1) and k(2) listed above.

(l). Performance Improvement Projects (PIP): The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:

- Measurements of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.

Planning and initiation of activities for increasing or sustaining improvement.
For the current contract year, a PIP will be conducted on the HEDIS measurement of cervical cancer screening and breast cancer screening for the female population, serviced by the MCO.

(m). The Contractor shall report the status and results of each project to SCDHHS as requested. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvements projects in the aggregated to produce new information on quality of care each year.

3. Submit information on quality of care studies undertaken which include care and services to be monitored in certain priority areas as designated annually by SCDHHS. Such information shall include sufficient detail on purpose, scope, methods, findings, and outcomes of such studies to enable the SCDHHS to understand the impact of the studies on the MCOs health care delivery system.

   At a minimum, required quality of care studies will include measures for prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT examinations. Quality Measure Reports must be submitted to SCDHHS on a quarterly basis.

4. Assist the SCDHHS in its quality assurance activities.

   The MCO will assist, in a timely manner, the SCDHHS and the External Quality Review Organization (EQRO) under contract with the SCDHHS, as needed, in identification of provider and recipient data required to carry out on-site medical chart reviews.

   The MCO will arrange orientation meetings for physician office staff concerning on-site medical chart reviews, and encourage attendance at these meetings by MCO and physician office staff, as needed.

   The MCO will assist the SCDHHS and the EQRO under contract with the SCDHHS, as needed, in securing records needed to conduct off-site medical chart reviews.

   MCO will facilitate training provided by the SCDHHS to its providers.

   MCO will allow duly authorized agents or representatives of the State or Federal government, during normal business hours, access to MCO's premises or MCO

subcontractor premises to inspect, audit, monitor or otherwise evaluate the performance of the MCOs or subcontractors contractual activities.

5. Assure that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the provider, are properly licensed and/or certified under applicable state law and/or regulations and are eligible to participate in the Medicaid/Medicare program.

   The MCO must have written policies and procedures for credentialing and re-credentialing. The MCO may use its own Credentialing Form or the South Carolina Uniform Managed Care Provider Credentialing Application developed by the South Carolina Medical Association. The MCO may use its own Re-Credentialing Form or the South Carolina Uniform Managed Care Provider Credentials Update Form also developed by the South Carolina Medical Association. Copies of these may be downloaded at the following site: http://www.scmca.org/download/UCA2004.pdf.
   The MCO shall maintain a copy of all plan providers current valid license to practice.

   The MCO shall have policies and procedures for approval of new providers and termination or suspension of a provider.

   The MCO shall have a mechanism for reporting quality deficiencies which result in suspension or termination of a provider.

6. The MCO must have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum:

   (a) Written policies and procedures for assigning every member a primary care provider.
   (b) Management and integration of health care through primary care providers. The MCO agrees to provide available, accessible and adequate numbers of institutional facilities, service location, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis.
   (c) Systems to assure referrals for medically necessary, specialty, secondary and tertiary care.
   (d) Systems to assure provision of care in emergency situations, including an education process to help assure that members know where and how to obtain medically necessary care in emergency situations.
   (e) Specific referral requirements for in and out of plan services. MCO shall clearly specify referral requirements to providers and subcontractors and keep copies of referrals (approved and denied) in a central file or the member's medical record.
   (f) The MCO must assign an MCO qualified representative to interface with the case manager for those members receiving out of plan continuity of care and case management services. The MCO representative shall work with the case manager to identify what Medicaid covered services, in conjunction with the other identified social services, are to be provided to the member.

7. The MCO shall have a system for maintaining medical records for all Medicaid members in the plan, to ensure the medical record:

   (a) Is accurate, legible and safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all individuals evaluated or treated, and is accessible for review and audit.

   The MCO shall maintain, or require its network providers and subcontractors to maintain, individual medical records for each Medicaid member which make readily available to the SCDHHS and/or its designee and to appropriate health professionals all pertinent and sufficient information relating to the medical management of each enrolled member. Procedures shall also exist to provide for the prompt transfer of patient care records to other in - or out-of-plan providers for the medical management of the member.

   (b) Is readily available for MCO-wide QA and UM activities and provides adequate medical and other clinical data required for QA/UM.

   (c) Has adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

   (d) Contains at least the following items:

   - ✓ Patient's name, identification number, age, sex, and places of residence and employment. Next of kin, sponsor or responsible party.
   - ✓ Services provided through the MCO, date of service, service site, and name of service provider.
   - ✓ Medical history, diagnoses, treatment prescribed, therapy prescribed and drug administered or dispensed, commencing at least with the first patient examination made through or by the MCO.
   - ✓ Referrals and results of specialist referrals.
   - ✓ Documentation of emergency and/or after-hours encounters and follow- up.
   - ✓ Signed and dated consent forms.
   - ✓ For pediatric records **(ages 6 and under)** there must be a notation that immunizations are up-to-date.
   - ✓ Documentation of advance directives, as appropriate.
   - ✓ Documentation for each visit must include:
     - Date
     - Grievance or purpose of visit
     - Diagnosis or medical impression
     - Objective finding
     - Assessment of patient's findings
     - Plan of treatment, diagnostic tests, therapies and other prescribed regimens.
     - Medications prescribed
     - Health education provided

- Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

8. Submit Encounter Data as required on a monthly basis. This data shall be submitted in a format as specified by SCDHHS.

(a) The MCO must report EPSDT and other preventive visit compliance rates.
(b) All MCO contracts with network providers/subcontractors shall have provisions for assuring that data required on the encounter report is reported to the MCO by the network provider/subcontractor.
(c) For the purposes of reporting individuals by age group, the individual's age should be the age on the date of service

9. The MCO shall have written utilization management policies and procedures that include at a minimum :

(a) Protocols for denial of services, prior approval, hospital discharge planning and retrospective review of claims.
(b) Processes to identify utilization problems and undertake corrective action.
(c) An emergency room log, or equivalent method, specifically to track emergency room utilization and prior authorization (to include denials) reports.
(d) Processes to assure that abortions comply with 42 CFR 441 subpart E-Abortions, and that hysterectomies and sterilizations comply with 42 CFR 441 subpart F-Sterilizations.

10. The MCO shall furnish Medicaid members with approved written information about the nature and extent of their rights and responsibilities as a member of the MCO. The minimum information shall include:

(a) Written information about their managed care plan,
(b) The practitioners providing their health care,
(c) Information about benefits and how to obtain them,
(d) Confidentiality of patient information,
(e) The right to file grievance about the MCO and/or care provided,
(f) Information regarding advance directives as described in 42 CFR 417.436 and 489 subpart I,
(g) Information that affects the members enrollment into the MCO

11. Establish and maintain grievance and appeal procedures. The MCO shall:

(a) Have written policies and procedures which detail what the grievance system is and how it operates. The grievance procedures must comply with the guidelines outlined in the Contract.
(b) Inform members about the existence of the grievance processes.
(c) Attempt to resolve grievances through internal mechanisms whenever possible.

(d) Maintain a record keeping system for oral and written grievances and appeals and records of disposition.

(e) Provide to SCDHHS on a quarterly basis written summaries of the grievances and appeals which occurred during the reporting period to include:

- Nature of grievances and/or appeals
- Date of their filing
- Current status
- Resolutions and resulting corrective action

The MCO will be responsible for forwarding any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MCO Program member.

(f) Notify the member who grieves, that if the member is not satisfied with the decision of the MCO, the member can make a request to the Division of Appeals and Hearings, SCDHHS. for a State fair hearing. If the grievance/appeal is not resolved during the fair hearing, the Grievant/Appellant may request a reconsideration by SCDHHS, or file an appeal with the Administrative Law Judge Division.

12. The SCDHHS is required to evaluate each MCOs compliance with SCDHHS program policies and procedures, identify problem areas and monitor the MCOs progress in this effort. At a minimum this will include, but is not limited to, :

(a) SCDHHS will review and approve the MCOs written Quality Assurance Plan. The MCO must submit any subsequent changes and/or revisions to its Quality Assurance Plan to SCDHHS for approval on or before December 15th annually.

(b) The SCDHHS will review and approve the MCOs written grievance and appeal policies and procedures. The MCO must submit any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval prior to implementation.

(c) The SCDHHS shall review monthly individual encounter/claim data. Encounter claim data shall be reported in a standardized format as specified by SCDHHS and transmitted through approved electronic media to SCDHHS.

(d) The SCDHHS shall review quarterly quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.

(e) SCDHHS staff will review the MCOs reports of grievances, appeals, and resolution.

(f) SCDHHS staff will approve the MCOs Plan of Correction (PoC) and monitor the MCOs progress with the corrective actions developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective actions.

13. External Quality Assurance Review. Annually, the SCDHHS will conduct an independent review of services provided or arranged by the MCO. The review will be performed by the External Quality Review Organization (EQRO) under contract with the SCDHHS. External quality assurance evaluation and EQRO responsibilities shall include:

- Readiness Review Survey. The EQRO will conduct a readiness review of the Contractor as designated by DHHS. The Medicaid Managed Care External Review Services Manual will serve as a guide for the readiness review survey. DHHS will receive a written report within 30 days of the survey. DHHS will convey the final report findings to the MCO with a request for a PoC.

- Assisting the MCO in developing quality of care studies which meet SCDHHS quality indicators as they may not have sufficient resources or expertise to develop a focused quality of care study plan to conduct internal studies.

- With SCDHHS staff, conduct workshop and training for MCO staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.

SCDHHS will evaluate the MCOs compliance with the QA standards through an annual comprehensive QA evaluation. The Medicaid Managed Care External Review Audit Tool will serve as a guide for the annual review and shall consist of:

Quality Of Care Studies: a review of medical records by specific criteria which are selected by a statistically valid sampling methodology. The quality of care studies will focus on important aspects of patient care in the clinical settings. The SCDHHS selected quality of care studies will require qualified surveyors to:

- Collect aggregate data pertaining to the populations from which the sample medical records and administrative data will be selected. The quality of care studies will include indicators for prenatal care, newborns, childhood immunizations, asthma, ER utilization, and EPSDT examinations. The EPSDT examinations must be broken down by age categories: under one year, one to five years, six to fourteen years, and fifteen to twenty years.

- Abstract data from selected medical records and claims data for childhood immunizations, prenatal care, newborns, asthma ER utilization and EPSDT examinations.

The EQRO will compare findings of quality care studies with findings of the MCOs internal QA programs. The University of South Carolina (USC) will also provide analysis and comparison of findings across all MCOs in the program and with findings from other state and national studies performed on similar populations.

Service Access Studies: A review and evaluation of the MCOs performance of availability and accessibility. Studies will focus on:

- Emergency room service and utilization
- Appointment availability and scheduling
- Referrals
- Follow up care provided
- Timeliness of services

Medical Record Survey: will describe the compliance with medical record uniformity of format, legibility and documentation.

Administrative Survey: the MCOs will be surveyed for administrative policies and procedures, committee structures, committee meeting minutes including governing body, executive, quality assurance, and patient advisory. A review of the MCOs credentialing and re-credentialing systems, professional contracts, support service contracts, personnel policies, performance evaluation examples, member education information, member grievance and appeal systems, member grievance files, and member disenrollment files will be conducted.

- An MCO summation meeting will be held to discuss the QA evaluation findings.

- QA evaluation reports: the EQRO will submit an individual draft report to SCDHHS 30 calendar days following the completion of each MCO survey. An individual MCO final report will be issued by SCDHHS.

The results shall be available to participating health care providers, members and potential members.

Final EQR results, upon request, must be made available in alternative formats for persons with sensory impairments and must be made available through electronic as well as printed copies. The report shall include, at a minimum, the following:

- ✓ An assessment of the MCO's strengths and weaknesses.
- ✓ Recommendations for improving the quality of health care services furnished by the MCO;
- ✓ As the state agency determine methodologically appropriate, comparative information about all MCOs operating within the state; and

- ✓ An assessment of the degree to which each MCO has addressed effectively the quality improvement recommendations made during the previous year.

Within 30 calendar days (or as specified by DHHS)of receipt of the final QA evaluation report, the MCO must submit any necessary Corrective Action Plan to SCDHHS.

A meeting with the MCO will be conducted by SCDHHS staff in order to monitor progress with the MCO's PoC developed as a result of the annual QA evaluation. The frequency for the meetings shall be determined by DHHS based on the findings of the annual QA evaluation.

The MCO shall provide SCDHHS with a copy of its accreditation review findings.

Quality Measures

Prenatal Care

Prenatal care is one of the services most frequently used by women of childbearing age. Most practitioners now emphasize that risk assessment and health promotion activities should occur early in pregnancy. Low birthweight infants (<2,500 grams) are 40 times more likely to die than infants of normal birthweights; very low birthweight infants (<1,500 grams) are 200 times more likely to die than infants of normal birthweight. In addition, these infants are more likely to experience neurodevelopmental handicaps, congenital anomalies, respiratory illness and complications acquired during neonatal intensive care. Due to the profound impact of prematurity and low birthweight on the morbidity and mortality of affected children, monitoring prenatal care services is important.

1. The following measurements shall be used:

   For all Medicaid enrollees who delivered single or multiple live or stillborn fetus(es) of greater than or equal to 20-weeks gestation for the most recent 12-month reporting period:

   - The timing of the enrollee's enrollment in the health plan;
   - Pregnancy outcome (i.e., fetal loss > 20 weeks or live birth); and
   - Birthweight for each live birth (<500 grams; 500 - 1499 grams; 1500 - 2499 grams; or > 2500 grams).

2. Identifying criteria: For some of these measures, criteria are necessary to promote collection of comparable and reliable data. Measures needing further definition are:

   To determine the weeks gestation of the first prenatal visit, first determine the date of delivery and then using a gestational wheel, determine the weeks gestation at the time of the first visit. Calculation (Nagele's Rule): Count back 3 months from the first day of the last menstrual period and add seven days.

Trimester at enrollment of Medicaid pregnant women

Weeks of Gestation	Number	Percent
<0		
1 - 12		
13 - 28		
29 - 40		
Unknown		
Total		

Distribution of risk assessment for pregnant Medicaid members

	Number	Percent
No Risk		
High Risk (Medically)		
Total		

Pregnancy outcome of pregnant Medicaid members

	Number	Percent
Fetal Loss > = 20 weeks		
Live Births		
Total		

Distribution of birthweights in live births of pregnant Medicaid mothers and delivered at Level I, II or III hospitals (Levels as defined by state licensing).

Birth weight	Number Delivered in Level I Hospitals	Percentage Delivered in Level I Hospitals	Number Delivered in Level II Hospitals	Percentage Delivered in Level II Hospitals	Number Delivered in Level III Hospitals	Percentage Delivered in Level III Hospitals	Number Unknown
<500 grams							
500-1499 grams							
1500-2499 grams							
>2499 grams							
Unknown							
Total							

Distribution of risk assessment Medicaid newborns

	Number	Percent
No Risk		
High Risk (Medically)		
Total		

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The EPSDT program is a Federally mandated program that provides for comprehensive and preventive health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in children and young people (birth through 20 years of age) before the conditions become serious and disabling.

1. The following indicator shall be used: Number of members receiving at least one initial or periodic screening service

2. Identifying criteria: For some of these indicators, criteria are necessary to promote collection of comparable and reliable data.

Initial or periodic screening services are comprised of a package of these components: comprehensive health and developmental history; comprehensive unclothed physical exam; developmental assessment; nutritional assessment; dental assessment; vision screening; hearing screening; age appropriate immunizations; laboratory test; health education; and anticipatory guidance.

Age Groups

	Total	<1*	1-2	3-5	6-9	10-14	15-18	19 – 20
1. Number of eligibles enrolled								
2. Number of recommended screening services per age group for the year	XXXXXX	6.00	3	1	0.50	0.50	0.50	0.50
3. Number of recommended screening services per age group for the quarter (Line 2 multiplied by .25)	XXXXXX	1.5	.75	.25	0.125	.125	.125	.125
4. Expected number of screening services for the quarter (Line 1 multiplied by Line 3)								
5. Actual number of screening services for the quarter								
6. Goal	80%	80%	80%	80%	80%	80%	80%	80%
7. Screening Ratio (Line 5 divided by Line 4)	%	%	%	%	%	%	%	%

Note: The codes for reporting screening services for new and established patients are as follows:

99381 - New Patient under one year
99382 - New Patient (ages 1-4 years)
99383 - New Patient (ages 5-11 years)
99384 - New Patient (ages 12-17)
99385 - New Patient (ages 18-39 years)
99391 - Established patient under one year
99392 - Established patient (ages 1-4 years)
99393 - Established patient (ages 5-11 years)
99394 - Established patient (ages 12-17 years)
99395 - Established patient (ages 18-39 years)
99431 - Newborn care (history and examination)
99432 - Normal newborn care

*Cut off is through the month of 21st birthday

There is no distinction for providers in initial and periodic screenings. Initial refers to the first screening after birth or the first screening after a child becomes eligible for Medicaid. Periodic screenings are all screenings thereafter - the term comes from the reference to the

periodicity schedule for Well Child Care recommended by the American Academy of Pediatrics.

HEDIS Reporting Measures

Using the most current HEDIS specifications available issued by the NCQA (National Committee for Quality Assurance), the MCO will report the results annually to SCDHHS. SCDHHS will review annually the results with the MCOs, to determine the need for the MCO to complete a performance improvement project.

MARKETING, ENROLLMENT, AND MEMBER EDUCATION

The Contractor shall be responsible for developing and implementing a written marketing plan designed to provide the Medicaid applicant/eligible with information about the Contractor's plan. All marketing and enrollment materials must contain the 1-888-549-0820 telephone number of the statewide Medicaid Beneficiary Services Help Line and the plan's toll free number. The marketing plan and all related accompanying materials, brochures, fact sheets, posters, lectures, videos, community events and presentations, shall be governed by the following requirements, in accordance with 42CFR § 438.104. Please note that **all enrollment activities** currently performed by Contractors in a region of the state shall cease upon the expansion of the enrollment broker into that region. All regions are projected to be served by the enrollment broker by May 1, 2008.

General Marketing and Enrollment Policies

All SCDHHS marketing, member education, and enrollment policies and procedures stated within this Guide apply to staff, agents, officers, subcontractors, volunteers and anyone acting for or on behalf of the Contractor.

Violation of any of the listed policies shall subject the Contractor to rescission of its authorization to provide marketing, enrollment, educational materials in all or specific locations, or through any or all methods, as determined by the SCDHHS. The Contractor may dispute rescission of its authority to market its plan, enrollment and educational materials in writing to SCDHHS.

The Contractor's Medicaid marketing plan and enrollment procedures design shall guide and control the actions of its marketing staff. In developing and implementing its Medicaid marketing, enrollment plan and materials, the Contractor shall abide by the following policies:

The contractor may not enroll members or conduct enrollment activities in any region that is served by the enrollment broker

- The MCO should clearly state that this program is limited to certain Medicaid eligibles during approved marketing/enrollment activities to minimize the number of non-eligible enrollment applications.

- The Contractor shall not implement any marketing and/or enrollment procedures and activities relative to the Contract without making full disclosure to and obtaining prior written approval from SCDHHS or its designee .

- The Contractor shall not market directly to Medicaid applicants/recipients in person or through direct mail advertising or telemarketing.

- The Contractor is not allowed to directly or indirectly, conduct door-to-door, telephonic, or other "cold call" marketing and/or enrollment activities. The Contractor cannot make

repeated follow up calls unless specifically requested by the Medicaid eligible. Repeated unsolicited contacts are prohibited.

- MCOs cannot utilize any governmental facility, program or procedures in marketing or enrollment activities for Medicaid eligible recipients except as authorized in writing by SCDHHS. MCOs can conduct marketing/enrollment activities at DSS county offices with the approval of the DSS County Director **and** the SCDHHS Regional Administrator. MCOs can conduct marketing/enrollment activities at WIC county offices with the WIC Director's approval. However, these marketing/enrollment activities must be in accordance with SCDHHS requirements, no direct or indirect "cold call" marketing or enrollment activities.

- The Contractor shall not make any claims or imply in any way that a Medicaid eligible/recipient will lose his/her benefits under the Medicaid program or any other health or welfare benefits to which he/she is legally entitled, if he/she does not enroll with the Contractor.

- MCOs cannot make offers of material or financial gain to potential/existing Medicaid eligibles to facilitate enrollment of Medicaid recipients. Some examples are:
    - Over the counter drug vouchers
    - Accidental death or dismemberment, disability, or life insurance policies
    - Grocery store gift certificates

- The Contractor shall not enlist the assistance of any employee, officer, elected official or agent of the state to assist in the enrollment process of Medicaid applicants/eligibles except as authorized in writing by the SCDHHS.

- Any claims stating that the Contractor is recommended or endorsed by any state or county agency, or by any other organization must be prior approved by SCDHHS and must be certified in writing by the State or county agency or other organization which is recommending or endorsing the Contractor.

- The Contractor shall not utilize any state facility in marketing and enrollment activities for Medicaid eligible recipients, except as authorized in writing by the SCDHHS.

- The Contractor shall not misrepresent or use fraudulent, misleading information about the Medicaid program, SCDHHS or its policies or any other governmental programs.

- During the marketing presentation the Contractor must ask the recipient the name of the doctor they currently see. **The Contractor must inform the recipient whether the doctor is a member of the Contractor's provider network.** If the doctor is not a member of the Contractor's provider network the recipient must be provided the Contractor's current provider listing from which he can choose a doctor.

Medicaid Applicant/Recipient Contact

- The Contractor may contact members who are listed on their monthly member listing to assist with Medicaid re-certification/eligibility.

- Contractor may conduct an initial follow up for all voluntary disenrollees listed on their monthly member listing. However, these activities must be in accordance with marketing/enrollment requirements with no direct or indirect "cold call" marketing or enrollment activities. The Contractor cannot make repeated follow up calls unless specifically requested by the Medicaid eligible.

- Contractors may initiate contact with Medicaid eligibles when the Medicaid eligible has completed and submitted an MCO enrollment form to the Contractor in order to obtain incomplete enrollment form information (i.e. Medicaid ID number). The Contractor is not allowed to make direct contact for purposes of solicitation of enrollment.

- The Contractor cannot discriminate among enrollees on the basis of health status or requirements for health care services. Discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual except as permitted by Title XIX.

- When the Medicaid eligible contacts the Contractor directly for information regarding their participation in the Medicaid MCO Program, the Contractor may provide marketing/ enrollment materials upon request. MCOs must maintain a log of Medicaid eligible persons initiating requests for information. This log, at a minimum, must contain the following data elements:

    - ✓ Medicaid eligible's name,
    - ✓ Address,
    - ✓ Medicaid number,
    - ✓ Date and method of contact,
    - ✓ MCO employee contacted and
    - ✓ Their location.

  When the recipient is located in a region served by the enrollment broker, all contacts must be referred to the broker and the MCO must provide the appropriate broker contact information, as requested.

- When the Medicaid eligible requests the Contractor to send a representative to their home, the Contractor's licensed marketing representatives (Employees and agents must follow all applicable provisions of the South Carolina Insurance regulations regarding accident and health licensure.) are required to utilize the SCDHHS approved "Permission for MCO Visit" document in order to obtain a signed statement from the Medicaid applicant/eligible giving permission for the marketing representative to conduct a home visit for the purpose of marketing or enrollment activities. This provision is designed to allow Medicaid applicants/eligibles a choice regarding the best

environment in which to make decisions and receive information regarding Medicaid options and assistance with enrollment.

- Marketing representatives may not solicit or accept names of Medicaid eligibles from Medicaid applicants/eligibles or current Medicaid MCO members for the purpose of offering information regarding its plan or offering enrollment. However, upon request by a Medicaid eligible/applicant, marketing representatives may provide information (excluding MCO enrollment form) about the MCO to the Medicaid applicant/eligible to give to other interested Medicaid eligibles/applicants (i.e. business card, marketing brochure).

Materials, Media and Mailings

- All materials/media must include the Medicaid **Beneficiary Services Help Line's toll free number (1-888-549-0820)** and the plan's toll free number. Promotional materials (items designed as "give-aways" at exhibits) are excluded.

- The materials/media must include a statement that enrollment is voluntary.

- MCOs can develop and **passively** distribute marketing and educational materials which have been approved by SCDHHS to potential and existing Medicaid eligibles at any sites approved by the contract (i.e. schools, churches, community centers, provider offices, governmental offices excluding DSS). This excludes the distribution of the MCO enrollment form.

- With prior written approval by SCDHHS, that is site specific, approved MCO videos can be shown in doctors' waiting rooms or other approved marketing/enrollment events.

- MCOs can, **with SCDHHS written prior approval**, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by Contractor), advertising in newspapers, magazines, church bulletins, billboards and buses..

- With prior written approval of SCDHHS, that is site specific, MCOs can develop and use interactive media that provides information on the MCO plan that could be assessed by persons waiting in facilities frequented by the Medicaid populations.

- MCOs may mail SCDHHS approved marketing and educational materials within its approved service areas . Mass mailings directed to only Medicaid recipients are prohibited.

- MCOs' Medicaid enrolled network providers can use SCDHHS approved letters to inform recipients about their participation status in the Medicaid Program and the MCO. Letters regarding providers' participation status in the Medicaid Managed Care Program may not contain MCOs' marketing materials or enrollment forms and must be

mailed and/or distributed directly by the network provider's office. This function cannot be delegated to the MCO or an agent of the MCO by the provider. In addition, the use of these letters must be in accordance with SCDOI's policy.

Enrollment Form

- **All enrollment activities currently performed by Contractors in a region of the state shall cease upon the expansion of the enrollment broker into that region. All regions are projected to be served by the enrollment broker by May 1, 2008. In all enrollment broker regions, any permission or assignment of enrollment duties or activities by the MCO, implicit or explicit, as contained in this Section or Policy and Procedure Guide, are terminated.**

- The Contractor cannot use non-licensed marketing representatives to present and/or complete MCO enrollment forms.

- MCO's may utilize the DHHS approved enrollment form to enroll Medicaid eligibles into its plan. If the MCO chooses to develop and utilize its own enrollment form, the form must be submitted to DHHS for approval. The enrollment form must be presented by a licensed marketing representative. No **passive** distribution of enrollment forms is allowed by an MCO or employee/agent of MCO. Passive distribution is defined as the availability of the enrollment form through the MCO or representative of the MCO without the presence of a licensed marketing representative (e.g. counter displays).

- Distribution of MCO enrollment form is not allowed through mass media marketing or mass mailings.

- The licensed marketing representative can assist a Medicaid eligible in completing the enrollment form and may submit the form on the eligible's behalf or the eligible can mail it directly to the Medicaid Beneficiary Services Unit. The licensed marketing representative should inform the Medicaid recipients that information regarding additional Medicaid options is available by calling DHHS's toll free Helpline number.

- The licensed marketing representative is responsible for ensuring that the individual signing the enrollment form is a legally responsible adult and is authorized to make decisions regarding Medicaid enrollment for each eligible listed on the enrollment form.

- The licensed marketing representative is responsible providing the enrollee information on participating PCPs and assisting the enrollee in determining if his/her current physician is a member of the MCO's network.

Enrollment Incentives

- No offers of material or financial gain, other than core benefits expressed in the Contract, may be made to any Medicaid applicant/eligible as incentives to enroll or

remain enrolled with the Contractor. The Contractor can only use, in marketing materials and activities, any benefit or service that is **clearly specified** under the terms of the Contract, and available to Medicaid MCO Program members for the full Contract period which has been approved by SCDHHS. Optional expanded benefits which have been approved by SCDHHS may be used in marketing materials and activities. These benefits include, but are not limited to: reduced or no copayments, OTC medications, additional services and visits, vision and dental benefits to adults or increases over Medicaid limitations, membership in clubs and activities)

- All incentive programs must be approved, in writing, by the DHHS prior to use.

- No over-the-counter drug vouchers shall be offered to Medicaid MCO Program members.

- No accidental death or dismemberment, disability, or life insurance policies shall be offered to any Medicaid applicants/eligibles or Medicaid MCO Program members.

Marketing Activities and Educational Materials

Marketing for the Contractor may include providing educational materials to enhance the ability of Medicaid applicants/recipients to make an informed choice of Medicaid managed care options. Such educational material may be in different formats (brochures, pamphlets, books, videos, and interactive electronic media). The SCDHHS and/or its designee will only be responsible for distributing general marketing material developed by the Contractor for inclusion in the SCDHHS enrollment package to be distributed to Medicaid applicants/recipients. The SCDHHS at its sole discretion will determine which materials will be included.

The Contractor shall be responsible for developing and distributing its own member specific marketing and educational materials including but not limited to, evidence of coverage, member handbook, and member education.

SCDHHS has established the following minimum requirements for the Contractor's Medicaid managed care marketing/educational materials:

- The Contractor shall ensure that all Medicaid managed care marketing and educational materials, brochures and presentations clearly present the core benefits and/or approved expanded benefits, as well as any limitations the Contractor may have. The Contractor shall also include a written statement to inform applicants/recipients that enrollment is voluntary.

- The Contractor shall ensure that all materials are accurate, not misleading or confusing and do not make material misrepresentations.

- All materials shall be reviewed and approved for readability, content, reading level and clarity by SCDHHS or its designee.

- The Contractor shall ensure that all written material will be written at a grade level no higher than the fourth (4) grade or as determined appropriate by DHHS.

- The Contractor shall ensure that appropriate foreign language versions of all marketing and educational materials are developed and available to Medicaid applicants/eligibles. The foreign language materials must also be approved, in writing, by the SCDHHS. Foreign language versions of materials are required if the population speaking a particular foreign (non-English) language in a county is greater than ten (10) percent. (South Carolina has no such counties at this time. If counties are later identified, SCDHHS will notify the Contractor.) Affidavits of accuracy and reading level compliance must be submitted by the professional translation service and accompany all foreign language translations.

- The Contractor shall issue a certificate of coverage (other than MCO card) or evidence of coverage which describes specific information on core benefits, approved expanded benefits, out-of-plan services or benefits, non-covered services, and which contains a glossary or definitions of generic MCO terms. A description of how the plan operates, a statement that enrollment is voluntary and that the decision to enroll or not to enroll will not affect eligibility for Medicaid benefits, an explanation of the plan's referral process, WIC, and well child program and how to obtain medical care, an explanation of how the plan's identification (ID) card(s) work and how to choose a primary care provider(s) must be included.

- When the Contractor identifies Medicaid members who have visual and/or hearing impairments, an interpreter must be made available for the South Carolina Medicaid MCO Program member(s).

- The Contractor's written material shall include its network provider list, which includes names, area of specialty, address, and telephones number(s) of all of the participating providers and facilities including primary care, specialty care, hospitals and clinics, pharmacies, ancillary providers (such as labs and x-ray) DME providers and all other required services providers. It shall also include a map or description of the Contractor's service area.

- The Contractor shall provide an explanation of any ancillary providers the Contractor may use, e.g. Physician Assistants or Nurse Practitioners in providing its health care services.

- The Contractor's written material must include a definition of the plan's term of "medical emergency" and "urgent emergency care" and the procedures on how to obtain such care within and outside of the Contractor's service area.

- The Contractor must provide a description of its family planning services and services for communicable diseases such as TB, STD, and HIV/AIDS. This document must contain a statement of the member's right to obtain family services from the plan or

from any approved Medicaid enrolled provider. This document must contain a statement of the member's right to obtain TB, STD, HIV/AIDS services from any state public health agency.

- The Contractor's written materials must include procedures for making appointments for medical care including appointments with a specialist, how to obtain medical advice, and how to access the Contractor's member/patient services.

- The Contractor's written materials must provide the following information on the responsibilities and rights of a Medicaid MCO program member and an explanation of its confidentiality of medical records and as required in Section **8.4** of the Contract:

    - An explanation of member's grievance(s), appeals rights, and advance directive rights;

    - Provide information on member disenrollment and termination. An explanation of the Medicaid MCO program member(s) effective date of enrollment and coverage;

    - The plan's toll-free telephone number; and

    - A statement that any brochure or mailer may contain only a brief summary of the plan and that detailed information can be found in other documents, e.g. evidence of coverage, or obtained by contacting the plan.

Marketing Events And Community Forums

MCOs can conduct marketing and/or enrollment activities only with prior notice to SCDHHS and with SCDHHS's written prior approval. Each specific marketing and/or enrollment event/site, including activities in contracted providers' offices, must be prior approved by SCDHHS. SCDHHS's approval will be specific by event/site/date. **The dates, times and locations of all community events must be sent to SCDHHS ten (10) days prior to the event using a form or format approved by SCDHHS SCDHHS reserves the right to attend all community events.**

- MCOs may conduct marketing/enrollment activities at community events, forums and business locations including but not limited to, health fairs, health screenings, local health agencies, schools, churches, housing authority meetings, local businesses (excluding presentations designed to perform marketing/enrollment activities at employees benefits orientation meetings and contacting community employers about employees receiving Medicaid who may be interested in hearing about the MCO Plan), presentations and activities at community events.

- Focus Groups: MCOs may conduct focus group research for the general Medicaid population in order to determine what the Medicaid population's expectations are for managed health care and what would be the best managed health care marketing

methods. Such focus group research may be conducted in any geographic areas of the state with prior written approval from SCDHHS. No enrollment activities can occur at focus groups.

- Show Vans: Show vans or similar vehicles can be used in various locations to distribute SCDHHS approved Medicaid managed care educational, marketing, and enrollment materials with SCDHHS written approval for each event/location. Enrollment materials must be presented by a licensed marketing representative.

Member Services

The Contractor shall maintain an organized, integrated member/patient services function to assist Medicaid MCO Program members in understanding the Contractor's policies and procedures. Member/Patient Services can provide additional information about the Contractor's primary care providers, facilitate referrals to participating specialists, and assist in the resolution of service and/or medical delivery concerns or problems a Medicaid MCO Program member may have. The Contractor shall identify and educate Medicaid MCO Program members who access the system inappropriately and provide additional education as needed.

The Contractor shall demonstrate its commitment to member/patient services by establishing a member/patient services department that can assist in the education of Medicaid MCO Program members. The Contractor shall provide a written description of

its member/patient services function to give to its Medicaid MCO Program members no later than fourteen (14) business days from receipt of enrollment data from SCDHHS. The written description must include information on the following:

- The appropriate utilization of services
- How to access services;
- How to select a primary care physician;
- Access to out-of-plan care;
- Emergency care (in or out-of-area);
- The process for prior authorization of services;
- Toll free telephone number for member services;
- Written explanation containing a Statement of Understanding; and
- An explanation of how to authorize the provider to release medical information to the federal and state governments or their duly appointed agents.

Medicaid MCO Program Identification (ID) Card

The Contractor shall issue an identification card for its Medicaid MCO program members to use when obtaining core benefits and any approved expanded services. To ensure immediate access to services, the Contractor shall accept the member's Medicaid ID Card as proof of enrollment in the Contractor's plan until the member receives its MCO ID card from the Contractor. A permanent MCO ID card must be issued by the Contractor within fourteen (14) calendar days of selection of a PCP by the Medicaid MCO Program member or date of receipt of enrollment data from SCDHHS, whichever is later.

The Contractor is responsible for issuing an ID card that identifies the holder as a Medicaid MCO program member. An alpha or numeric indicator can be used but should not be observably different in design from the card issued to commercial MCO members.

The ID card must include at least the following information:

A. MCO name;

B. A twenty-four (24) hour telephone number for Medicaid MCO Program members use in urgent or emergency situations and to obtain any other information;

C. Primary care physician name;

D. Member name and identification number;

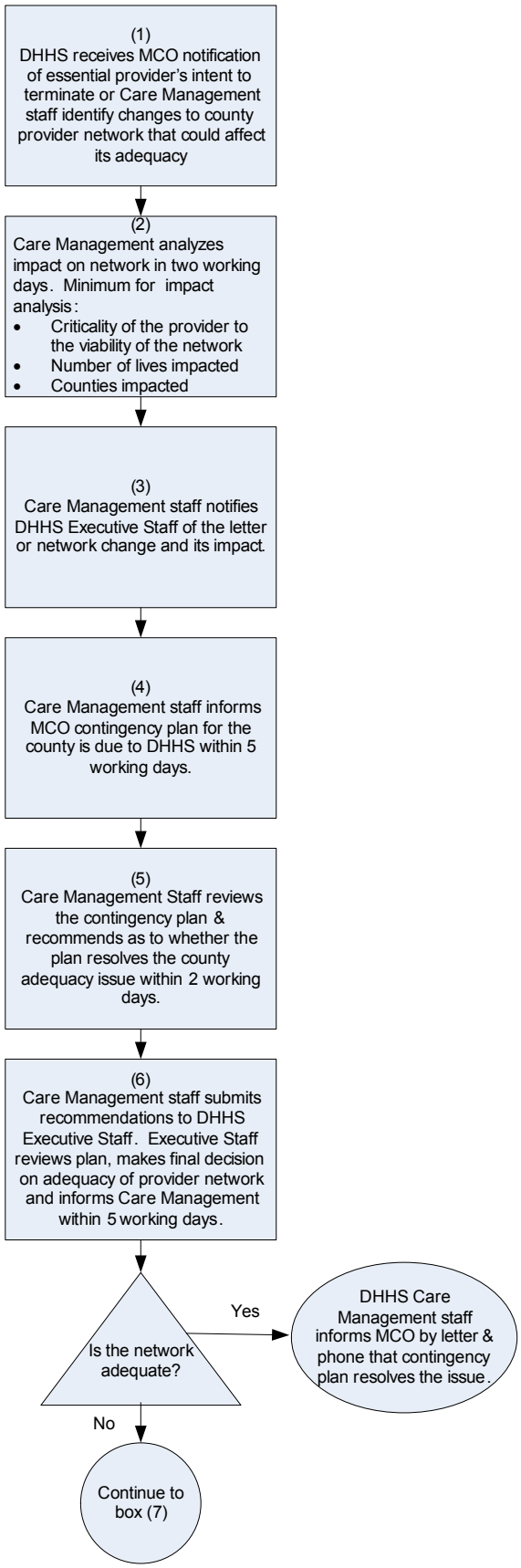
E. Expiration date (optional);

F. Toll free telephone number.

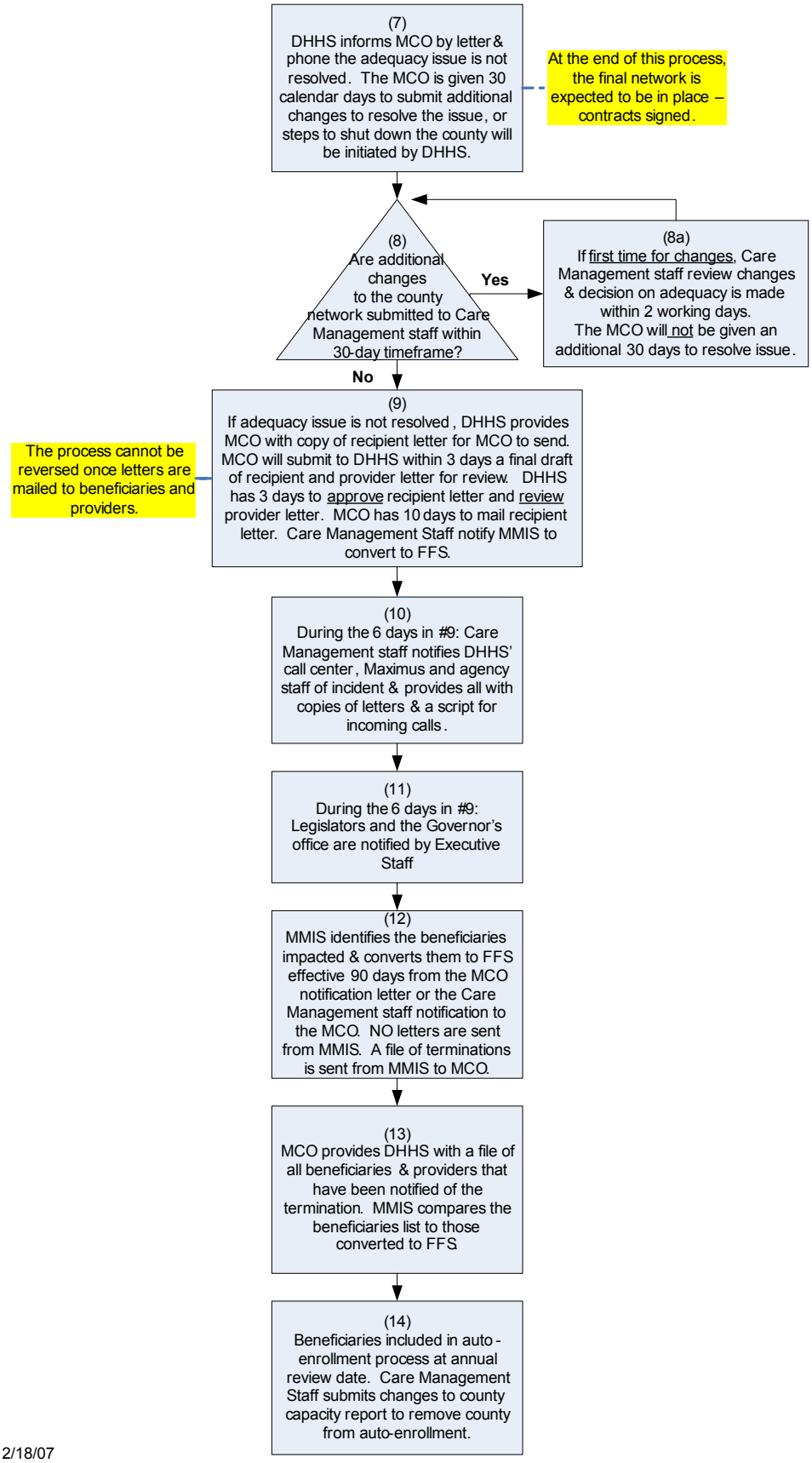
NETWORK TERMINATION PROCEDURES

In the event an approved MCO provider network loses essential providers and is not able to receive approval from SCDHHS, the network must be terminated. SCDHHS has developed a 90 Day Transition Plan, which will go into effect upon notification that the network is judged to be inadequate and unable to provide the contracted level of care while meeting state and/or federal standards. The following flowchart details the steps and critical decision points which would result in the termination of a county network. The loss of a key provider/s that serves multiple counties can result in the termination of multiple counties.

MCO Provider County Network Termination 90-Day Transition Plan



12/18/07


(7)
DHHS informs MCO by letter & phone the adequacy issue is not resolved. The MCO is given 30 calendar days to submit additional changes to resolve the issue, or steps to shut down the county will be initiated by DHHS.
At the end of this process, the final network is expected to be in place – contracts signed.
(8)
Are additional changes to the county network submitted to Care Management staff within 30-day timeframe?
Yes
(8a)
If first time for changes, Care Management staff review changes & decision on adequacy is made within 2 working days.
The MCO will not be given an additional 30 days to resolve issue.
No
(9)
If adequacy issue is not resolved, DHHS provides MCO with copy of recipient letter for MCO to send. MCO will submit to DHHS within 3 days a final draft of recipient and provider letter for review. DHHS has 3 days to approve recipient letter and review provider letter. MCO has 10 days to mail recipient letter. Care Management Staff notify MMIS to convert to FFS.
The process cannot be reversed once letters are mailed to beneficiaries and providers.
(10)
During the 6 days in #9: Care Management staff notifies DHHS' call center, Maximus and agency staff of incident & provides all with copies of letters & a script for incoming calls.
(11)
During the 6 days in #9: Legislators and the Governor's office are notified by Executive Staff
(12)
MMIS identifies the beneficiaries impacted & converts them to FFS effective 90 days from the MCO notification letter or the Care Management staff notification to the MCO. NO letters are sent from MMIS. A file of terminations is sent from MMIS to MCO.
(13)
MCO provides DHHS with a file of all beneficiaries & providers that have been notified of the termination. MMIS compares the beneficiaries list to those converted to FFS.
(14)
Beneficiaries included in auto-enrollment process at annual review date. Care Management Staff submits changes to county capacity report to remove county from auto-enrollment.

12/18/07

INCENTIVE PLANS

Rules Regarding Physician Incentive Plans (PIP) in Prepaid Health Organizations

The PIP rules apply to Medicaid prepaid organizations subject to section 1903(m) of the Social Security Act, i.e., requirements for federal financial participation in contract costs, including both Federally qualified MCOs and State Plan defined MCOs.

The Contractor may operate a PIP only if - (1) no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

The Contractor must maintain adequate information specified in the PIP regulations and make available to the DHHS, if requested, in order that the SCDHHS may adequately monitor the Contractor's PIP if applicable. The disclosure must contain the following information in detail sufficient to enable the SCDHHS to determine whether the incentive plan complies with the PIP requirements:

1. Whether services not furnished by the physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

2. The type of incentive arrangement; for example, withhold, bonus, capitation.

3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.

4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.

5. The panel size and, if patients are pooled, the approved method used.

6. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent calendar year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example, nursing home and home health agency) services.

7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results (which must be provided in a timely manner to Medicaid recipients upon request)

The disclosure requirements numbers 1 through 5 must be provided prior to contract approval and upon the effective date of its contract renewal. Disclosure requirement number 6 must be provided for the previous calendar year by April 1 of each year.

The Contractor must disclose this information to the SCDHHS when requested. The Contractor must provide the capitation data required no later than three (3) months after the end of the calendar year. The Contractor will provide to the beneficiary upon request whether the prepaid plan uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

Disclosure Requirements Related to Subcontracting Arrangements

A Contractor that contracts with a physician group that places the individual physician members at substantial financial risk for services they do not furnish must do the following:

- Disclose to the SCDHHS, upon request, any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid recipients. The disclosure must include the required information and be made at the times specified.

- Provide adequate stop-loss protection to the individual physicians.

- Conduct enrollee surveys

A Contractor that contracts with an intermediate entity (e.g., an individual practice association, or physician hospital organization) and which bases compensation to its contracting physicians or physician groups on the use or cost of referral services furnished to Medicaid recipients must comply with requirements above.

Recipient Survey

42 CFR 417.479(g)(1) requires that organizations that operate incentive plans that place physicians or physician groups at Substantial Financial Risk (SFR) must conduct surveys of enrollees. Surveys must include either all current Medicaid enrollees in the Contractor's plan and those that have disenrolled other than because of loss of eligibility or relocation, or choose to conduct a valid statistical sample.

According to 42 CFR 417.479(g)(iv), enrollee surveys must be conducted no later than one year after the effective date of the contract and at least annually thereafter. As long as physicians or physician groups are placed SFR for referral services, surveys must be conducted **annually**. The survey must address enrollees/disenrollees satisfaction with

the quality of services, and their degree of access to the services. Medicare contracting MCOs will meet the survey requirement via a CMS sponsored survey conducted by the Agency for Health Care Policy and Research through their Consumer Assessments of Health

Plans Study (CAHPS) process. SCDHHS has the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. Contractors, upon completion of approved survey tool, will be expected to compile, analyze and summarize survey data within a reasonable period of time (generally within four months) and submit the results to the SCDHHS.

Note: If disenrollment information is obtained at the time of disenrollment from all recipients, or a survey instrument is administered to a sample of disenrollees, your current method will meet the disenrollee survey requirements for the contract year.

Sanctions

Withholding of FFP

Section 1903(m) of the Act specifies requirements that must be met for states to receive FFP for contracts with Contractors 42 CFR 434.70(a)(2002, as amended) sets the conditions for FFP. Federal funds will be available to Medicaid for payments to Contractors only for the periods that the Contractors comply with the PIP requirements in 42 CFR 417.479(d)-(g), (h)(1), (h)(3), and 417.479(I) requirements related to subcontractors. These regulations cover: 1) the prohibition of physician payments as an inducement to reduce or limit covered medically necessary services furnished to an individual enrollee, 2) proper computation of substantial financial risk, 3) physician stop-loss protection, 4) enrollee survey requirements, and 5) disclosure requirements.

42 CFR 434.70(b) provides that CMS may withhold FFP for any period during which the State fails to meet the State plan requirements of this part.

Intermediate Sanctions and/or Civil Money Penalties

42 CFR 438.700(a) states that intermediate sanctions (42 CFR 438.702, types of intermediate sanctions) may be imposed on a Contractor with a risk comprehensive contract which fails to comply with any of the requirements of 417.479(d) - (g), or fails to submit to SCDHHS its physician incentive plans as required or requested in 42 CFR 422.208 and 422.210.

In accordance with 42 CFR 1003.103(f)(1)(vi), the OIG may impose a Civil Monetary Penalty of up to $25,000 for each determination by CMS that a contracting organization has failed to comply with 417.479(d) - (g) and 434.70. Civil Monetary Penalties may be imposed on the organization in addition to, or in place of the imposed sanctions.

Definitions for Physician Incentive Plan Requirements

Physicians Incentive Plan - Any compensation arrangement between a Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid recipients enrolled in the Contractor.

Physician Group - A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Intermediate Entity - Entities which contract between an MCO or one of its subcontractors and a physician or physician group. An Individual Practice Association (IPA) is considered an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

Substantial Financial Risk - An incentive arrangement based on referral services that place the physician or physician group at risk for amounts beyond the risk threshold. The risk threshold is 25 percent.

Bonus - A payment that a physician or entity receives beyond any salary, fee-for service payment, capitation, or returned withhold. Quality bonuses and other compensation that are not based on referral levels (such as bonuses based solely on care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk, but may revisited at a later date.

Capitation - A set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Payments - The amount a Contractor pays physicians or physician group for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this subpart.

Referral Services - Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish.

Risk Threshold - The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. The risk threshold is 25 percent.

Withhold - A percentage of payments or set dollar amount that an organization deducts for a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on the specific predetermined factors.

PUBLIC REPORTING BURDEN

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0700. The time required to complete this information collection is estimated to average 100 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503."

CMS will accept copies of state-mandated submissions in lieu of the Disclosure Form if such submissions include all the necessary elements of information as required by CMS and statute. MCOs may maintain records supporting the Disclosure Forms in any format, as long as these records sufficiently document the disclosure information the MCO submits and are available for inspection by appropriate regulators.

INDEX OF REQUIRED FILES, REPORTS AND FORMS

This chart is a summary listing of 1) all files to be submitted by MCOs to SCDHHS, 2) all reports to be submitted by MCOs to SCHHHS, 3) all files to be submitted by SCDHHS to MCOs and 4) all applicable SCDHHS forms to be used by MCOs in the conduct of business. A file is defined as a set of related records compiled in a specified format. A report is defined as a written document containing pre-defined data elements or record of information and a form is defined as a document used to collect or report information. The medium of all files and reports shall be electronic and follow the specifications noted in Section 13.43 Software Reporting Requirement of the 2008 MCO Contract **or** MMIS guidelines and requirements (as applicable).

All files/reports with a frequency of "monthly" are due no later than the 15th (fifteenth) day after the end of the reporting month. **The exceptions to this requirement are 1) the Medicaid Enrollment Capacity Report, which is due by the 5th (fifth) day of the following month, 2) Third Party Liability File, which is due by the 8th (eighth) day of the month and 3) encounter files, which can be submitted no later than the 25th (twenty-fifth) of the following month.** All files/reports with a quarterly frequency are due no later than the 30th (thirtieth) day after the end of the reporting quarter. All annual reports are due no later than the 90th (ninetieth) day after the end of the reporting year period.

General Instructions			
Data Transmission Requirements		Page 102	
Security Requirements For Users of SCDHHS'S Computer Systems		Page 103	
Use of Control Files for EDI Transfers		Page 104	
MCO Files to SCDHHS	**Frequency**	**Format Specifications**	**Recipient**
Encounter Data Submission Process	NA	Page 109	NA
Protocol for File Exchange Between SCDHHS and MCOs	NA	Page 110	NA

MCO HCFA 1500 Encounter Rec (ambulatory encounters) File	Monthly*	Page 113	SCDHHS MMIS
MCO Hospital Encounter Rec (hospital encounters) File	Monthly*	Page 119	SCDHHS MMIS
MCO Drug Encounter Rec INP – 3 (drug encounters) File	Monthly*	Page 124	SCDHHS MMIS
Third Party Liability File	Monthly	Page 126	SCDHHS MMIS
MCO Provider Identification Record File	Monthly	Page 127	SCDHHS MMIS
MCO Reports to SCDHHS	**Frequency**	**Format Specifications**	**Recipient**
Network Providers and Subcontractors Listing	Monthly	Page 129	Department of Managed Care Nurse Administrator for Quality
Grievance Log with Summary Information	Collected Monthly and Reported Quarterly	Page 130	Department of Managed Care Nurse Administrator for Quality
Appeals Log with Summary Information	Collected Monthly and Reported Quarterly	Page 131	Department of Managed Care Nurse Administrator for Quality
Medicaid Enrollment Capacity by County Report	Monthly by the 5th of the following month	Page 132	Department of Managed Care Nurse Administrator for Quality
Maternity Kicker Payment Notification Log	Monthly	Page 133	Department of Managed Care Nurse Administrator for Quality

Newborn Kicker Payment Notification Log	Monthly	Page 134	Department of Managed Care Nurse Administrator for Quality
Quality Assurance (QA) A. QA Plan B. QA Plan of Correction C. Quality Indicators D. HEDIS Reporting Measures	 As required As required Quarterly Annually	 See Contract See Contract Page 73 Page 77	Department of Managed Care Nurse Administrator for Quality
Member Satisfaction Survey	Annually	Instrument and Survey Results	Department of Managed Care Nurse Administrator for Quality
Performance Standards – Claims Time to Pay Report	Monthly	Format determined by MCO	Department of Managed Care Nurse Administrator for Quality
Summary of Claim Turnaround Report	Monthly	Format determined by MCO	Department of Managed Care Nurse Administrator for Quality
SCDHHS Files to MCOs	**Frequency**	**Format Specifications**	**Recipient**
Managed Care Member Listing File (MLE)	Monthly	Page 136	MCO
Provider Identification File	Monthly	Page 138	MCO

Output Encounter File for Pharmacy Services	One business day after processing	Page 139	MCO
Output Encounter File for Ambulatory Services	One business day after processing	Page 141	MCO
Output Encounter File for Hospital Services	One business day after processing	Page 144	MCO
EPSDT File for Visits and Immunizations	Monthly	Page 147	MCO
Claims History File	Monthly	Page 148	MCO
Other Files to be received (no examples in this Guide): - Carrier Codes File - Contract Rates File - Fee Schedule File - Recertification File - 820 File	Monthly	NA	MCO
Files Exchanged between MCOs and SCDHHS	**Frequency**	**Format Specifications**	**Recipient**
MCO/MHN/MAXIMUS Sync File Layout	At least monthly	Page 153	MCO/SCDHHS
Form Listing			
- SCDHHS Managed Care Plan Change Form (DHHS Form 280-2) - WIC Referral Form - Hysterectomy			

Acknowledgement Form (Acknowledgement of Receipt of Hysterectomy Information) - Instructions for Completion of Hysterectomy Acknowledgement Form - Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients Form (DHHS 1723) - Instructions for Completion of Sterilization Consent Form - Abortion Statement - Instructions for Completion of Abortion Statement -Request for Medicaid ID Number Form -SCHCC Plan Initiated Disenrollment Form			

*****Encounter files may be submitted more frequently than monthly. See following page for instructions
Note: The SCDHHS Nurse Administrator for Quality will distribute all reports to appropriate staff for action after they have been logged.

GENERAL INSTRUCTIONS

Data Transmission Requirements

The State Of South Carolina, Department of Health And Human Services (SCDHHS), utilizes the product Connect: Direct (C:D) to support EDI utilizing the TCP/IP protocol.

The State requires C:D FTP connections to be on a specified port. It is the responsibility of the connecting agency/entity to provide access through their firewall, on a designated port.

CDFTP+ provides a simple, reliable way to transfer files securely between a C:D server, at a central processing center, and remote sites. This is accomplished either through a graphical user interface (GUI), or through a command line interface that accepts common FTP commands and scripts.

- C:D FTP+ has checkpoint and restart capability.
- FTP+ is utilized at SCDHHS, on a mainframe, with Secure+, a data encryption product.
- Data integrity checking is utilized ensuring integrity of the transferred data and verifies that no data is lost during transmission.
- CDFTP+, the PC client software, is provided at no cost.

After the appropriate security and data sharing agreements are completed a connection with SCDHHS can be established. Technicians from both entities will be required to establish and test the C:D connection. At the time of connection the appropriate software, keys files, documentation, E-mail addresses, contact information, and file naming conventions will be exchanged, by SCDHHS and the agency/entity technicians, to ensure a secure connection is established.

SECURITY REQUIREMENTS FOR USERS OF SCDHHS'S COMPUTER SYSTEMS

SCDHHS uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of The State of South Carolina programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in the State of South Carolina computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. SCDHHS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of SCDHHS's computerized information and resources. SCDHHS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to SCDHHS computer systems must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Do not browse or use SCDHHS data files for unauthorized or illegal purposes.
- Do not use SCDHHS data files for private gain or to misrepresent yourself or SCDHHS.
- Do not make any disclosure of SCDHHS data that is not specifically authorized.
- Do not duplicate SCDHHS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter SCDHHS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of SCDHHS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from the State of South Carolina Service, depending upon the seriousness of the offense. In addition, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

Organization Contact Signature: _____Date: _____

HHS Approver Signature: _____Date: _____

Use of Control Files for EDI

PURPOSE:
This document describes the layout and use of control files in the transfer of data using Electronic Data Interchange (EDI).

DEFINITION:

South Carolina Department of Health and Human Services utilizes a CONTROL FILE for each file to be used with EDI.

Use of a control file allows the sender and receiver to know the status of the file. The logic is:

Sender: If control file is present, last copy of data file was not used.
Sender: If control file is not present, it is ok to overwrite existing data file.
Receiver: If control file is not present, there is no file to transfer.

Consider: if the Sender is wanting to create a new file he will check to see if a control fileexists. If it does, the run is aborted. Reasoning is; the file from the last run was not picked up. This should cause the Sender to call the Receiver and clarify if the last file was picked up.
If YES then the Receiver will delete the control file and the file will be created.
If NO then the Receiver will download the last file, delete the control file and then the Sender will produce the new file.

A recommendation is at a specified time prior to file creation, a job can run to verify if it is ok to create a new file. If the control files are verified to exist, a message can be sent alerting appropriate persons of a problem. This enhances production as a proactive approach in reducing after-hours calls.

Control file details:

- Each file will contain a minimum of 5 records. Even if a record is not used it will still be present in the control file.
- Each control file is application specific. Use of the comment record can be used to tailor to the specific need.
- Each record has its own purpose.
- Each record is a fixed 80 byte record.
- A hash total is not required. Some files transferred may not have a common offset that will always be numeric. Recommended to always include comment record stating no hash total present. Optionally, the decision may be made to include additional bytes at the end of the record for the purpose of hash totaling. A suggestion is to use MMSS (minutes and seconds) as the value of the additional bytes.

Refer to control file description of records below.

- Record One contains a count of all records in the file.
  When the recipient of the data processes the file they should at least verify the count of records.
- Record Two contains the date and time the file was created.
- Record three is for creating a hash total.
  This will be the sum of a defined area of the record in the file being transferred.
  The area that is being hash totaled will be specified in a comment record. An example is: HASH TOTAL IS SUM OF OFFSET 5 FOR LENGTH OF 5
  This record may not always be used. It is application specific. If a hash total is not created this record will be present but will not contain a value. If the hash total is created it provides one more level of integrity for the file being transferred.
- Record Four contains contact information, should the user of the file have problems. If this is a file created by HHS BIS, then the contact information will probably be the analyst who is responsible for the job. If the file being created is truly production (i.e., HHSMMIS), then the contacted information would more than likely be Contract Services at Clemson. HHS Analysts will need to coordinate with Clemson Analysts on who the contact should be.
- Record Five is the comment record. There may be occasion to include a description that is more than one record in length. Therefore there may be multiple comment records. This will depend on the application and the file being transferred.

Control files will be the same name as the file they are referencing with the following suffix:

(filename).DCF = daily control file
(filename).WCF = weekly control file
(filename).MCF = monthly control file
(filename).QCF = quarterly control file
(filename).YCF = yearly control file
(filename).OCF = file is created only on demand
(filename).ZCF = file is created as a one time only file

*** all reports that are put into a text file for transfer will have the last node as .RPT***
*** All .RPT files will have a control file with the appropriate extension. Control ***
*** files for report files will not have a hash total. ***

EXAMPLE of file contents:

Below is the contents, just FYI, for this month.

NUMBER OF RECORDS 8241
FILE CREATION DATE&TIME 20060223 11:19
HASH TOTAL 0041104394
CONTACT NAME AND PHONE JIM WOOD-MMIS HELPDESK (803)898-2610
COMMENTS HASH TOTAL=SUM DISPLACEMENT 124 FOR 4
COMMENTS MHN0195.PCM999.MEMBER.FILE
COMMENTS LRECL= 340

A couple of good examples can be found in the @DSU and @MHN jobs.

RECORD ONE 80 bytes:

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	Description	25	1	25	Contains constant value NUMBER OF RECORDS:
2	Record Count	10	26	35	Contains the total count of records in the file
	Filler	45	36	80	

RECORD TWO 80 bytes:

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	Description:	25	1	25	Contains constant value FILE CREATION DATE&TIME:
2	Creation Date And Time	14	26	39	Contains file creation date and time CCYYMMDD HH:MM

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
	Filler	41	40	80	

RECORD THREE 80 bytes:

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	Description:	25	1	25	Contains constant value Hash Total:
2	Hash Total	15	26	40	Contains the hash sum value of the records in the file
	Filler	40	41	80	

RECORD FOUR 80 bytes:

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	Description:	25	1	25	Contains constant value CONTACT NAME AND PHONE:
2	CONTACT NAME AND PHONE:	55	26	80	Contains contact information for SCDHHS

RECORD FIVE 80 bytes: (may contain multiple comment records)

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	Description:	25	1	25	Contains constant value COMMENTS
2	Comment	55	26	80	Contains freeform text

MCO FILES TO SCDHHS

ENCOUNTER DATA SUBMISSION PROCESS

Each encounter data submission shall be accompanied by a statement of certification of the number of paid claims/encounters included in the submission identified by date of service. SCDHHS shall conduct validation studies of encounter data, testing for timeliness of payment, accuracy and completeness. All submitted data must be 100% correct no later than 90 days following the end of the month of submission. There is no limit on the number of times encounter data can be resubmitted within the 90 day limit. Submissions shall be comprised of encounter records, or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claims records of any contracted services rendered to the member.

Steps in processing Encounter data:

1) MCO transmits encounter data to SCDHHS.
2) The file is processed by SCDHHS and the status set to accept or reject, with reject reason codes if applicable.
3) All valid encounters are accepted and processed into the MMIS.
4) SCDHHS makes the status file available for the MCO to retrieve and notifies the MCO the file is ready.
5) MCO retrieves their file.
6) MCO will correct any encounters with errors.
7) Go to step 1.

The MCO may resubmit corrected encounters as a separate file, or include them with any new encounters.

Along with this process, file layouts have been redefined in the input file, field 8 offset 14 – 17, as CLAIM-PAID-DATE. SCDHHS redefined in the output file, field 44 offset 378 – 381 as CLAIM-PAID-DATE. The RESUBMIT-IND is no longer used as you cannot delete an encounter and SCDHHS treats a corrected encounter as a NEW encounter. Please use the new layouts with your monthly encounters.

SCDHHS now requires the use of control files. Document ‘0016 Use of Control Files For EDI’ is provided to you. This document explains the creation and use of control files. There will be one control file for each file we create. You are welcome to use the same format for creating a control file for each file you submit. At a minimum you must create a blank file with the proper naming scheme.

PROTOCOL FOR FILE EXCHANGE BETWEEN SCDHHS AND MCOs

Basic rules for exchanging Electronic Data Interchange (EDI) files between South Carolina Department of Health and Human Services (SCDHHS) and a Managed Care entity will adhere to the following guidelines. These guidelines will work in conjunction with other documentation contained within this document. Additional documentation may be provided during implementation.

NAMING CONVENTIONS

These files are proprietary files.
Files follow these naming conventions.
XXXXXX.YYYYYYYY
where XXXXXX is the provider number assigned by DHHS (ex: HM0500)
where YYYYYYYY is a descriptive extension of up to 8 characters (does not have to be 8, but at most, 8 characters). May not always contain this node.

EXAMPLE: HM0500.ENCOUN.TEST
Each node name (between the '.') has a max of eight characters.

ACTUAL FILES SENT TO SCDHHS FROM MCO

XXXXXX.PROV
This complete file must precede submission of the **EVERY** encounter file from the MCO.

XXXXXX.TPL
This file is required to be submitted to DHHS by the 8th of the month. This file must be submitted even if you have no input. In the case of no input, a blank file must be submitted to SCDHHS.

XXXXXX.ENCOUN
First submission will contain all encounters. Second and subsequent submissions will only contain encounters that have been fixed and any new encounters obtained by the MCO since your last submission to SCDHHS that the MCO may want to add to be processed by DHHS. Each submission must be coordinated with DHHS. This alerts DHHS to process the resubmissions. This file is requested no later than the 25th of the month.

FILES UPLOADED:

Files may be uploaded at any point in time during a day. Files uploaded will be processed during the night. If possible please do not upload files Saturday and Sunday.

All files will be required to have a control file associated with it. Control file details are contained in the SCDHHS document named: 0016 Use of control files for EDI.doc.

ACTUAL FILES AND FILE NAMES SENT TO MCO FROM SCDHHS

ENXXXXXX
This is the return encounter file sent back to the MCO. This is sent after processing which is usually 1 business day.

XXXXXX.CLAIMS.HISTORY
Historical Fee for Service (FFS) claims not encounter data. This file contains the prior 6 months of FFS claims data for each member in your cutoff MLE file. History for those assigned to the plan between cutoff and the 1st of the month will be included in the following months FFS claims history extract. This file is sent within 3 business days after cutoff.

MCXXXXXX
This is a complete provider file created at MGC cutoff.

RSXXXXXX
This is the MLE file created at MGC cutoff. It is also created on the 1st of the month. The 1st file is still an MLE but has special significance. During the MGC cutoff run some recipients will be auto closed. These recipients will be reviewed and if necessary reinstated. All of those reinstated will be reported in this file.

Example:

During the cutoff run of August some recipients are auto closed. This means that the MCO will not get paid for them. During DHHS review, they are reinstated. They will be included in the MLE produced on the 1st of September. When the MGC cutoff run is completed for September (approximately the 3rd week), the MCO will receive two premium payments. One will be retro for the payment missed in August and the second payment will be for the current month of September. The MCO will be able to identify the retro payment. "If the member regains eligibility within 60 days of the disenrollment date, the member will be automatically re-enrolled with the Contractor. If eligibility is regained after 60 days of the disenrollment date, the member will need to contract SCDHHS to initiate re-enrollment."

Also of importance to note, retro payment for newborns will be included in the MLE at MGC cutoff.

XXXXXX.EPSDT
A special EPSDT system was developed, by DHHS, when the Federal EPSDT system was shut down. There are two files created with visit codes. One set for office visits and one set for injections. These files are created after the last payment run of the month. There is only 1 file that is sent on the last day of the month.

XXXXXX.REVIEW.RECIP
Monthly file for re-certification is prepared by the 5th of each month.

Monthly files for pricing information and procedure codes. These files are prepared by the 5th of each month.

FEE.CARR – list of carrier codes
FEE.RATE – provider contract rates
FEE.SCHD – fee schedule

NOTIFICATION:

The MCO is required to notify DHHS, via E-mail, when files are ready to be processed. DHHS will notify the MCO, via E-mail, when files are ready for the MCO to download. The exception to this is, there is no notification at this time for HIPAA transactions. Details of this process will be exchanged at time of business startup. DHHS will provide its E-mail address to the MCO. The MCO must provide a reciprocal E-mail address to DHHS.

HIPAA FILE NAMING CONVENTION:

RUNNUMBER.EDI where 'RUNNUMBER' = an eight digit number assigned by the translator when the file is put in the mailbox. This number has no intelligence associated with it.
A submitter ID is required to exchange HIPAA EDI files.

An 834 transaction file is utilized.
An 820 transaction file is used.
Refer to the SCDHHS companion guides at;
http://www.dhhs.state.sc.us/dhhsnew/hipaa/Companion%20Guides.asp

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MCO HCFA-1500-ENCOUNTER-REC (AMBULATORY)

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	JULIAN-SUBMISSION-DATE	7	1	7	N	This is the last date of the period for which you are reporting Mask: CCYYDDD
2.	CLAIM-TYPE	1	8	8	C	HCFA-7500-DATA VALUE 'A'
3.	TPL-RECOVERY-IND	1	9	9	C	Use 'R' in the indicator if claim represents recovery from TPL by the HMO
4.	FILLER	1	10	10	C	
5.	HMO-PAYMENT-DENIED-INDICATOR	1	11	11	C	Denied encounter value 'D'
6.	ADJUSTMENT-INDICATOR	1	12	12	C	Adjustment of a previously approved encounter VOID-CANCEL value 'V'
7.	MISC-IND-1	1	13	13	C	Future use
8.	CLAIM-PAID-DATE	4	14	17	C	Date claim paid Mask: YYMM
9.	RECIPIENT-MEDICAID-NUM	10	18	27	N	Client Medicaid number
10.	INSURED-POLICY-NUMBER	15	28	42	C	HMO Client ID number
11.	HMO-NUMBER	6	43	48	C	Managed Care plan number
12.	TPL-INFO-1	71				THIRD PARTY INSURANCE INFORMATION
13.	CARRIER-CODE-1	5	49	53	C	
14.	CARRIER-POLICY-NUM-1	25	54	78	C	
15.	INSURED-NAME-1.	32			C	
16.	INSURED-LAST-NAME-1	17	79	95	C	
17.	INSURED-FIRST-NAME-1	14	96	109	C	
18.	INSURED-MIDDLE-INIT-1	1	110	110	C	
19.	TPL-AMOUNT-PAID-1	9	111	119	N	999999999 Assumed 2 decimal places
20.	TPL-INFO-2	71				THIRD PARTY INSURANCE INFORMATION
21.	CARRIER-CODE-2	5	120	124	C	
22.	CARRIER-POLICY-NUM-2	25	125	149	C	
23.	INSURED-NAME-2	32			C	
24.	INSURED-LAST-NAME-2	17	150	166	C	
25.	INSURED-FIRST-NAME-2	14	197	180	C	
26.	INSURED-MIDDLE-INIT-2	1	181	181	C	
27.	TPL-AMOUNT-PAID-2	9	182	190	N	Mask: 9999999V99
28.	TPL-INFO-3	71				THIRD PARTY INSURANCE INFORMATION
29.	CARRIER-CODE-3	5	191	195	C	
30.	CARRIER-POLICY-NUM-3	25	196	220	C	
31.	INSURED-NAME-3	32			C	
32.	INSURED-LAST-NAME-3	17	221	237	C	
33.	INSURED-FIRST-NAME-3	14	238	251	C	
34.	INSURED-MIDDLE-INIT-3	1	252	252	C	
35.	TPL-AMOUNT-PAID-3	9	253	261	N	Mask: 9999999V99
36.	REFERRING-PROVIDER	6	262	267	C	Provider who referred patient for service
37.	PRINCIPAL-DIAGNOSIS	6	268	273	C	Diagnosis code for principal condition
38.	OTHER-DIAGNOSIS-1	6	274	279	C	Diagnosis other than principal
39.	OTHER-DIAGNOSIS-2	6	280	285	C	Diagnosis other than principal
40.	OTHER-DIAGNOSIS-3	6	286	291	C	Diagnosis other than principal
41.	LINE-ENCOUNTER-DATA-1		292	348		Data line for up to eight procedures
42.	PROCEDURE-CODE-1	5	292	296	C	
43.	FILLER	1	297	297	C	
44.	MODIFIER-1	2	298	299	C	
45.	UNITS-MILES-1	3	300	302	N	
46.	FIRST-DATE-OF-SERV-1		303	310		
47.	FIRST-DATE-CENTURY-1	2	303	304	N	
48.	FIRST-DATE-YEAR-1	2	305	306	N	
49.	FIRST-DATE-MONTH-1	2	307	308	N	
50.	FIRST-DATE-DAY-1	2	309	310	N	
51.	LAST-DATE-OF-SERV-1		311	318		
52.	LAST-DATE-CENTURY-1	2	311	312	N	
53.	LAST-DATE-YEAR-1	2	313	314	N	
54.	LAST-DATE-MONTH-1	2	315	316	N	
55.	LAST-DATE-DAY-1	2	317	318	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
56.	PLACE-OF-SERVICE-1	2	319	320	C	See PLACE OF SERVICE table for values
57.	SERV-PROVIDER-NUM-1	6	321	326	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
58.	GROUP-PROVIDER-NUM-1	6	327	332	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
59.	EPSDT-INDICATOR-1	1	333	333	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
60.	REIMBURSE-IND-1	1	334	334	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
61.	AMOUNT-BILLED-1	7	335	341	N	Amount billed by provider of service Mask: 99999V99
62.	AMOUNT-PAID-1	7	342	348	N	Amount paid by HMO plan for service Mask: 99999V99
63.	LINE-ENCOUNTER-DATA-2		349	405		
64.	PROCEDURE-CODE-2	5	349	353	C	
65.	FILLER	1	354	354	C	
66.	MODIFIER-2	2	355	356	C	
67.	UNITS-MILES-2	3	357	359	N	
68.	FIRST-DATE-OF-SERV-2		360	367		
69.	FIRST-DATE-CENTURY-2	2	360	361	N	
70.	FIRST-DATE-YEAR-2	2	362	363	N	
71.	FIRST-DATE-MONTH-2	2	364	365	N	
72.	FIRST-DATE-DAY-2	2	366	367	N	
73.	LAST-DATE-OF-SERV-2		368	375		
74.	LAST-DATE-CENTURY-2	2	368	369	N	
75.	LAST-DATE-YEAR-2	2	370	371	N	
76.	LAST-DATE-MONTH-2	2	372	373	N	
77.	LAST-DATE-DAY-2	2	374	375	N	
78.	PLACE-OF-SERVICE-2	2	376	377	C	See PLACE OF SERVICE table for values
79.	SERV-PROVIDER-NUM-2	6	378	383	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
80.	GROUP-PROVIDER-NUM-2	6	384	389	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
81.	EPSDT-INDICATOR-2	1	390	390	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
82.	REIMBURSE-IND-2	1	391	391	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
83.	AMOUNT-BILLED-2	7	392	398	N	Amount billed by provider of service Mask: 99999V99
84.	AMOUNT-PAID-2	7	399	405	N	Amount paid by HMO plan for service Mask: 99999V99
85.	LINE-ENCOUNTER-DATA-3		406	462		
86.	PROCEDURE-CODE-3	5	406	410	C	
87.	FILLER	1	411	411	C	
88.	MODIFIER-3	2	412	413	C	
89.	UNITS-MILES-3	3	414	416	N	
90.	FIRST-DATE-OF-SERV-3		417	424		
91.	FIRST-DATE-CENTURY-3	2	417	418	N	
92.	FIRST-DATE-YEAR-3	2	419	420	N	
93.	FIRST-DATE-MONTH-3	2	421	422	N	
94.	FIRST-DATE-DAY-3	2	423	424	N	
95.	LAST-DATE-OF-SERV-3		425	432		
96.	LAST-DATE-CENTURY-3	2	425	426	N	
97.	LAST-DATE-YEAR-3	2	427	428	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
98.	LAST-DATE-MONTH-3	2	429	439	N	
99.	LAST-DATE-DAY-3	2	431	432	N	
100.	PLACE-OF-SERVICE-3	2	433	434	C	See PLACE OF SERVICE table for values
101.	SERV-PROVIDER-NUM-3	6	435	440	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
102.	GROUP-PROVIDER-NUM-3	6	441	446	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
103.	EPSDT-INDICATOR-3	1	447	447	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
104.	REIMBURSE-IND-3	1	448	448	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
105.	AMOUNT-BILLED-3	7	449	455	N	Amount billed by provider of service Mask: 99999V99
106.	AMOUNT-PAID-3	7	456	462	N	Amount paid by HMO plan for service Mask: 99999V99
107.	LINE-ENCOUNTER-DATA-4		463	467		
108.	PROCEDURE-CODE-4	5	463	467	C	
109.	FILLER	1	468	468	C	
110.	MODIFIER-4	2	469	470	C	
111.	UNITS-MILES-4	3	471	473	N	
112.	FIRST-DATE-OF-SERV-4		474	481		
113.	FIRST-DATE-CENTURY-4	2	474	475	N	
114.	FIRST-DATE-YEAR-4	2	476	477	N	
115.	FIRST-DATE-MONTH-4	2	478	479	N	
116.	FIRST-DATE-DAY-4	2	480	481	N	
117.	LAST-DATE-OF-SERV-4		482	489		
118.	LAST-DATE-CENTURY-4	2	482	483	N	
119.	LAST-DATE-YEAR-4	2	484	485	N	
120.	LAST-DATE-MONTH-4	2	486	487	N	
121.	LAST-DATE-DAY-4	2	488	489	N	
122.	PLACE-OF-SERVICE-4	2	490	491	C	See PLACE OF SERVICE table for values
123.	SERV-PROVIDER-NUM-4	6	492	497	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
124.	GROUP-PROVIDER-NUM-4	6	498	503	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
125.	EPSDT-INDICATOR-4	1	504	504	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
126.	REIMBURSE-IND-4	1	505	505	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
127.	AMOUNT-BILLED-4	7	506	512	N	Amount billed by provider of service Mask: 99999V99
128.	AMOUNT-PAID-4	7	513	519	N	Amount paid by HMO plan for service Mask: 99999V99
129.	LINE-ENCOUNTER-DATA-5		520	576		
130.	PROCEDURE-CODE-5	5	520	524	C	
131.	FILLER	1	525	525	C	
132.	MODIFIER-5	2	526	527	C	
133.	UNITS-MILES-5	3	528	530	N	
134.	FIRST-DATE-OF-SERV-5		531	538		
135.	FIRST-DATE-CENTURY-5	2	531	532	N	
136.	FIRST-DATE-YEAR-5	2	533	534	N	
137.	FIRST-DATE-MONTH-5	2	535	536	N	
138.	FIRST-DATE-DAY-5	2	537	538	N	
139.	LAST-DATE-OF-SERV-5		539	546		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
140.	LAST-DATE-CENTURY-5	2	539	540	N	
141.	LAST-DATE-YEAR-5	2	541	542	N	
142.	LAST-DATE-MONTH-5	2	543	544	N	
143.	LAST-DATE-DAY-5	2	545	546	N	
144.	PLACE-OF-SERVICE-5	2	547	548	C	See PLACE OF SERVICE table for values
145.	SERV-PROVIDER-NUM-5	6	549	554	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
146.	GROUP-PROVIDER-NUM-5	6	555	560	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
147.	EPSDT-INDICATOR-5	1	561	561	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
148.	REIMBURSE-IND-5	1	562	562	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
149.	AMOUNT-BILLED-5	7	563	569	N	Amount billed by provider of service Mask: 99999V99
150.	AMOUNT-PAID-5	7	570	576	N	Amount paid by HMO plan for service Mask: 99999V99
151.	LINE-ENCOUNTER-DATA-6		577	563		
152.	PROCEDURE-CODE-6	5	577	581	C	
153.	FILLER	1	582	582	C	
154.	MODIFIER-6	2	583	584	C	
155.	UNITS-MILES-6	3	585	587	N	
156.	FIRST-DATE-OF-SERV-6		588	595		
157.	FIRST-DATE-CENTURY-6	2	588	589	N	
158.	FIRST-DATE-YEAR-6	2	590	591	N	
159.	FIRST-DATE-MONTH-6	2	592	593	N	
160.	FIRST-DATE-DAY-6	2	594	595	N	
161.	LAST-DATE-OF-SERV-6		596	603		
162.	LAST-DATE-CENTURY-6	2	596	597	N	
163.	LAST-DATE-YEAR-6	2	598	599	N	
164.	LAST-DATE-MONTH-6	2	600	601	N	
165.	LAST-DATE-DAY-6	2	602	603	N	
166.	PLACE-OF-SERVICE-6	2	604	605	C	See PLACE OF SERVICE table for values
167.	SERV-PROVIDER-NUM-6	6	606	611	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
168.	GROUP-PROVIDER-NUM-6	6	612	617	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
169.	EPSDT-INDICATOR-6	1	618	618	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
170.	REIMBURSE-IND-6	1	619	619	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
171.	AMOUNT-BILLED-6	7	620	626	N	Amount billed by provider of service Mask: 99999V99
172.	AMOUNT-PAID-6	7	627	633	N	Amount paid by HMO plan for service Mask: 99999V99
173.	LINE-ENCOUNTER-DATA-7		634	690		
174.	PROCEDURE-CODE-7	5	634	638	C	
175.	FILLER	1	639	639	C	
176.	MODIFIER-7	2	640	641	C	
177.	UNITS-MILES-7	3	642	644	N	
178.	FIRST-DATE-OF-SERV-7		645	652		
179.	FIRST-DATE-CENTURY-7	2	645	646	N	
180.	FIRST-DATE-YEAR-7	2	647	648	N	
181.	FIRST-DATE-MONTH-7	2	649	650	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
182.	FIRST-DATE-DAY-7	2	651	652	N	
183.	LAST-DATE-OF-SERV-7		653	660		
184.	LAST-DATE-CENTURY-7	2	653	654	N	
185.	LAST-DATE-YEAR-7	2	655	656	N	
186.	LAST-DATE-MONTH-7	2	657	658	N	
187.	LAST-DATE-DAY-7	2	659	660	N	
188.	PLACE-OF-SERVICE-7	2	661	662	C	See PLACE OF SERVICE table for values
189.	SERV-PROVIDER-NUM-7	6	663	668	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
190.	GROUP-PROVIDER-NUM-7	6	669	674	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
191.	EPSDT-INDICATOR-7	1	675	675	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
192.	REIMBURSE-IND-7	1	676	676	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
193.	AMOUNT-BILLED-7	7	677	683	N	Amount billed by provider of service Mask: 99999V99
194.	AMOUNT-PAID-7	7	684	690	N	Amount paid by HMO plan for service Mask: 99999V99
195.	LINE-ENCOUNTER-DATA-8		691	747		
196.	PROCEDURE-CODE-8	5	691	695	C	
197.	FILLER	1	696	696	C	
198.	MODIFIER-8	2	697	698	C	
199.	UNITS-MILES-8	3	699	701	N	
200.	FIRST-DATE-OF-SERV-8		702	709		
201.	FIRST-DATE-CENTURY-8	2	702	703	N	
202.	FIRST-DATE-YEAR-8	2	704	705	N	
203.	FIRST-DATE-MONTH-8	2	706	707	N	
204.	FIRST-DATE-DAY-8	2	708	709	N	
205.	LAST-DATE-OF-SERV-8		710	717		
206.	LAST-DATE-CENTURY-8	2	710	711	N	
207.	LAST-DATE-YEAR-8	2	712	713	N	
208.	LAST-DATE-MONTH-8	2	714	715	N	
209.	LAST-DATE-DAY-8	2	716	717	N	
210.	PLACE-OF-SERVICE-8	2	718	719	C	See PLACE OF SERVICE table for values
211.	SERV-PROVIDER-NUM-8	6	720	725	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
212.	GROUP-PROVIDER-NUM-8	6	726	731	C	Number assigned to group provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
213.	EPSDT-INDICATOR-8	1	732	732	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
214.	REIMBURSE-IND-8	1	733	733	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
215.	AMOUNT-BILLED-8	7	734	740	N	Amount billed by provider of service Mask: 99999V99
216.	AMOUNT-PAID-8	7	741	747	N	Amount paid by HMO plan for service Mask: 99999V99
217.	FILLER	520	748	1267		
218.	HMO-OWN-REF-NUMBER	16	1268	1283	C	HMO own reference number
219.	RE-SUBMIT-ENCOUNTER-NUMBER	17	1284	1300	C	System assigned number for encounter

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
Unless otherwise specified there will be no signed fields

* AMBULATORY ENCOUNTER DATA RECORD LAYOUT FOR:
* - PHYSICIANS
* - OTHER PRACTITIONERS * NURSE PRACTITIONER, CERTIFIED NURSE MIDWIFE, * CERTIFIED REGISTERED NURSE ANESTHETIST, PODIATRIST,
* AND PHYSICIAN ASSISTANT
* - CLINICS
* FQHC, RHC, ASC ESRD, MENTAL HEALTH, INFUSION CENTERS,
* AND ALCOHOL AND SUBSTANCE ABUSE
* - OTHER CAPITATED SERVICES
* INDEPENDENT LAB, RADIOLOGY, DME, HOME HEALTH, AMBULANCE *

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MCO HOSPITAL-ENCOUNTER-REC

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	JULIAN-SUBMISSION-DATE	7	1	7	N	This is the last date of the period for which you are reporting. Mask CCYYDDD
2.	CLAIM-TYPE	1	8	8	C	HCFA-7500-DATA VALUE 'Z'
3.	TPL-RECOVERY-IND	1	9	9	C	Use 'R' in the indicator if claim represents recovery from TPL by the HMO
4.	FILLER	1	10	10	C	
5.	HMO-PAYMENT-DENIED-INDICATOR	1	11	11	C	Denied encounter value 'D'
6.	ADJUSTMENT-INDICATOR	1	12	12	C	Adjustment of a previously approved encounter VOID-CANCEL value 'V'
7.	MISC-IND-1	1	13	13	C	Future use
8.	CLAIM-PAID-DATE	4	14	17	C	Date claim paid Mask: YYMM
9.	RECIPIENT-MEDICAID-NUM	10	18	27	N	Client Medicaid number
10.	INSURED-POLICY-NUMBER	15	28	42	C	HMO Client ID number
11.	HMO-NUMBER	6	43	48	C	Managed Care plan number
12.	TPL-INFO-1	71				THIRD PARTY INSURANCE INFORMATION
13.	CARRIER-CODE-1	5	49	53	C	
14.	CARRIER-POLICY-NUM-1	25	54	78	C	
15.	INSURED-NAME-1.	32			C	
16.	INSURED-LAST-NAME-1	17	79	95	C	
17.	INSURED-FIRST-NAME-1	14	96	109	C	
18.	INSURED-MIDDLE-INIT-1	1	110	110	C	
19.	TPL-AMOUNT-PAID-1	9	111	119	N	999999999 Assumed 2 decimal places
20.	TPL-INFO-2	71				THIRD PARTY INSURANCE INFORMATION
21.	CARRIER-CODE-2	5	120	124	C	
22.	CARRIER-POLICY-NUM-2	25	125	149	C	
23.	INSURED-NAME-2	32			C	
24.	INSURED-LAST-NAME-2	17	150	166	C	
25.	INSURED-FIRST-NAME-2	14	197	180	C	
26.	INSURED-MIDDLE-INIT-2	1	181	181	C	
27.	TPL-AMOUNT-PAID-2	9	182	190	N	Mask: 9999999V99
28.	TPL-INFO-3	71				THIRD PARTY INSURANCE INFORMATION
29.	CARRIER-CODE-3	5	191	195	C	
30.	CARRIER-POLICY-NUM-3	25	196	220	C	
31.	INSURED-NAME-3	32			C	
32.	INSURED-LAST-NAME-3	17	221	237	C	
33.	INSURED-FIRST-NAME-3	14	238	251	C	
34.	INSURED-MIDDLE-INIT-3	1	252	252	C	
35.	TPL-AMOUNT-PAID-3	9	253	261	N	Mask: 9999999V99
36.	ATTENDING-PHYSICIAN	6	262	267	C	Attending physician
37.	SERVICE-PROVIDER-NUM	6	268	273	C	Provider of the service (Hospital's Medicaid ID)
38.	AMOUNT-BILLED	9	274	282	N	Amount billed by the service provider
39.	AMOUNT-PAID BY HMO	9	283	291	N	Amount paid by HMO plan for service
40.	REIMBURSE-IND	1	292	292	C	Value 'C' for capitalized Value 'F' for fee for service
41.	FIRST-DATE-OF-SERV-1	8	293	300		
42.	FIRST-DATE-CENTURY-1	2	293	294	N	
43.	FIRST-DATE-YEAR-1	2	295	296	N	
44.	FIRST-DATE-MONTH-1	2	297	298	N	
45.	FIRST-DATE-DAY-1	2	299	300	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
46.	LAST-DATE-OF-SERV-1		301	308		
47.	LAST-DATE-CENTURY-1	2	301	302	N	
48.	LAST-DATE-YEAR-1	2	303	304	N	
49.	LAST-DATE-MONTH-1	2	305	306	N	
50.	LAST-DATE-DAY-1	2	307	308	N	
51.	ADMISSION-DATE	8	309	316		Admission date
52.	ADMIT-DATE-CENTURY-1	2	309	310	N	
53.	ADMIT-DATE-YEAR-1	2	311	312	N	
54.	ADMIT-DATE-MONTH-1	2	313	314	N	
55.	ADMIT-DATE-DAY-1	2	315	316	N	
56.	DISCHARGE-DATE	8	317	324		Discharge date
57.	DISCH-DATE-CENTURY-1	2	317	318	N	
58.	DISCH-DATE-YEAR-1	2	319	320	N	
59.	DISCH-DATE-MONTH-1	2	321	322	N	
60.	DISCH-DATE-DAY-1	2	323	324	N	
61.	PATIENT-STATUS	2	325	326	C	See PATIENT STATUS table for values
62.	ADMISSION-DIAGNOSIS	6	327	332	C	
63.	PRINCIPAL-DIAGNOSIS	6	333	338	C	ICD-9 code for principal condition
64.	OTHER-DIAGNOSIS-1	6	339	344	C	ICD-9 diagnoses other than principal
65.	OTHER-DIAGNOSIS-2	6	345	350	C	ICD-9 diagnoses other than principal
66.	OTHER-DIAGNOSIS-3	6	351	356	C	ICD-9 diagnoses other than principal
67.	OTHER-DIAGNOSIS-4	6	357	362	C	ICD-9 diagnoses other than principal
68.	OTHER-DIAGNOSIS-5	6	363	368	C	ICD-9 diagnoses other than principal
69.	OTHER-DIAGNOSIS-6	6	369	374	C	ICD-9 diagnoses other than principal
70.	OTHER-DIAGNOSIS-7	6	375	380	C	ICD-9 diagnoses other than principal
71.	OTHER-DIAGNOSIS-8	6	381	386	C	ICD-9 diagnoses other than principal
72.	PRINCIPAL-SURGERY	14	387	400		
73.	PRIM-SURG-PROC	6	387	392	C	ICD-9 Performed
74.	PRIM-SURG-DATE	8	393	400	N	CCYYMMDD
75.	OTHER-SURGERY-1	14	401	414		
76.	OTHER-SURG-PROC-1	6	401	406	C	ICD-9 Performed
77.	OTHER-SURG-DATE-1	8	407	414	N	CCYYMMDD
78.	OTHER-SURGERY-2	14	415	428		
79.	OTHER-SURG-PROC-2	6	415	420	C	ICD-9 Performed
80.	OTHER-SURG-DATE-2	8	421	428	N	CCYYMMDD
81.	OTHER-SURGERY-3	14	429	442		
82.	OTHER-SURG-PROC-3	6	429	434	C	ICD-9 Performed
83.	OTHER-SURG-DATE-3	8	435	442	N	CCYYMMDD
84.	OTHER-SURGERY-4	14	443	456		
85.	OTHER-SURG-PROC-4	6	443	448	C	ICD-9 Performed
86.	OTHER-SURG-DATE4	8	449	456	N	CCYYMMDD
87.	OTHER-SURGERY-5	14	457	470		
88.	OTHER-SURG-PROC-5	6	457	462	C	ICD-9 Performed
89.	OTHER-SURG-DATE-5	8	463	470	N	CCYYMMDD
90.	DRG	3	471	473	N	
91.	REVENUE-CODE-1	4	474	477	N	Code for specific hospital service
92.	PROCEDURE-CODE-1	5	478	482	C	HCPCS Code applicable to revenue code
93.	UNITS-1	4	483	486	N	
94.	REVENUE-CODE-2	4	487	490	N	Code for specific hospital service
95.	PROCEDURE-CODE-2	5	491	495	C	HCPCS Code applicable to revenue code
96.	UNITS-2	4	496	499	N	
97.	REVENUE-CODE-3	4	500	503	N	Code for specific hospital service
98.	PROCEDURE-CODE-3	5	504	508	C	HCPCS Code applicable to revenue code
99.	UNITS-3	4	509	512	N	
100.	REVENUE-CODE-4	4	513	516	N	Code for specific hospital service
101.	PROCEDURE-CODE-4	5	517	521	C	HCPCS Code applicable to revenue code
102.	UNITS-4	4	522	525	N	
103.	REVENUE-CODE-5	4	526	529	N	Code for specific hospital service
104.	PROCEDURE-CODE-5	5	530	534	C	HCPCS Code applicable to revenue code
105.	UNITS-5	4	535	538	N	
106.	REVENUE-CODE-6	4	539	542	N	Code for specific hospital service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
107.	PROCEDURE-CODE-6	5	543	547	C	HCPCS Code applicable to revenue code
108.	UNITS-6	4	548	551	N	
109.	REVENUE-CODE-7	4	552	555	N	Code for specific hospital service
110.	PROCEDURE-CODE-7	5	556	560	C	HCPCS Code applicable to revenue code
111.	UNITS-7	4	561	564	N	
112.	REVENUE-CODE-8	4	565	568	N	Code for specific hospital service
113.	PROCEDURE-CODE-8	5	569	573	C	HCPCS Code applicable to revenue code
114.	UNITS-8	4	574	577	N	
115.	REVENUE-CODE-9	4	578	581	N	Code for specific hospital service
116.	PROCEDURE-CODE-9	5	582	586	C	HCPCS Code applicable to revenue code
117.	UNITS-9	4	587	590	N	
118.	REVENUE-CODE-10	4	591	594	N	Code for specific hospital service
119.	PROCEDURE-CODE-10	5	595	599	C	HCPCS Code applicable to revenue code
120.	UNITS-10	4	600	603	N	
121.	REVENUE-CODE-11	4	604	607	N	Code for specific hospital service
122.	PROCEDURE-CODE-11	5	608	612	C	HCPCS Code applicable to revenue code
123.	UNITS-11	4	613	616	N	
124.	REVENUE-CODE-12	4	617	620	N	Code for specific hospital service
125.	PROCEDURE-CODE-12	5	621	625	C	HCPCS Code applicable to revenue code
126.	UNITS-12	4	626	629	N	
127.	REVENUE-CODE-13	4	630	633	N	Code for specific hospital service
128.	PROCEDURE-CODE-13	5	634	638	C	HCPCS Code applicable to revenue code
129.	UNITS-13	4	639	642	N	
130.	REVENUE-CODE-14	4	643	646	N	Code for specific hospital service
131.	PROCEDURE-CODE-14	5	647	651	C	HCPCS Code applicable to revenue code
132.	UNITS-14	4	652	655	N	
133.	REVENUE-CODE-15	4	656	659	N	Code for specific hospital service
134.	PROCEDURE-CODE-15	5	660	664	C	HCPCS Code applicable to revenue code
135.	UNITS-15	4	665	668	N	
136.	REVENUE-CODE-16	4	669	672	N	Code for specific hospital service
137.	PROCEDURE-CODE-16	5	673	677	C	HCPCS Code applicable to revenue code
138.	UNITS-16	4	678	681	N	
139.	REVENUE-CODE-17	4	682	685	N	Code for specific hospital service
140.	PROCEDURE-CODE-17	5	686	690	C	HCPCS Code applicable to revenue code
141.	UNITS-17	4	691	694	N	
142.	REVENUE-CODE-18	4	695	698	N	Code for specific hospital service
143.	PROCEDURE-CODE-18	5	699	703	C	HCPCS Code applicable to revenue code
144.	UNITS-18	4	704	707	N	
145.	REVENUE-CODE-19	4	708	711	N	Code for specific hospital service
146.	PROCEDURE-CODE-19	5	712	716	C	HCPCS Code applicable to revenue code
147.	UNITS-19	4	717	720	N	
148.	REVENUE-CODE-20	4	721	724	N	Code for specific hospital service
149.	PROCEDURE-CODE-20	5	725	729	C	HCPCS Code applicable to revenue code
150.	UNITS-20	4	730	733	N	
151.	REVENUE-CODE-21	4	734	737	N	Code for specific hospital service
152.	PROCEDURE-CODE-21	5	738	742	C	HCPCS Code applicable to revenue code
153.	UNITS-21	4	743	746	N	
154.	REVENUE-CODE-22	4	747	750	N	Code for specific hospital service
155.	PROCEDURE-CODE-22	5	751	755	C	HCPCS Code applicable to revenue code
156.	UNITS-22	4	756	759	N	
157.	REVENUE-CODE-23	4	760	763	N	Code for specific hospital service
158.	PROCEDURE-CODE-23	5	764	768	C	HCPCS Code applicable to revenue code
159.	UNITS-23	4	769	772	N	
160.	REVENUE-CODE-24	4	773	776	N	Code for specific hospital service
161.	PROCEDURE-CODE-24	5	777	781	C	HCPCS Code applicable to revenue code
162.	UNITS-24	4	782	785	N	
163.	REVENUE-CODE-25	4	786	789	N	Code for specific hospital service
164.	PROCEDURE-CODE-25	5	790	794	C	HCPCS Code applicable to revenue code
165.	UNITS-25	4	795	798	N	
166.	REVENUE-CODE-26	4	799	802	N	Code for specific hospital service
167.	PROCEDURE-CODE-26	5	803	807	C	HCPCS Code applicable to revenue code
168.	UNITS-26	4	808	811	N	
169.	REVENUE-CODE-27	4	812	815	N	Code for specific hospital service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
170.	PROCEDURE-CODE-27	5	816	820	C	HCPCS Code applicable to revenue code
171.	UNITS-27	4	821	824	N	
172.	REVENUE-CODE-28	4	825	828	N	Code for specific hospital service
173.	PROCEDURE-CODE-28	5	829	833	C	HCPCS Code applicable to revenue code
174.	UNITS-28	4	834	837	N	
175.	REVENUE-CODE-29	4	838	841	N	Code for specific hospital service
176.	PROCEDURE-CODE-29	5	842	846	C	HCPCS Code applicable to revenue code
177.	UNITS-29	4	847	850	N	
178.	REVENUE-CODE-30	4	851	854	N	Code for specific hospital service
179.	PROCEDURE-CODE-30	5	855	859	C	HCPCS Code applicable to revenue code
180.	UNITS-30	4	860	863	N	
181.	REVENUE-CODE-31	4	864	867	N	Code for specific hospital service
182.	PROCEDURE-CODE-31	5	868	872	C	HCPCS Code applicable to revenue code
183.	UNITS-31	4	873	876	N	
184.	REVENUE-CODE-32	4	877	880	N	Code for specific hospital service
185.	PROCEDURE-CODE-32	5	881	885	C	HCPCS Code applicable to revenue code
186.	UNITS-32	4	886	889	N	
187.	REVENUE-CODE-33	4	890	893	N	Code for specific hospital service
188.	PROCEDURE-CODE-33	5	894	898	C	HCPCS Code applicable to revenue code
189.	UNITS-33	4	899	902	N	
190.	REVENUE-CODE-34	4	903	906	N	Code for specific hospital service
191.	PROCEDURE-CODE-34	5	907	911	C	HCPCS Code applicable to revenue code
192.	UNITS-34	4	912	915	N	
193.	REVENUE-CODE-35	4	916	919	N	Code for specific hospital service
194.	PROCEDURE-CODE-35	5	920	924	C	HCPCS Code applicable to revenue code
195.	UNITS-35	4	925	928	N	
196.	REVENUE-CODE-36	4	929	932	N	Code for specific hospital service
197.	PROCEDURE-CODE-36	5	933	937	C	HCPCS Code applicable to revenue code
198.	UNITS-36	4	938	941	N	
199.	REVENUE-CODE-37	4	942	945	N	Code for specific hospital service
200.	PROCEDURE-CODE-37	5	946	950	C	HCPCS Code applicable to revenue code
201.	UNITS-37	4	951	954	N	
202.	REVENUE-CODE-38	4	955	958	N	Code for specific hospital service
203.	PROCEDURE-CODE-38	5	959	963	C	HCPCS Code applicable to revenue code
204.	UNITS-38	4	964	967	N	
205.	REVENUE-CODE-39	4	968	971	N	Code for specific hospital service
206.	PROCEDURE-CODE-39	5	972	976	C	HCPCS Code applicable to revenue code
207.	UNITS-39	4	977	980	N	
208.	REVENUE-CODE-40	4	981	984	N	Code for specific hospital service
209.	PROCEDURE-CODE-40	5	985	989	C	HCPCS Code applicable to revenue code
210.	UNITS-40	4	990	993	N	
211.	REVENUE-CODE-41	4	994	997	N	Code for specific hospital service
212.	PROCEDURE-CODE-41	5	998	1002	C	HCPCS Code applicable to revenue code
213.	UNITS-41	4	1003	1006	N	
214.	REVENUE-CODE-42	4	1007	1010	N	Code for specific hospital service
215.	PROCEDURE-CODE-42	5	1011	1015	C	HCPCS Code applicable to revenue code
216.	UNITS-42	4	1016	1019	N	
217.	REVENUE-CODE-43	4	1020	1023	N	Code for specific hospital service
218.	PROCEDURE-CODE-43	5	1024	1028	C	HCPCS Code applicable to revenue code
219.	UNITS-43	4	1029	1032	N	
220.	REVENUE-CODE-44	4	1033	1036	N	Code for specific hospital service
221.	PROCEDURE-CODE-44	5	1037	1041	C	HCPCS Code applicable to revenue code
222.	UNITS-44	4	1042	1045	N	
223.	REVENUE-CODE-45	4	1046	1049	N	Code for specific hospital service
224.	PROCEDURE-CODE-45	5	1050	1054	C	HCPCS Code applicable to revenue code
225.	UNITS-45	4	1055	1058	N	
226.	REVENUE-CODE-46	4	1059	1062	N	Code for specific hospital service
227.	PROCEDURE-CODE-46	5	1063	1067	C	HCPCS Code applicable to revenue code
228.	UNITS-46	4	1068	1071	N	
229.	REVENUE-CODE-47	4	1072	1075	N	Code for specific hospital service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
230.	PROCEDURE-CODE-47	5	1076	1080	C	HCPCS Code applicable to revenue code
231.	UNITS-47	4	1081	1084	N	
232.	REVENUE-CODE-48	4	1085	1088	N	Code for specific hospital service
233.	PROCEDURE-CODE-48	5	1089	1093	C	HCPCS Code applicable to revenue code
234.	UNITS-48	4	1094	1097	N	
235.	REVENUE-CODE-49	4	1098	1101	N	Code for specific hospital service
236.	PROCEDURE-CODE-49	5	1102	1106	C	HCPCS Code applicable to revenue code
237.	UNITS-49	4	1107	1110	N	
238.	REVENUE-CODE-50	4	1111	1114	N	Code for specific hospital service
239.	PROCEDURE-CODE-50	5	1115	1119	C	HCPCS Code applicable to revenue code
240.	UNITS-50	4	1120	1123	N	
241.	FILLER	144	1124	1267	C	
242.	HMO-OWN-REF-NUMBER	16	1268	1283	C	HMO own reference number
243.	RE-SUBMIT-ENCOUNTER-NUMBER	17	1284	1300		System assigned number for encounter

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 4223 will appear as 004223 Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
Unless otherwise specified there will be no signed fields

```
*****************************************************************
                                                              *
*            AMBULATORY ENCOUNTER DATA RECORD LAYOUT FOR:       *
*                                                               *
*      - PHYSICIANS                                             *
*                                                               *
*      - OTHER PRACTITIONERS                                    *
*          NURSE PRACTITIONER, CERTIFIED NURSE MIDWIFE,         *
*          CERTIFIED REGISTERED NURSE ANESTHETIST, PODIATRIST,  *
*          AND PHYSICIAN ASSISTANT                              *
*                                                               *
*      - CLINICS                                                *
*          FQHC, RHC, ASC ESRD, MENTAL HEALTH, INFUSION CENTERS,*
*          AND ALCOHOL AND SUBSTANCE ABUSE                      *
*                                                               *
*      - OTHER CAPITATED SERVICES                               *
*          INDEPENDENT LAB, RADIOLOGY, DME, HOME HEALTH, AMBULANCE *
*                                                               *
                      *****************************************************************
```

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DRUG-ENCOUNTER-REC-INP-3 (1300 BYTES)

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	*DEI-CC*	2	1	2	N	ENCOUNTER SUBMIT DATE CENTURY
2.		2	3	4	N	ENCOUNTER SUBMIT DATE YEAR
3.	DEI-DDD	3	5	7	N	ENCOUNTER SUBMIT DATE DAYS (JULIAN)
4.	DEI-ENC-DOC-TYPE	1	8	8	C	RECORD TYPE, DRUG='D'
5.	FILLER	3	9	11	C	FILLER
6.	DEI-ADJUSTMENT-IND	1	12	12		VOID-CANCEL = 'V'
7.	FILLER	1	13	13	C	
8.	DEI-CLAIM-PAID-DATE	4	14	17	C	DATE CLAIM PAID Mask: YYMM
9.	DEI-INDIV-NO	10	18	27	N	RECIPIENT MEDICAID NUMBER
10.	DEI-HMO-RECIP-ID	15	28	42	C	HMO RECIPIENT NUMBER
11.	DEI-PROV-NUMBER	6	43	48		SC ASSIGNED PROVIDER NUMBER
12.	FILLER	62	49	110	C	
13.	FILLER	9	111	119	N	
14.	FILLER	62	120	181	C	
15.	FILLER	9	182	190	N	
16.	FILLER	62	191	252	C	
17.	FILLER	9	253	261	N	
18.	FILLER	12	262	273	C	
19.	DEI-SERVICE-PROV-NO	6	274	279	C	SERVICE PROVIDER NUMBER (sc assigned to pharmacy)
20.	DEI-TOT-AMT-HMO-BILLED-INPUT	9	280	288		AMOUNT BILLED BY HMO (AMT BEING BILLED BY PDP) MASK 9999999V99 ZERO FILLED, NO SIGN
21.	FILLER	9	289	297	N	
22.	FILLER	1	298	298	C	
23.	DEI-DD-CCYY	4	299	302		DISPENSE DATE CENTURY AND YEAR
24.	DEI-DD-MO	2	303	304	N	DISPENSE DATE MONTH
25.	DEI-DD-DA	2	305	306	N	DISPENSE DATE DAY OF MONTH
26.	DEI-DRUG-CODE	11	307	317	C	NDC DRUG CODE
27.	FILLER	3	318	320	C	
28.	DEI-QUANTITY-DISPENSED-INPUT	6	321	326		QUANTITY DISPENSED
29.	DEI-DAYS-SUPPLY-INPUT	3	327	329	N	DAYS SUPPLY DISPENSED
30.	DEI-ENC-PRESCRIPTION-NO	15	330	344	C	PRESCRIPTION NUMBER
31.	DEI-PHYSICIAN-NO	6	345	350	C	PHYSICAN PROVIDER NUMBER
32.	FILLER	2	351	352	C	
33.	FILLER	2	353	354	N	
34.	DEI-SERV-PROV-NPI	10	355	364		SERVICE PROVIDER (PHARMACY) NPI
35.	DEI-SERV-PROV-NCPDP	7	365	371	C	PHARMACY NCPCP (NABP) NUMBER
36.	DEI-SERV-PROV-NAME	25	372	396	C	PHARMACY NAME
37.	DEI-PHYSICIAN-NPI	10	397	406	N	PRESCRIBING PHYSICIAN'S NPI NUMBER
38.	DEI-PHYSICIAN-DEA	9	407	415	C	GAPS PHYSICIAN DEA NUMBER
39.	DEI-PHYSICAN-NAME	25	416	440	C	PRESCRIBING PHYSICIAN'S NAME
40.	DEI-RECIP-SSN	9	441	449	C	RECEIPIENT SOCIAL SECURITY NUMBER
41.	DEI-GAPS-LAST-NAME	17	450	466	C	GAPS MEMBER LAST NAME
42.	DEI-GAPS-FIRST-NAME	14	467	480	C	GAPS MEMBER FIRST NAME
43.	DEI-GAPS-MIDDLE-INITIAL	1	481	481	C	GAPS MEMBER MIDDLE INITIAL
44.	FILLER	8	482	489	C	
45.	DEI-MEDICARE-ID	15	490	504		15 BYTE MEDICARE NUMBER Mask: XXX-999999999-XXX
46.	DEI-RAILROAD-NUM	3	490	492		USED ONLY IF USING THE RAILROAD NUMBER (spaces if not used)
47.	DEI-SSN-MEDICARE-NUM	9	493	501		NUMERIC PORTION OF MEDICARE NUMBER (Typically SSN)
48.	DEI- SUFFIX-MEDICARE-NUM	3	502	504		LAST 3 CHARACTERS OF MEDICARE NUMBER

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						Mask: Characters are left justified Example: value is 'a..', 'b1.', 'c12' (.) indicates space
49.	FILLER	763	505	1267		
50.	DEI-HMO-OWN-REF-NUMBER	16	1268	1283		PROVIDER'S OWN REFERENCE NUMBER
51.	DEI-CCN-JULIAN	7	1284	1290	N	CCN (7 BYTE JULIAN DATE OF SUBMISSION DATE)
52.	DEI-CCN-UNIQUE	9	1291	1299		9 BYTE UNIQUE NUMBER
53.	DEI-CCN-ENC	1	1300	1300	C	SUBMISSION TYPE ENCOUNTER = 'E'

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left EX: 5 bytes 123 will appear as 00123
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

This is the standard, proprietary, input record for drug encounter claims.

Please note; this is a fixed length record built for processing in the mainframe environment. Fields that are numeric in nature must be right justified and zero filled to the left. Fields that are character in nature should contain all capital letters.

Field number 1,2,3: This will be the date of submission to DHHS.

Field number 6: If you have VOID transactions you will place a 'V" in this field. Do not place minus '-' signs in any amount fields.

Field number 11: DEI-PROV-NUMBER, This is the provider number assigned to you by DHHS.

Field number 20: DEI-TOT-AMT-HMO-BILLED-INPUT, this should be the gross amount. This is not a signed field. Is assumed two decimal.
Mask is 9999999v99 zero filled to the left.

Field number 31: DEI-PHYSICIAN-NO is the SCDHHS physician assigned number.

Field number 38: DEI-PHYSICIAN-DEA it is acceptable to report "NOT FOUND" when unable to report the physician's DEA#

Field number 39: DEI-PHYSICAN-NAME , it is acceptable to report "NOT FOUND" when unable to report the physician's DEA#

Field number 50: DEI-HMO-OWN-REF-NUMBER, This is a number which is unique to you and your system. It is used to help resolve queries if needed. For example this could possibly be your claim control number.

Field number 51, 52: These 2 fields, though separate, combine to make a unique Claim Control Number within the DHHS system.
DEI-CCN-JULIAN, is normally the date you processed the claim. Can be another date that is meaningful to you.
DEI-CCN-UNIQUE, is any unique number you assign. Could be your recipient number or some other number that will assist in problem resolution if necessary.

Highlighted fields SCDHHS would like populated if possible but are not mandatory.

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LAYOUT FOR MCO THIRD PARTY LIABILITY FILE

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	RECIPIENT-MEDICAID-NUM	10	1	10	N	
2.	RECIP-LAST-NAME	17	11	27	C	
3.	RECIP-FIRST-NAME	14	28	41	C	
4.	RECIP-MIDDLE-INITIAL	1	42	42	C	
5.	RECIPIENT-DATE-OF-BIRTH	8	43	50	C	Mask: CCYYMMDD
6.	MCO-NUMBER	6	51	56	C	Managed care plan number
7.	TPL-INFO	173	57	575		Third party payer information (occurs 3 times)
8.	CARRIER-NAME	50	57	106	C	Preferred Provider last name
9.	CARRIER-GROUP-NAME(if applicable)	50	107	156	C	
10.	CARRIER-POLICY-NUMBER	25	157	181		
11.	INSURED-LAST-NAME	17	182	198	C	
12.	INSURED-FIRST-NAME	14	199	212	C	
13.	INSURED-MIDDLE-INITIAL	1	213	213	C	
14.	POLICY EFFECTIVE DATE	8	214	221	C	Mask: CCYYMMDD
15.	POLICY LAPSE DATE (if applicable)	8	222	229	C	
16.	FILLER	25	576	600	C	
17.						
18.						
19.						
20.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
RECORD LAYOUT FOR HMO PROVIDER IDENTIFICATION RECORD

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	HMO-MEDICAID-NUM	6	1	6	C	Managed care plan Medicaid number
2.	PROVIDER-ID-NUMBER	6	7	12	C	Identifies a provider or group provider who is not enrolled as a Medicaid provider. The 1st byte of the number must be the symbol assigned that will identify the MCO on our database.
3.	PROVIDER-NAME	26	13	38	C	
4.	PROVIDER-CAREOF	26	39	64	C	Provider address line 1
5.	PROVIDER- STREET	26	65	90	C	
6.	PROVIDER-CITY	20	91	110	C	
7.	PROVIDER-STATE	2	111	112	C	
8.	PROVIDER-ZIP	9	113	121	C	
9.	PROVIDER-COUNTY	12	122	133		
10.	PROVIDER-EIN-NUM	10	134	143	C	Employee identification number
11.	PROVIDER-SSN-NUM	9	144	152	C	
12.	PHARMACY-PERMIT-NUM	10	153	162	C	Pharmacy permit number
13.	PROVIDER-TYPE	2	163	164	C	Refer to table for provider types
14.	PROVIDER-SPECIALTY	2	165	166	C	Refer to table for provider specialties
15.	PROVIDER-CATEG-SERV	2	167	168	C	Refer to table for categories of service
16.	PROVIDER-LICENSE-NUMBER	10	169	178	C	
17.	FILLER	22	179	200	C	
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

MCO REPORTS TO SCDHHS

NETWORK PROVIDER and SUBCONTRACTOR LISTING SPREADSHEET REQUIREMENTS

, Please provide the following information regarding network providers and subcontractors:

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.

2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.

3. Street Address, City, State, Zip Code, Telephone Number of Practice/Provider - Self-explanatory

4. License Number - Indicate the provider/practitioner license number, if appropriate.

5. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number

6. Specialty Code - Indicate the practitioner's specialty using the listing located on page XXX.

7. New Patient - Indicate whether or not the provider is accepting new patients.

8. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 18, indicate < 18; if a physician only sees patients age 13 or above, indicate ≥ 13.

9. Contract Name/Number – Indicate which MCO subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.

10. Contract Begin Date – Indicate the date the contract became effective.
Contract Termination Date – Indicate the date the contract ended.

12. County Served – Indicate which county or counties the provider serves by placing an "X" in the appropriate column. See County Listing on page xxx**.**

On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month.

Grievance Log with Summary Information

For each grievance, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the grievance was received by the contractor.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the Contractor by SCDHHS.

Summary of Grievance: Give a brief description of the member's grievance. Include enough information to provide SCDHHS with an understanding of the member's grievance.

Current Status: Indicate the current status of the grievance at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc..

Resolution/Response Given: Indicate the resolution, the response given to the member, and the date the resolution was achieved. Include enough information to provide SCDHHS with an understanding of how the grievance was resolved.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the grievance.

Plan Name (Medicaid Number)
Grievance Log
Month/Year: _____

Date Filed	Member Name	Member Number	Summary of Grievance	Current Status	Resolution/ Response Given	Resulting Corrective Action

Appeals Log with Summary Information

For each appeal, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the appeal was received by the contractor.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the Contractor by SCDHHS.

Summary of Appeal: Give a brief description of the member's appeal. Include enough information to provide SCDHHS with an understanding of the member's appeal.

Current Status: Indicate the current status of the appeal at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc..

Resolution/Response Given: Indicate the resolution, the response given to the member, and the date the resolution was achieved. Include enough information to provide SCDHHS with an understanding of how the appeal was resolved.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the appeal.

Plan Name (Medicaid Number)
Appeals Log
Month/Year: _

Date Filed	Member Name	Member Number	Summary of Appeal	Current Status	Resolution/ Response Given	Resulting Corrective Action

Medicaid Enrollment Capacity by County Report

Reporting Month/Year: Specify reporting month and year.

County Name: Specify each county served by plan. Report **only** the counties in which you are approved to operate.

Total Primary Care Providers: Specify the number of Full Time Equivalent (FTE) Primary Care Providers (PCPs) in each county. An FTE is equal to one (1) PCP whose time is allocated 100% to one (1) county. If a PCP serves more than one county, count only a portion of the PCP's time in each county. **DO NOT USE FRACTIONS IN THE TOTAL COUNT. ALWAYS round all fractions down to the next lowest whole number.**

Total Medicaid Enrollment Capacity: For each county, specify the number of Medicaid enrollees the plan can serve. (Total FTEs x 2500 = Capacity)

Current Medicaid Enrollment: Specify, by county, the total number of Medicaid enrollees.

Note: This report is due to SCDHHS the first of each month.

Plan Name (Medicaid Number)

Medicaid Enrollment Capacity by County

Reporting Month/Year: _____

County Name	Total Full Time Equivalent PCPs	Total Medicaid Enrollment Capacity	Current Medicaid Enrollment

<<MCO Name>>

Monthly Maternity Notification Log

<< Month>>

Count	DOB	Mother's Last Name	Mother's First Name	Mother's Medicaid ID #	Baby's Last Name	Baby's First Name	Sex	Multiple Birth

<<MCO Name>>

Monthly Newborn Notification Log

<< Month>>

	Mother's			Baby's			
Count DOB	Last Name	First Name	Medicaid ID #	Last Name	First Name	Sex	Medicaid #

SCDHHS FILES TO MCOS

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MLE OUTPUT RECORD LAYOUT

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	MLE-RECORD-TYPE	1	1	1		Internal, H=HMO, P=PEP, C=MHN, ? = Other
2.	MLE-CODE	1	2	2		Status in Managed Care: A – AUTO ENROLLED R - RETROACTIVE N - NEW P – PREVIOUSLY ENROLLED WITH SAME PHYSICIAN C - CONTINUING D – DISENROLLED
3.	MLE-PROV-NO	6	3	8		Physician recipient is enrolled with.
4.	MLE-PROV-NAME	26	9	34		Provider Name
5.	MLE-CAREOF	26	35	60		Provider Address
6.	MLE-STREET	26	61	86		Provider Street
7.	MLE-CITY	20	87	106		City
8.	MLE-STATE	2	107	108		State
9.	MLE-ZIP	9	109	117		Zip code + 4
10.	MLE-RECIP-NO	10	118	127		Recipient identifying Medicaid number.
11.	MLE-RECIP-LAST-NAME	17	128	144		Recipient Last name
12.	MLE-RECIP-FIRST-NAME	14	145	158		Recipient First name
13.	MLE-RECIP-MI	1	159	159		Recipient Middle initial
14.	MLE-ADDR-CARE-OF	25	160	184		Recipient address
15.	MLE-ADDR-STREET	25	185	209		Street
16.	MLE-ADDR-CITY	23	210	232		City
17.	MLE-ADDR-STATE	2	233	234		State
18.	MLE-ADDR-ZIP	9	235	243		Zip code + 4
19.	MLE-ADDR-AREA-CODE	3	244	246		Recipient phone number Area code
20.	MLE-ADDR-PHONE	7	247	253		Recipient phone number
21.	MLE-COUNTY	2	254	255		Recipient county where eligible
22.	MLE-RECIP-AGE	3	256	258		Recipient Age
23.	MLE-AGE-SW	1	259	259		Y=year, M=month, <=less than 1 month, U=unknown
24.	MLE-RECIP-SEX	1	260	260		M =Male, F=Female, U =Unknown
25.	MLE-RECIP-PAY-CAT	2	261	262		Recipient category of eligibility – see Table 01 for values
26.	MLE-RECIP-DOB.	8	263	270		Recipient date of birth CCYYMMDD
27.	MLE-ENROLL-DATE	6	271	276		Managed Care Enrollment Date YYMMDD
28.	MLE-DISENROLL-DATE	6	277	282		Managed Care Disenrollment Date YYMMDD
29.	MLE-DISENROLL-REASON	2	283	284		Reason Code for Disenrollment: 01 - NO LONGER IN HMO PROGRAM 02 - TRANSFERRED TO ANOTHER MANAGED CARE PROVIDER 03 - MEDICAID ELIGIBILITY TERMINATED 04 - HAS MEDICARE OR IS >= 65 YEARS OF AGE 05 - CHANGE TO NON MEDICAID PAYMENT CATEGORY 06 - MANAGED CARE PROVIDER TERMINATED 07 - OCWI (PEP AND PAYMENT CATEGORY 87) 08 - RECIPIENT HAS TPL HMO POLICY
30.	MLE-PR-KEY	3	285	287		Premium Rate Category
31.	MLE-PREMIUM-RATE	9	288	296		Amount of Premium paid
32.	MLE-PREM-DATE.	6	297	302		CCYYMM – Month for which the premium is paid.
33.	MLE-MENTAL-HEALTH-	3	303	305		Obsolete

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	ARRAY					
34.	MLE-PREFERRED-PHYS	25	306	330		Recipient's preferred provider
35.	MLE-REVIEW-DATE-CCYYMMDD.	8	331	338		CCYYMMDD – Date recipient will be reviewed for eligibility and/or managed care enrollment.
36.	PREGNANCY-INDICATOR	1	339	339		Pregnancy indicator
37.	MLE-SSN	9	340	348		Member's social security number
38.	*TPL-NBR-POLICIES*	*2*	*349*	*350*		**Number of TPL policies**
39.	**TPL INFORMATION below REPEATS 10 TIMES IF APPLICABLE This occurs only 5 times on the 834**	**4140**	351	4490		
40.	**POLICY-CARRIER-NAME**	50	351	400		Policy carrier name
41.	*POLICY-NUMBER*	25	401	425		Policy number
42.	*CARRIER-CODE*	5	426	430		Code to signify a carrier
43.	*POLICY- RECIP-EFFECTIVE DATE*	8	431	438		Recipient effective date of policy
44.	*POLICY-RECIP-LAST UPDATE*	6	439	444		Last update policy recipient record
45.	*POLICY-RECIP-OPEN DATE*	8	445	452		Recipient policy open date
46.	*POLICY-RECIP-LAPSE DATE*	8	453	460		Recipient lapse date policy
47.	*POLICY-RECIP-PREG-COV-IND*	1	461	461		Pregnancy coverage indicator
48.	*POLICY-TYPE*	2	462	463		Type of policy-health or casualty
49.	*POLICY-GROUP-NO*	20	464	483		Policy group number
50.	*POLICY-GROUP-NAME*	50	484	533		Policy group name
51.	*POLICY-GROUP-ATTN*	50	534	583		Policy group attention
52.	*POLICY-GROUP-ADDRESS*	50	584	633		Policy group address
53.	*POL-GRP-CITY*	39	634	672		Policy group city
54.	*POL-GRP-STATE*	2	673	674		Policy group state
55.	*POL-GRP-ZIP*	9	675	683		Policy group zip code + 4
56.	*POL-POST-PAYREC-IND*	1	684	684		0-cost avoid, 1-no cost avoid
57.	*POLICY-INSURED-LAST NAME*	17	685	701		Insured last name
58.	*POLICY-INSURED-FIRST NAME*	14	702	715		Insured first name
59.	*POLICY-INSURED-MI-NAME*	1	716	716		Insured middle Initial
60.	*POLICY--SOURCE-CODE*	1	717	717		Source of info about policy (ie. champus, highway)
61.	*POLICY--LETTER-IND*	1	718	718		If present, pass group address info
62.	*POL-EFFECTIVE-DATE*	8	719	726		Effective date of policy CCYYMMDD
63.	*POL-OPEN-DATE*	8	727	734		First stored date
64.	*POL-COVER- IND-ARRAY*	30	735	764		1 BYTE FIELDS X 30 What policy will cover
65.	*RECIPIENT-RACE*	2	4491	4492		Race code - Reference Table 13
66.	*RECIPIENT-LANGUAGE*	1	4493	4493		Language code -Reference Table 21
67.	*RECIPIENT-FAMILY--NUM*	8	4494	4501		Family Number
68.	*FILLER*	99	4502	4600		Filler

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left EX: 5 bytes 123 will appear as 00123
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OUTPUT RECORD LAYOUT FOR HMO PROVIDER IDENTIFICATION RECORD

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	PROVIDER-ID-NUMBER	6	1	6	C	Medicaid provider number
2.	PROVIDER-NAME	26	7	32	C	
3.	PROVIDER-CAREOF	26	33	58	C	Provider address line 1
4.	PROVIDER- STREET	26	59	84	C	
5.	PROVIDER-CITY	20	85	104	C	
6.	PROVIDER-STATE	2	105	106	C	
7.	PROVIDER-ZIP	9	107	115	C	
8.	PROVIDER-PHONE-NUMBER	10	116	125	C	
9.	PROVIDER-COUNTY	12	126	137	C	
10.	PROVIDER-TYPE	2	138	139	C	Refer to table for provider types
11.	PROVIDER-SPECIALTY	2	140	141	C	Refer to table for provider specialties
12.	PROV-PRICING-SPECIALTY	2	142	143	C	
13.	FILLER	48	144	191	C	
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OUTPUT ENCOUNTER LAYOUT FOR PHARMACY SERVICES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	DEC-ENC-KEY	23	1	23		
2.	DEC-ENC-ID-NO	16	1	16	C	
3.	DEC-ENC-IND	1	17	17	C	Value = 'E'
4.	DEC-PROV-NUMBER	6	18	23	C	State assigned number of MCO
5.	DEC-INDIVIDUAL-NO	10	24	33	C	Recipient Medicaid number
6.	DEC-INDIV-NO-CHECK-DIGIT	1	24	24	C	Check digit
7.	DEC-INDIV-NO	9	25	33	C	Number
8.	DEC-ENC-DOC-TYPE	1	34	34	C	Value 'A' = HIC 'D' = Drug 'Z' = Hospital UB
9.	DEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
10.	DEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
11.	DEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
12.	DEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted Mask: CCYYDDD
13.	DEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS Mask: CCYYMMDD
14.	DEC-ENC-DATA-STATUS	1	68	68	C	Status of encounter after edit Value 'G' = good data 'F' = flawed data 'I' = ignore data 'T' = TPL data
15.	DEC-HMO-PROV-INFO	28	69	96	C	Provider information
16.	DEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
17.	DEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
18.	DEC-ENC-RECIP-INFO	63	97	159		Recipient information
19.	DEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
20.	DEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
21.	DEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
22.	DEC-DOB-8	8	129	136	C	Recipient date of birth Mask: CCYYMMDD
23.	DEC-SEX	1	137	137	C	Sex
24.	DEC-AGE	3	138	140	N	Age in years
25.	DEC-RACE	2	141	142	C	Race code
26.	DEC-COUNTY	2	143	144	C	County Code
27.	DEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
28.	DEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
29.	DEC-QMB-IND	1	149	149	C	Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level
30.	DEC-RSP-PGM-IND (occurs 6 times)	1	150	155	C	Indicates enrollment in special programs This is an array field and occurs 6 times in this space.
31.	FILLER	4	156	159	C	
32.	DEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
33.	DEC-CARRIER-CODE	5	160	164	C	Carrier Code
34.	DEC-POLICY-NUMBER	25	165	189	C	Policy number
35.	DEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
36.	DEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
37.	DEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
38.	DEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
39.	DEC-TPL-RECOVERY-IND	1	373	373	C	Value 'R' = recoupment
40.	FILLER	1	374	374	C	
41.	DEC-PAYMENT-DENIED-IND	1	375	375	C	Identifies as being denied payment by HMO Value 'D' = denied encounter

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
42.	DEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
43.	DEC-ENC-IND-1	1	377	377	C	Possible future use
44.	DEC-CLAIM-PAID-DATE	4	378	381	C	Date claim paid Mask: YYMM
45.	DEC-ENCOUNTER-STATUS	1	382	382	C	Indicates if the encounter was accepted Value 'A' = accepted 'R' = replacement needed 'D' = duplicate 'T' = TPL 'V' = voided 'X' = deleted
46.	DEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
47.	DEC-REPORTING-QUARTER	5	400	404	C	Quarter in which encounter reported
48.	DEC-CC	2	400	401	C	Century
49.	DEC-YY	2	402	403	C	Year
50.	DEC-QUARTER	1	404	404	C	Quarter reported ???? Calendar or state fiscal ??? Value '1 – 4'
51.	FILLER	45	405	449		
52.	DEC-ERROR-COUNT	2	450	451		Number of errors on the encounter Mask: S9999 COMP (signed packed EBCDIC)
53.	DEC-ERROR-CODE-ARRAY	300	452	751		This array allows for 50 entries, 6 bytes each
54.	DEC-ERROR-LINE-NO	2	452	453	C	Line on which the error occurred
55.	DEC-ERROR-CODE	3	454	456	C	Error code assigned
56.	DEC-ENC-ERROR-STATUS	1	457	457	C	Type of error Value 'C' = critical 'N' = non critical 'I' = ignore
57.	DEC-PERFORMING-PROV-NO	6	752	757	C	Provider number who rendered service
58.	DEC-PROV-COUNTY	2	758	759	C	Performing provider county
59.	DEC-DRUG-CODE	11	760	770	C	National drug code number
60.	DEC-DRUG-NAME	40	771	810	C	Desi drug name
61.	DEC-ENC-PRESCRIPTION-NO	15	811	825	C	Prescription number
62.	DEC-DISPENSE-DATE-8	8	826	833	C	Date which prescription was dispensed Mask: CCYYMMDD
63.	DEC-DAYS-SUPPLY-INPUT	3	834	836	N	Number of days supply
64.	DEC-UNIT-TYPE	3	837	839	X	
65.	DEC-QUANTITY-DISPENSED	6	840	845	N	Amount dispensed
66.	DEC-THERAPEUTIC-CLASS	6	846	851	C	Therapeutic class from drug record
67.	DEC-REIMBURSE-METHOD	1	852	852	C	Indicates type of reimbursement for service Value 'F' = fee for service 'C' = capitated
68.	DEC-TOT-AMT-HMO-BILLED	9	853	861	N	Amount billed for service Mask: S9999999V99 (this is zone signed)
69.	DEC-TOT-AMT-HMO-PAID	9	862	870	N	Amount paid for service rendered Mask: S9999999V99 (this is zone signed)
70.	DEC-PRESC-PROV-NO	6	871	876	C	Prescribing physician number
71.	DEC-REFILL	2	877	878	N	Indicates new RX (blank) or number f refills used
72.	FILLER	1386	879	2264		

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OUTPUT ENCOUNTER LAYOUT FOR AMBULATORY SERVICES

CField Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	HEC-ENC-KEY	23	1	23		
2.	HEC-ENC-ID-NO	16	1	16	C	
3.	HEC-ENC-IND	1	17	17	C	Value = 'E'
4.	HEC-PROV-NUMBER	6	18	23	C	State assigned number of MCO
5.	HEC-INDIVIDUAL-NO	10	24	33	C	Recipient Medicaid number
6.	HEC-INDIV-NO-CHECK-DIGIT	1	24	24	C	Check digit
7.	HEC-INDIV-NO	9	25	33	C	Number
8.	HEC-ENC-DOC-TYPE	1	34	34	C	Value 'A' = HIC 'D' = Drug 'Z' = Hospital UB
9.	HEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
10.	HEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
11.	HEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
12.	HEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted CCYYDDD
13.	HEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS Mask: CCYYMMDD
14.	HEC-ENC-DATA-STATUS	1	68	68	C	Status of encounter after edit Value 'G' = good data 'F' = flawed data 'I' = ignore data 'T' = TPL data
15.	HEC-HMO-PROV-INFO	28	69	96	C	Provider information
16.	HEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
17.	HEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
18.	HEC-ENC-RECIP-INFO	63	97	159		Recipient information
19.	HEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
20.	HEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
21.	HEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
22.	HEC-DOB-8	8	129	136	C	Recipient date of birth CCYYMMDD
23.	HEC-SEX	1	137	137	C	Sex
24.	HEC-AGE	3	138	140	N	Age in years
25.	HEC-RACE	2	141	142	C	Race code
26.	HEC-COUNTY	2	143	144	C	County Code
27.	HEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
28.	HEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
29.	HEC-QMB-IND	1	149	149	C	Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level
30.	HEC-RSP-PGM-IND (occurs 6 times)	1	150	155	C	Indicates enrollment in special programs This is an array field and occurs 6 times in this space.
31.	FILLER	4	156	159	C	
32.	HEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
33.	HEC-CARRIER-CODE	5	160	164	C	Carrier Code
34.	HEC-POLICY-NUMBER	25	165	189	C	Policy number
35.	HEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
36.	HEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
37.	HEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
38.	HEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
39.	HEC-TPL-RECOVERY-IND	1	373	373	C	Value 'R' = recoupment
40.	FILLER	1	374	374	C	
41.	HEC-PAYMENT-DENIED-IND	1	375	375	C	Identifies as being denied payment by HMO

CField Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						Value 'D' = denied encounter
42.	HEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
43.	HEC-ENC-IND-1	1	377	377	C	Possible future use
44.	HEC-CLAIM-PAID-DATE	4	378	381	C	Date claim paid Mask: YYMM
45.	HEC-ENCOUNTER-STATUS	1	382	382	C	Indicates if the encounter was accepted Value 'A' = accepted 'R' = replacement needed 'D' = duplicate 'T' = TPL 'V' = voided 'X' = deleted
46.	HEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
47.	HEC-REPORTING-QUARTER	5	400	404	C	Quarter in which encounter reported
48.	HEC-CC	2	400	401	C	Century
49.	HEC-YY	2	402	403	C	Year
50.	HEC-QUARTER	1	404	404	C	Quarter reported ???? Calendar or state fiscal ??? Value '1 – 4'
51.	FILLER	45	405	449		
52.	HEC-ERROR-COUNT	2	450	451		Number of errors on the encounter Mask: S9999 COMP (signed packed EBCDIC)
53.	HEC-ERROR-CODE-ARRAY	300	452	751		This array allows for 50 entries, 6 bytes each
54.	HEC-ERROR-LINE-NO	2	452	453	C	Line on which the error occurred
55.	HEC-ERROR-CODE	3	454	456	C	Error code assigned
56.	HEC-ENC-ERROR-STATUS	1	457	457	C	Type of error Value 'C' = critical 'N' = non critical 'I' = ignore
57.	HEC-PRIMARY-CARE-PROV	6	752	757	C	Primary care physician
58.	HEC-PRIM-DIAG-CODE	6	758	763	C	Primary diagnosis
59.	HEC-OTHER-DIAG-CODE-TABLE	18	764	781		Other diagnoses table contains 3 entries – 6 bytes each
60.	HEC-OTHER-DIAG-CODE	6	764	769	C	Other diagnoses code
61.	HEC-TOTAL-NUM-LINES	2	782	783	N	Total number of encounter lines
62.	HEC-HIC-ENC-LINE	76	784	1391		Information for up to 8 lines (table has 8 entries)
63.	HEC-FDOS-CCYY	4	784	787	C	First date of service full year CCYY
64.	HEC-FDOS-mm	2	788	789	C	First date of service month MM
65.	HEC-FDOS-DD	2	790	791	C	First date of service day DD
66.	HEC-LDOS-CCYY	4	792	795	C	Last date of service full year CCYY
67.	HEC-LDOS-mm	2	796	797	C	Last date of service month MM
68.	HEC-LDOS-DD	2	798	799	C	Last date of service day DD
69.	HEC-PROC-CODE-6	6	800	805		Full 6 byte code
70.	HEC-PROC-BYTE-1	1	800	800	C	For future use
71.	HEC-PROCEDURE-CODE	5	801	805	C	HCPCS code
72.	HEC-PROC-CODE-MODIFIER	3	806	808	C	Procedure code modifier
73.	HEC-UNITS-OF-SERVICE	3	809	811	C	Number of visits or services Mask: S999 (field is zone signed)
74.	HEC-TWO-BYTE-POS	2	812	813	C	Location at which service was rendered Field broke into byte 1 and byte 2
75.	HEC-GROUP-PROV-NO	6	814	819	C	Group provider number, if applicable
76.	HEC-SERVICE-PROV-NO	6	820	825	C	Provider rendering service
77.	HEC-PROV-COUNTY	2	826	827	C	County of service provider
78.	HEC-SERVICE-PROV-TYPE	2	828	829	C	Service provider type
79.	HEC-PRACTICE-SPECIALTY	2	830	831	C	Service provider specialty
80.	HEC-CATEGORY-OF-SERVICE	2	832	833	C	Service provider category of service
81.	HEC-EPSDT-INDICATOR	1	834	834	C	Indicator showing screening follow up needed

CField Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
82.	HEC-REIMBURSE-METHOD	1	835	835	C	Indicates type of reimbursement for service Value 'F' = fee for service 'C' = capitated
83.	HEC-AMT-BILLED-BY-PROV	7	836	842	N	Amount billed for service Mask: S99999V99 (field is zone signed)
84.	HEC-AMT-PAID-TO-PROV	7	843	849	N	Amount paid for service Mask: S99999V99 (field is zone signed)
85.	HEC-HIC-LINE-IND	1	850	850	C	Indicates previous payment for service Value 'D' = duplicate line
86.	FILLER	9	851	859		
87.	FILLER	873	1392	2264		

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OUTPUT ENCOUNTER LAYOUT FOR HOSPITAL SERVICES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	ZEC-ENC-KEY	23	1	23		
2.	ZEC-ENC-ID-NO	16	1	16	C	
3.	ZEC-ENC-IND	1	17	17	C	Value = 'E'
4.	ZEC-PROV-NUMBER	6	18	23	C	State assigned number of MCO
5.	ZEC-INDIVIDUAL-NO	10	24	33	C	Recipient Medicaid number
6.	ZEC-INDIV-NO-CHECK-DIGIT	1	24	24	C	CHECK digit
7.	ZEC-INDIV-NO	9	25	33	C	Number
8.	ZEC-ENC-DOC-TYPE	1	34	34	C	Value 'A' = HIC 'D' = Drug 'Z' = Hospital UB
9.	ZEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
10.	ZEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
11.	ZEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
12.	ZEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted CCYYDDD
13.	ZEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS CCYYMMDD
14.	ZEC-ENC-DATA-STATUS	1	68	68	C	Status of encounter after edit Value 'G' = good data 'F' = flawed data 'I' = ignore data 'T' = TPL data
15.	ZEC-HMO-PROV-INFO	28	69	96	C	Provider information
16.	ZEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
17.	ZEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
18.	ZEC-ENC-RECIP-INFO	63	97	159		Recipient information
19.	ZEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
20.	ZEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
21.	ZEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
22.	ZEC-DOB-8	8	129	136	C	Recipient date of birth CCYYMMDD
23.	ZEC-SEX	1	137	137	C	Sex
24.	ZEC-AGE	3	138	140	N	Age in years
25.	ZEC-RACE	2	141	142	C	Race code
26.	ZEC-COUNTY	2	143	144	C	County Code
27.	ZEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
28.	ZEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
29.	ZEC-QMB-IND	1	149	149	C	Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level
30.	ZEC-RSP-PGM-IND (occurs 6 times)	6	150	155	C	Indicates enrollment in special programs This is an array field and occurs 6 times in this space.
31.	FILLER	4	156	159	C	
32.	ZEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
33.	ZEC-CARRIER-CODE	5	160	164	C	Carrier Code
34.	ZEC-POLICY-NUMBER	25	165	189	C	Policy number
35.	ZEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
36.	ZEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
37.	ZEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
38.	ZEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
39.	ZEC-TPL-RECOVERY-IND	1	373	373	C	Value 'R' = recoupment
40.	FILLER	1	374	374	C	
41.	ZEC-PAYMENT-DENIED-IND	1	375	375	C	Identifies as being denied payment by HMO

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						Value 'D' = denied encounter
42.	ZEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
43.	ZEC-ENC-IND-1	1	377	377	C	Possible future use
44.	ZEC-CLAIM-PAID-DATE	4	378	381	C	Date claim paid Mask: YYMM
45.	ZEC-ENCOUNTER-STATUS	1	382	382	C	Indicates if the encounter was accepted Value 'A' = accepted 'R' = replacement needed 'D' = duplicate 'T' = TPL 'V' = voided 'X' = deleted
46.	ZEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
47.	ZEC-REPORTING-QUARTER	5	400	404	C	Quarter in which encounter reported
48.	ZEC-CC	2	400	401	C	Century
49.	ZEC-YY	2	402	403	C	Year
50.	ZEC-QUARTER	1	404	404	C	Quarter reported ???? Calendar or state fiscal ??? Value '1 – 4'
51.	FILLER	45	405	449		
52.	ZEC-ERROR-COUNT	2	450	451		Number of errors on the encounter Mask: S9999 COMP (signed packed EBCDIC)
53.	ZEC-ERROR-CODE-ARRAY	300	452	751		This array allows for 50 entries, 6 bytes each
54.	ZEC-ERROR-LINE-NO	2	452	453	C	Line on which the error occurred
55.	ZEC-ERROR-CODE	3	454	456	C	Error code assigned
56.	ZEC-ENC-ERROR-STATUS	1	457	457	C	Type of error Value 'C' = critical 'N' = non critical 'I' = ignore
57.	ZEC-PRIMARY-CARE-PROV	6	752	757	C	Primary care physician
58.	ZEC-SERVICE-PROV-NO	6	758	763	C	Provider rendering service
59.	ZEC-SERVICE-PROV-TYPE	2	764	765	C	Service provider type
60.	ZEC-SERVICE-PROV-COS	2	766	767	C	Service provider category of service
61.	ZEC-SERVICE-PROV-COUNTY	2	768	769	C	County of service provider
62.	ZEC-ADMIT-DIAGNOSIS	6	770	775	C	Inpatient admission diagnosis
63.	ZEC-ADMIT-DATE-8	8	776	783	C	Date of hospital admission Mask: CCYYMMDD
64.	ZEC-DISCHARGE-DATE-8	8	784	791	C	Date of discharge from hospital
65.	ZEC-PATIENT-STATUS	2	792	793	C	Status of patient upon discharge
66.	ZEC-PRIM-DIAG-CODE	6	794	799	C	Primary diagnosis
67.	ZEC-OTHER-DIAG-CODE	48	800	847	C	Other diagnoses
68.	ZEC-FROM-DATE-8	8	848	855	C	Date service began Mask: CCYYMMDD
69.	ZEC-TO-DATE-8	8	856	863	C	Last date of service Mask: CCYYMMDD
70.	ZEC-PRIN-SURG-CODE	6	864	869	C	Principal surgical code
71.	ZEC-PRIN-SURG-DATE-8	8	870	877	C	Date principal surgical procedure performed
72.	ZEC-OTHER-SURG-DATA	14	878	947	C	Other surgical data (occurs 5 times
73.	ZEC-OTHER-SURG-CODE	6	878	883	C	Other surgical codes
74.	ZEC-OTHER-SURG-DATE-8	8	884	891	C	Date other surgical procedure performed Mask: CCYYMMDD
75.	ZEC-DRG-VALUE	3	948	950	C	DRG assigned to encounter
76.	ZEC-TOT-AMT-HMO-BILLED	9	951	959	N	Amount billed for hospital services Mask S9999999v99 (zone signed)
77.	ZEC-TOT-AMT-HMO-PAID	9	960	968	N	Amount billed for hospital services Mask S9999999v99 (zone signed)
78.	ZEC-REIMBURSE-METHOD	1	969	969	C	Indicates type of reimbursement for service Value = F – fee for service Value = C – capitated
79.	ZEC-TOTAL-NUM-LINES	2	970	971	N	Total number of revenue lines
80.	ZEC-ENC-REV-LINE	1150	972	2121	C	Revenue line (occurs 50 times x 23 bytes)
81.	ZEC-REVENUE-CODE-4	4	972	975	C	Revenue code Mask: X – not used at this time XXX – revenue code

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
82.	ZEC-PROCEDURE-CODE	5	976	980	C	Procedure code
83.	ZEC-REV92-UNITS-SERV	4	981	984	N	Number of days or units of service
84.	FILLER	10	985	994	C	
85.	FILLER	143	2122	2264	C	

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
RECORD FOR EPSDT VISITS AND IMMUNIZATIONS

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	RECIPIENT-MEDICAID-NUMBER	10	1	10	C	
2.	RECIPIENT-LAST-NAME	17	11	27	C	
3.	RECIPIENT-FIRST-NAME	14	28	41	C	
4.	RECIPIENT-MIDDLE-INITIAL	1	42	42	C	
5.	SERVICE-PROVIDER	6	43	48	C	
6.	PAY-TO-PROVIDER	6	49	54	C	
7.	PAY-TO-PROVIDER-NAME	24	55	80	C	
8.	RECIPIENT-COUNTY	2	81	82	C	
9.	PROCEDURE-CODE	5	83	87	C	
10.	DATE-OF-SERVICE-8	8	88	95	C	Mask: YYYYMMDD
11.	FILLER	1	96	96	C	
12.	DATE-OF-BIRTH	8	97	104	C	Mask: YYYYMMDD
13.	FILLER	1	105	105	C	
14.	AGE-ON-DATE-OF-SERVICE	3	106	108	N	
15.	FILLER	12	109	120	C	
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						
26.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CLAIMS RECORD DESCRIPTION

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Claim-Indicator	1	12	12		'M' – Verified MHN claim – Recipient is member of a MHN on date of service on the claim. This will be the only indicator found in the sure MHN monthly files. Is not valid for MCO files, or history files. 'H' – Verified MCO claim – Recipient is a member of a MCO on the date of service on the claim. Is not valid for MHN files, or history files. 'S' - History Claim – Recipient was a current member of the MCO or MHN at run time. Their claims are provided for information.
4.	Filler	1	13	13	C	
5.	Recipient Pay Category	2	14	15	C	Table 01 – Assistance Pay Category – at time of claim
6.	Filler	1	16	16		
7.	Recipient RSP code1	1	17	17	C	Table 02 – RSP (Recipient Special Program) Codes
8.	Filler	1	18	18		
9.	Recipient RSP code2	1	19	19	C	Table 02 Note: If any of the RSP fields (3-9) = '5'
10.	Filler	1	20	20		then the recipient was in a MHN
11.	Recipient RSP code3	1	21	21	C	Table 02 at the date of service of this claim.
12.	Filler	1	22	22		
13.	Recipient RSP code4	1	23	23	C	Table 02
14.	Filler	1	24	24		
15.	Recipient RSP code5	1	25	25	C	Table 02
16.	Filler	1	26	26		
17.	Recipient RSP code6	1	27	27	C	Table 02
18.	Filler	1	28	28		
19.	Recipient County	2	29	30	C	Table 03 - County Codes - residence county at time of claim
20.	Filler	1	31	31		
21.	Recipient Qualifying Category	2	32	33	C	Table 04 - Qualifying Category – at time of claim
22.	Filler	1	34	34		
23.	Recipient Date of Birth	6	35	40	C	YYMMDD
24.	Filler	1	41	41		
25.	Recipient Sex	1	42	42	C	Table 12 – Gender
26.	Filler	1	43	43		
27.	Claim Control #	16	44	59	C	
28.	Filler	1	60	60		
29.	Claim Type	1	61	61	C	see table 5 – Claim Type
30.	Filler	1	62	62		
31.	Type of Bill	1	63	63	C	M=Medicaid, X=Crossover
32.	Filler	1	64	64		
33.	From Date of Service	6	65	70	C	YYMMDD Claim Type Z: Admit Date Claim Type J: Premium Date Claim Type G: First DOS = From All others: Date of Service=FROM
34.	Filler	1	71	71		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
35.	To Date of Service	6	72	77	C	YYMMDD Claim Type Z: Discharge Date = TO Claim Type J: Effective Date of any change Claim Type G: First DOS = TO All others: Date of Service=TO
36.	Filler	1	78	78		
37.	Date Paid	6	79	84	C	YYMMDD
38.	Filler	1	85	85		
39.	Paid Amount	10	86	95	N	9999999.99 Claim Type D,Z,J,G: Total Paid – Claim All others: Total Paid – Line
40.	Filler	1	96	96		
41.	Charged Amount	10	97	106	N	9999999.99 Claim Type D,Z,J,G: Total Charged – Claim All others: Total Charged for Line
42.	Filler	1	107	107		
43.	Amt received - other (TPL)	10	108	117	N	9999999.99 Claim Type G (Nursing Home): Patient income applied to bill. All others claim types – Any other amt received. CLAIM Level field, not line i.e. for HIC & Dental, use only 1 per claim
44.	Filler	1	118	118		
45.	Clm Copayment Amount	8	119	126	N	99999.99 A(HIC), (B)Dental - Line Level D(Drug), (Z) UB92 - Claim Level
46.	Filler	1	127	127		
47.	Line number	2	128	129	C	A (HIC) B (Dental) - Line number D - Medically necessary (field 1) Values: Y=YES, N or Blank or zero = NO All others: not used, will be 01
48.	Filler	1	130	130		
49.	Payment Message Indicator	1	131	131	C	Table 16 – Payment Messages HIC – Payment Message indicator (determines how surgical claim is paid. DRUG – Brand name medically necessary code DENTAL – Oral surgery indicator UB92 - Reimbursement Type
50.	Filler	1	132	132		
51.	Service Code	11	133	143	C	A (HIC), B(DENTAL) – Procedure Subfile & Code (first 6 bytes) Subfile = Table 6, Procedure Code – File 1 D (DRUG) - NDC code (all 11 bytes) - File 6 – NDC Drug Code Z (UB92) – attending MD UPIN if present
52.	Filler	1	144	144		
53.	Proc code modifier	3	145	147	C	A (HIC), B (DENT) – Procedure Code Modifier -Table 7 Z (UB92) - Type of Bill - Table7Z
54.	Filler	1	148	148		
55.	Place of service	2	149	150	C	A (HIC) - 2 byte place of service Table 8 B (DENT) - 1 byte place of service Table 8 Z (UB92) - Patient Status Table 8Z All others – not used
56.	Filler	1	151	151		
57.	Units	4	152	155	N	A (HIC), B (DENT) - units D (DRUG) – Quantity Z (UB92) - Inpatient - Covered Days G (NH) - Total days All Others – not used
58.	Filler	1	156	156		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
59.	Diagnosis code Primary	6	157	162	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) - Therapeutic Class if present – Table 19
60.	Filler	1	163	163		
61.	Diagnosis code Second	6	164	169	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) – Generic Class if present
62.	Filler	1	170	170		
63.	Diagnosis code Admit	6	171	176	C	Z (UB92) only - Admit diagnosis: File #2 – Diagnosis Codes
64.	Filler	1	177	177		
65.	Funding code-1	2	178	179	C	File # 3 Fund Codes – valid for all claim types
66.	Filler	1	180	180		
67.	Funding code-2	2	181	182	C	File # 3 Fund Codes - valid only for hospital claims
68.	Filler	1	183	183		
69.	Funding code-3	2	184	185	C	File # 3 Fund Codes - valid only for hospital claims
70.	Filler	1	186	186		
71.	Paid Provider #	6	187	192	C	Provider Paid for the Services File # 4 and # 8 – Provider and Provider Group Affiliations
72.	Filler	1	193	193		
73.	Paid Provider Type	2	194	195	C	Table # 9 – Provider Types
74.	Filler	1	196	196		
75.	Paid Provider Specialty	2	197	198	C	Table # 10 – Provider Specialty
76.	Filler	1	199	199		
77.	Servicing Provider #	6	200	205		A (HIC) and B (DENT) – Provider of services All others – same as Paid Provider File # 4 and # 8 – Provider and Provider Group Affiliations
78.	Filler	1	206	206		
79.	Servicing Prov Type	2	207	208	C	A (HIC) and B (DENT): Provider of services All others – same as Paid Provider Table # 9 – Provider Types
80.	Filler	1	209	209		
81.	Servicing Prov Specialty	2	210	211	C	For A (HIC) and B (DENT) – provider of services UB92, BIO – Category of Service of Paid Provider – Table 20 All others – same as Paid Provider Table # 10 – Provider Specialty
82.	Filler	1	212	212		
83.	Prescriber ID	6	213	218	C	Prescriber Medicaid # if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.
84.	Filler	1	219	219		
85.	Prescriber ID-Type	2	220	221	C	Prescriber Provider Type if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.
86.	Filler	1	222	222		
87.	Prescriber ID-SSN	9	223	231		Prescriber SSN if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:
88.	Filler	1	232	232	C	
89.	Prescriber ID-NAPB	7	233	239	C	Prescriber NABP if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:
90.	Filler	1	240	240		
91.	Refill # (blank if orig)	2	241	242	C	Blank or zeroes if original RX, otherwise # refills
92.	Filler	1	243	243		
93.	Days Supply	3	244	246	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
94.	Filler	1	247	247		
95.	DRG	3	248	250	C	File # 6 – DRG Codes
96.	Filler	1	251	251		
97.	Outpt Visit Type	1	252	252	C	E=emergency room , Table # 11 Outpatient visit codes
98.	Filler	1	253	253		
99.	ICD9 Surgical Code 1	6	254	259	C	File # 7, Surgical Codes
100.	Filler	1	260	260		
101.	ICD9 Surgical Code 2	6	261	266	C	File # 7, Surgical Codes
102.	Filler	1	267	267		
103.	ER Revenue Code	3	268	270	C	ER Revenue code. N/A unless field #49 is equal to "E" (i.e. the claim is an ER claim)
104.	Filler	1	271	271		
105.	Provider Own Reference #	15	272	286	C	A (HIC) B (DENT) G (NH) – Provider own reference D (DRUG) – Prescription number Z (UB92) – Medical Records number
106.	Filler	1	287	287		
107.	Paid Provider Ownership Code	3	288	290	C	Table #18 – Provider Ownership
108.	Filler	1	291	291		
109.	Prescriber Number	10	292	301	C	Match to file on DHHS Drug Website # assigned to a physician which is used to identify the prescriber.
110.	Filler	1	302	302		
111.	HIC- Authorization Number	8	303	310	C	Prior authorization # for Claim Type A
112.	Filler	1	311	311		
113.	Provider County	2	312	313	C	Provider county Table 3 – County codes
114.	Filler	1	314	314		
115.	Prior Authorization Number 1	13	315	327	C	Prior Authorization # for Claim Type B
116.	Filler	1	328	328		
117.	Prior Authorization Number 2	7	329	335	C	Prior Authorization number 2
118.	Filler	1	336	336		
119.	MHN/MCO Provider number	6	337	342	C	For sure claims (PCCM indicator = M or H) this is the MHN or MCO the recipient is a member of at the date of service. For history claims (PCCM indicator = S) this is the MHN or MCO the recipient is a current member of.
120.	Filler	1	343	343		
121.	Check Number	7	344	350	C	
122.	Filler	1	351	351		
123.	Gatekeeper Physician	6	352	357	C	Valid for MHN sure claims only (PCCM indicator = M) – This is the physician number of the gatekeeper at the date of service of the claim.
124.	Filler	3	358	360		Reserved for future use

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

FILES EXCHANGED BETWEEN SCDHHS AND MCOs

MCO/MHN/MAXIMUS Sync File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	MCO or MHN Provider Number	06	11	16	C	
3.	Enroll Date	08	17	24	C	Mask - CCYYMMDD
4.	Termination Date	08	25	32	C	Mask – CCYYMMDD Blank or all 9's = open eligibility
5.	PCP Provider Number	6	33	38	C	Valid only for MHN's – preferred physician
6.	Filler	2	39	40	C	
7.	County	2	41	42	C	
8.	Recipient Last Name	17	43	59	C	
9.	Recipient First Name	14	60	73	C	
10.	Middle Initial	1	74	74	C	
11.	Filler	6	75	80		
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Special instruction:
All records must be fixed length:
Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left
EX: 5 bytes 123 will appear as 00123
Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
C = Character – All character fields are left justified and space filled to the right
Unless otherwise specified there will be no signed fields

FORMS

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

MANAGED CARE PLAN ENROLLMENT/DISENROLLMENT/CHANGE FORM

For Use by Members Only

I wish to change from the Managed Care Program I am currently in and join a new Managed Care Program or return to Regular Medicaid. ***Please complete all sections of this form.***

Please **DISENROLL** me from the following plan (check one):	Please **ENROLL** me in the following plan (check one):
□First Choice (HM1000) □South Carolina Solutions (PCM120) □Unison (HM1600) □Palmetto Medical Home Network (PCM130) □Carolina Crescent (HM2600) □Total Carolina Care (HM2200) □CHCcares of SC (HM2000) □AMERIGROUP Community Care (HM2400)	□First Choice (HM1000) □South Carolina Solutions (PCM120) □Unison (HM1600) □Palmetto Medical Home Network (PCM130) □Carolina Crescent (HM2600) □Total Carolina Care (HM2200) □CHCcares of SC (HM2000) □AMERIGROUP Community Care (HM2400) □Regular Medicaid
My current doctor is _____	*My new doctor is* _____

I want to change plans because of the following reason (Check the **one reason** that best describes your problem): ***Reasons to support your request are necessary. Please give your reasons on this form. If reasons are not given, your request may not be honored.***

☐ I am receiving poor quality care. (31)	☐ I am not able to get the care I need. (33)	☐ Access to care issues (Plan doctor too far away for me to get to). (32)
I have moved outside service area. (30)	☐ My doctor/my specialist/my pharmacy is not part of the network. (35)	☐ I can't get the medicines I used to get with regular Medicaid. (39)
I am entering a waiver program. (37) Circle one: CLTC or MFCP	☐ I need hospice services or am entering a nursing home. (38)	☐ The doctor I was assigned to does not know or understand my health care needs. (36)
Placed out of home/Foster Care (70)	☐ I didn't realize what I was signing up for. (53)	☐ Lack of access to services covered under contract. (34)
I'm unhappy with the doctor. (51)	☐ Dissatisfaction with Plan (50)	☐ I have changed my mind (1st 90 days only). (52)
☐ Other (41): _____		

PRINT NAME (S) --(LAST, FIRST, MIDDLE INITIAL)	BIRTH DATE	MEDICAID ID NUMBER

ADDRESS WHERE I GET MY MAIL: _____ **CITY:**_____ **STATE**_____ **ZIP**_____

PHONE NUMBER or CELL where I can be reached: (_____)_____ **COUNTY I LIVE IN** _____
Area Code

ADDRESS WHERE I LIVE (if different from where you get your mail): _____

I certify that I have legal custody of any minor children listed on this Change Form and have the authority to make health care decisions on their behalf.

Name (Please Print): _____**Signature:** _____**Date:** _____

SAMPLE WIC REFERRAL FORM

PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation.

Name of Person Being Referred: _____

Address: _____

Telephone Number: _____

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

____ Pregnant woman

____ Woman who is breast-feeding her infant(s) up to one year postpartum

____ Woman who is non-breast feeding up to six months postpartum

____ Infant (age 0-1)

____ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

Provider's Name _____

Provider's Phone _____

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

Send completed form to:

WIC Program Contact
Address
Phone Number

HYSTERECTOMY ACKNOWLEDGMENT FORM
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

□ ALWAYS COMPLETE THIS SECTION □

Recipient Name _____ Medicaid ID No. _____

Physician's Name _____ Date of Hysterectomy _____

□ COMPLETE ONLY ONE OF REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION □

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomies being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

PATIENT'S SIGNATURE DATE

WITNESS' SIGNATURE DATE

INTERPRETER'S SIGNATURE (if necessary) DATE

PHYSICIAN STATEMENT

IT HAS BEEN EXPLAINED TO THE ABOVE PATIENT AND/OR HER REPRESENTATIVE BY ME PRIOR TO SURGERY BOTH ORALLY AND IN WRITING THAT THE HYSTERECTOMY TO BE PERFORMED IS MEDICALLY NECESSARY AND NOT FOR THE SOLE PURPOSE OF RENDERING HER INCAPABLE OF BEARING CHILDREN (REPRODUCING) NOR IS THE HYSTERECTOMY FOR MEDICAL PURPOSES WHICH BY THEMSELVES DO NOT MANDATE A HYSTERECTOMY.

PHYSICIAN'S SIGNATURE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW ARE APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient listed above:
(Check one)

1 □ I informed her that this operation would make her permanently incapable of reproducing (This certification for retroactively eligible recipient only - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made).

2 □ She was already sterile due to

_____.
CAUSE OF STERILITY

3 □ She had a hysterectomy performed because of a life-threatening situation due to

_____.
DESCRIBE EMERGENCY SITUATION
and the information concerning sterility could not be given prior to the hysterectomy.

For the above reason(s), I am requesting an exception to the acknowledgment requirement for the hysterectomy.

PHYSICIAN'S SIGNATURE

This form may be reproduced locally

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

Always complete this section

1. Member Name: Member's Name can be typed or handwritten. Must be completed.

2. Medicaid ID No: Member's Identification Number can be typed or handwritten. Must be completed.

3. Physician's Name: Physician's Name can be typed or handwritten. Must be completed.

4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete this section for enrollee who acknowledges receipt prior to hysterectomy

5. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery. (if the patient cannot sign her name she can mark an "X" in patient's signature blank if there is a witness)

6. Witness Signature/Date: The witness must sign and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting.

7. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in is/her own handwriting.

If Section A is completed, **STOP HERE.**

Section B: Complete this section when any of the exceptions listed below are applicable

8. Retroactive Eligible Member Only: This box is checked only if the enrollee was approved retroactively. A copy of the Medicaid card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.

9. This box is checked if the patient was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.

10. This box is checked if the patient had a hysterectomy performed because if a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.

11. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

DEPT. OF HEALTH & HUMAN SERVICES
P.O. Box 8206
Columbia, S.C. 29202-8206

INDIVIDUALS INFORMED CONSENT TO NON - THERAPEUTIC STERILIZATION FOR MEDICAID RECIPIENTS

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

PART I CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for the
(Doctor or clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____.
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature Month Day Year

MEDICAID ID NUMBER

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check):

( ) American Indian or Alaska Native
( ) Black (not of Hispanic origin)
( ) Hispanic
( ) Asian or Pacific Islander
( ) White (not of Hispanic origin)

PART II INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

_____ _____
Interpreter Date

FORM
DHHS 1723
3 - 97

PART III STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of individual)
Consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary, I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at ant time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PART IV PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on _____
(Name: Individual to be sterilized) (Date sterilized)
I explained to him/her the nature of the sterilization operation

_____
(Specify type of operation)
the fact that it is intended to be a final and irreversible procedure and the discomfort, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (CROSS OUT THE PARAGRAPH WHICH IS NOT USED.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstance (check applicable box and fill in information requested):

( ) Premature delivery
Individual expected date of delivery: _____
( ) Emergency abdominal surgery (describe circumstance):

_____ Date _____
Physician

License No: _____ Group No: _____

INSTRUCTIONS FOR COMPLETING THE STERILIZATION CONSENT FORM

All sections of the "Sterilization for Medicaid Recipients" consent form (SCDHHS form 1723, Jan. 1989 edition) must be completed. If the consent form is correctly completed and meets the Federal Regulations, the service may be rendered. Please see the Correctable/Non-Correctable Error Chart for a listing of errors that can and cannot be changed on a Consent form. Listed below are instructions on completing the form followed by the Error Chart.

Part I

1. Name of physician or group scheduled to do sterilization procedure. If the physician or group is unknown, put the phrase "OB on call".

2. Name of the sterilization procedure (i.e., bilateral tubal ligation [BTL]).

3. Birth date of the member. The member must be 21 years old when he/she signs the consent form.

4. Member's name.

5. Name of the physician or group scheduled to do the sterilization or the phrase "OB on call".

6. Name of the sterilization procedure.

7. Member's signature and date. If the member signs with an "X", an explanation must accompany the consent form.

8. Member's Medicaid number.

Part II

9. If the member had an interpreter translate the consent form information in a foreign language (i.e., Spanish, French, etc.), the interpreter must complete this section. **If an interpreter was not necessary, put N/A in these blanks.**

Part III

10. Member's name.

11. Name of sterilization procedure.

12. Signature and date of the person who counseled the member on the sterilization procedure. This date should match the date of the member's signature date. Also complete the facility address. An address stamp is acceptable if legible.

Part IV (This part is completed after the sterilization procedure is performed).

13. Member's name.

14. Date of the sterilization procedure. (Be sure this date matches the date on the claim.)

15. Name of the sterilization procedure.

16. EDC date is required if sterilized within the 30 day waiting period and the member was pregnant.

17. An explanation must be attached if an emergency abdominal surgery was performed within the 30 day waiting period. At least 72 hours is required to pass before the sterilization and the sterilization procedure may not be the reason for the emergency surgery.

Please note: If the member is pregnant, premature delivery is the only exception to the 30 day waiting period.

18. Physician signature and date. A physician's stamp is acceptable. The rendering or attending physician must sign the consent form. The physician's date must be dated the same as the sterilization date or after.

Correctable/Non-Correctable Error Chart for Sterilization Consent Form	
A. Doctor or Group Name	Correctable Error
B. Name of Procedure	Correctable Error
C. Patient Date of Birth	Correctable Error. Date of Birth on the CMS 1500 form, and consent form should all match. Patient **MUST** be 21 years old to sign form.
D. Patient Name	Correctable Error. Name should match name on the CMS 1500 form.
E. Doctor or Group Name	Correctable Error
F. Name of Procedure	Correctable Error
G. Patient Signature	NOT A CORRECTABLE ERROR. The signature must be the patient's signature. If the patient is unable to sign or signs with an "X", an explanation must accompany the consent form.
G. Date	NOT A CORRECTABLE ERROR without detailed medical records documentation.
H. Medicaid ID Number	Correctable Error
Part II – Interpreter's Statement	
A. Foreign Language Used	Correctable Error
A. Interpreter Signature	Correctable Error
A. Date	Correctable Error
Part III – Statement of Person Obtaining Consent	
A. Patient Name	Correctable Error
B. Procedure	Correctable Error. This procedure must match B and F.
C. Signature of Person Obtaining Consent	NOT A CORRECTABLE ERROR
C. Date	NOT A CORRECTABLE ERROR without detailed medical records documentation. This date must match PARTI-G. *
C. Facility Address	Correctable Error. An address stamp is acceptable if legible.
Part IV – Physician's Statement	
A. Patient's Name	Correctable Error
B. Date of Procedure	Correctable Error. This date must match the date of service on the claim form.
C. Procedure	Correctable Error. This procedure must match PART I B and F, and procedure code on claim.
D. Expected Date of Delivery	Correctable Error
D. Emergency Abdominal Surgery	Correctable Error. An explanation must be attached to the claim.
F. Physician Signature	Correctable Error. A physician's stamp is acceptable.
F. Date	NOT A CORRECTABLE ERROR if the date is prior to the sterilization without detailed medical records documentation. * CORRECTABLE ERROR if field is blank.
F. License Number (Medicaid Individual Provider Number)	Correctable Error. The provider number is the same as on the CMS claim form.
F. Group Number (Medicaid Group Provider Number)	Correctable Error. The group provider number is the same as on the CMS claim form.

* Most commonly occurring errors.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: _____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____, certify that it was necessary to terminate the pregnancy of _____ for the following reason:

( ) A. Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: _____

( ) B. The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

( ) C. The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____, certify that my pregnancy was the result of an act of rape of incest.

_____ _____

Patient's Signature Date

Both the completed Abortion Statement and appropriate medial records must be submitted with the claim. Form.

INSTRUCTIONS FOR COMPLETING THE ABORTION STATEMENT FORM

1. Patient's Name: The name of the patient can be typed or handwritten.

2. Patient's Medicaid ID #: The patient's Medicaid identification number can be typed or handwritten.

3. Patient Address: Patient's complete address. This can be typed or handwritten.

4. Name of Physician: The physician who performed the abortion procedure. This can be typed or handwritten.

5. Patient's Name: This can be typed or handwritten.

6. Reason: Check the box that indicates the necessity to terminate the pregnancy.

7. Name of Condition: The diagnosis or name of medical condition which makes abortion necessary.

8. Physician Signature: The physician must sign his/her name and date in his/her own handwriting.

9. Patient's Certification Statement: Complete this section only in cases of rape or incest.

10. Patient's Name: This can be typed or handwritten.

11. Patient's Signature: Patient must sign his/her name and date in his/her own handwriting.

South Carolina Department of Health and Human Services
REQUEST FOR MEDICAID ID NUMBER

FROM (Provider name and address):	TO: (DHHS Medicaid Eligibility)

IDENTIFYING INFORMATION FURNISHED BY MEDICAID PROVIDER

A. MOTHER:

Name:_____ _____

Address:_____ _____

Social Security Number:_____ Date of Birth:_____ _____

Did the mother have a permanent sterilization procedure? __Yes ___ No

Medicaid ID Number:_____ County:_____

Medicaid Eligibility Worker Name (if known):_____

B. CHILD:

Name:_____ _____

Date of Birth:_____ Race:_____ Sex:_____

Has application been made for a SSN for the child? ___Yes ___No

Is the child a member of the mother's household? ___Yes ___No

Provider representative furnishing information:_____

Telephone number:_____ Date:_____

MEDICAID ELIGIBILITY INFORMATION FURNISHED BY DHHS
(within 5 working days)

Child's Medicaid ID Number:_____

Effective date of eligibility:_____

Medicaid Eligibility Worker:_____ Date:_____

Location:_____Telephone number: _____

DHHS Form 1716 ME (November 2003)

Plan Initiated Disenrollment Request

The member(s) listed below is to be disenrolled from the following plan _____ for the reason listed below. Please check all that apply.

- ☐ Member demonstrates a pattern of disruptive abusive behavior that could be construed as non-compliant and is not caused by a presenting illness;
- ☐ Member's utilization of services is fraudulent or abusive;
- ☐ Member is in a long-term care nursing facility beyond (30) calendar days;
- ☐ Member is placed in an intermediate care facility for the mentally retarded (ICF/MR);
- ☐ Member moved out of the service area and plan does not operate in the new service area;
- ☐ Member has died or is incarcerated.
- ☐ Other _____

Print the Name of Member to be Disenrolled (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number	Requested Disenrollment Date

Address c/o _____ Street _____ City/State/Zip _____	Phone Number (_____) _____ County _____

Signature: _____ Date: _____

The South Carolina Department of Health and Human Services will determine if the Health Plan has shown a good cause to disenroll the Medicaid member. The Health Plan Liaison will give written notification to the Health Plan of the decision. Medicaid members have the right to appeal enrollment and disenrollment decisions with the South Carolina Department of Health and Human Services.

The Health Plan shall not discriminate against any Medicaid member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

Mail completed form to: South Carolina Healthy Connections Choices
Attn: Larissa Hendley
140 Stoneridge Drive, Suite 385
Columbia, SC 29210

Definition of Terms

DEFINITION OF TERMS

The following terms, as used in this guide, shall be construed and interpreted as follows unless the context clearly requires otherwise.

AAFP – Academy of Family Physicians

Abuse – Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

ACIP – Centers for Disease Control Advisory Committee on Immunization Practices.

Administrative Days – Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient stay.

Actuarially sound capitation rates - Capitation rates that--(1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the contract; and (3) have been certified, as meeting the requirements of this paragraph, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Adjustments to smooth data – Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

AFDC/Family Independence - Aid to Families with Dependent Children.

Applicant - An individual seeking Medicaid eligibility through written application.

CFR - Code of Federal Regulations.

CPT - Current Procedural Terminology, most current edition.

Capitation Payment - The monthly payment which is paid by SCDHHS to a Contractor for each enrolled Medicaid MCO Program member for the provision of benefits during the payment period.

Care Coordination - The manner or practice of planning, directing and coordinating health care needs and services of Medicaid MCO Program members.

Care Coordinator - The individual responsible for planning, directing and coordinating services to meet identified health care needs of Medicaid MCO Program members.

Case - A household consisting of one or more Medicaid eligibles.

Case Manager - The individual responsible for identifying and coordinating services necessary to meet service needs of Medicaid MCO Program members.

Certificate of Coverage - The term which describes services and supplies provided to Medicaid MCO program member, which includes specific information on benefits, coverage limitations and services not covered. The term "certificate of coverage" is interchangeable with the term "evidence of coverage".

Clean Claim - Claims that can be processed without obtaining additional information from the Provider of the service or from a third party.

CMS – Centers for Medicare and Medicaid Services

CMS 1500 - Universal claim form, required by CMS, to be used by non-institutional and institutional Contractors that do not use the UB-92.

Cold-Call Marketing – Any unsolicited personal contact by the MCO with a potential member for the purpose of marketing.

Co-payment - Any cost-sharing payment for which the Medicaid MCO Program member is responsible for in accordance with 42 CFR , § 447.50.

Comprehensive Risk Contract – A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: (1) Outpatient hospital services; (2) Rural health clinic services; (3) FQHC services; (4) Other laboratory and X-ray services; (5) Nursing facility (NF) services; (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) Family planning services; (8) physician services; and (9) Home health services.

Contract Dispute - A circumstance whereby the Contractor and SCDHHS are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under the Contract.

Conversion Coverage - Individual coverage is available to a member who is no longer covered under the Medicaid MCO Contract coverage.

Core Benefits - A schedule of health care benefits provided to Medicaid MCO Program members enrolled in the Contractor's plan as specified under the terms of the Contract.

Cost Neutral – The mechanism used to smooth data, share risk, or adjust for risk will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Covered Services - Services included in the South Carolina State Medicaid Plan.

Contractor - The domestic licensed MCO that has executed a formal agreement with SCDHHS to enroll and serve Medicaid MCO Program members under the terms of the Contract. The term Contractor shall include all employees, subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a Contractor.

DAODAS - Department of Alcohol and Other Drug Abuse Services.

DDSN - Department of Disabilities and Special Needs.

DHEC - Department of Health and Environmental Control.

Days - Calendar days unless otherwise specified.

Direct Marketing/Cold Call - Any unsolicited personal contact with or solicitation of Medicaid applicants/eligibles in person, through direct mail advertising or telemarketing by an employee or agent of the MCO for the purpose of influencing an individual to enroll with the MCO plan.

Disease Management – Activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management.

Disenrollment - Action taken by SCDHHS or its designee to remove a Medicaid MCO Program member from the Contractor's plan following the receipt and approval of a written request for disenrollment or a determination made by SCDHHS or its designee that the member is no longer eligible or Medicaid or the Medicaid MCO Program.

Dual-eligibles - Applicants that receive Medicaid and Medicare benefits.

Dually Diagnosed - An individual who has more than one diagnosis and in need of services from more than one discipline.

EPSDT - An Early and Periodic Screening, Diagnosis and Treatment Program mandated by Title XIX of the Social Security Act.

Eligible(s)- A person whom has been determined eligible to receive services as provided for in the Title XIX SC State Medicaid Plan.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an emergency medical condition.

Encounter Data - Any service provided to a Medicaid MCO Program member regardless of who provides the service used in accumulating utilization data. This includes preventive, diagnostic, therapeutic, and any other service provided to the member.

Enrollment - The process in which a Medicaid eligible selects an MCO and goes through a managed care educational process as provided by either DHHS or the MCO's Department of Insurance (DOI) licensed marketing representative.

Enrollment (Voluntary) - The process in which an applicant/recipient selects a Contractor and goes through an educational process to become a Medicaid MCO Program member of the Contractor.

External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services than an MCO or their contractors furnish to Medicaid recipients.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in §438.354, and performs external quality review, other EQR-related activities set forth in §438.358, or both.

Evidence of Coverage - The term which describes services and supplies provided to Medicaid MCO Program members, which includes specific information on benefits, coverage limitations and services not covered. The term "evidence of coverage" is interchangeable with the term "certificate of coverage".

Expanded Services - A covered service provided by the Contractor which is currently a non-covered service(s) by the State Medicaid Plan or is an additional Medicaid covered service furnished by the Contractor to Medicaid MCO Program members for which the Contractor receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the Contract.

FPL - Federal Poverty Level.

FFP - Federal Financial Participation. Any funds, either title or grant, from the Federal Government.

FTE - A full time equivalent position.

FQHC - A South Carolina licensed health center is certified by the Centers for Medicare and Medicaid Services and receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a Medically under served Area.

Family Planning Services - Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Fee-for-Service Medicaid Rate - A method of making payment for health care services based on the current Medicaid fee schedule.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself of some other person. It includes any act that constitutes fraud under applicable Federal or State law.

GAO - General Accounting Office.

Health Care Professional – A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, Physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

HCPCS - CMS's Common Procedure Coding System.

Health Maintenance Organization (HMO) (Contractor) - A domestic licensed organization which provides or arranges for the provision of basic and supplemental health care services for members in the manner prescribed by the South Carolina State Department of Insurance and qualified by CMS.

HEDIS- Health Plan Employer Data and Information Set

HHS - United States Department of Health and Human Services.

Home and Community Based Services - In-home or community-based support services that assist persons with long term care needs to remain at home.

Hospital Swing Beds – Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as "swing bed" hospitals. A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting Federal and State requirements of participation for swing bed hospitals.

ICD-9 - International Classification of Disease, 9th revision.

Incentive Arrangement – Any payment mechanism under which a contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

Inmate - A person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.

Insolvency - A financial condition in which a Contractor's assets are not sufficient to discharge all its liabilities or when the Contractor is unable to pay its debts as they become due in the usual course of business.

Institutional Long Term Care - A system of health and social services designed to serve individuals who have functional limitations which impair their ability to perform activities of daily living (ADL's). It is care or services provided in a facility that is licensed as a nursing facility, or hospital that provides swing bed or administrative days.

MMIS - Medicaid Management Information System.

Managed Care Organization – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is—(1) A Federally qualified HMO that meets the advance directive requirements of subpart I of 42CFR § 489; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area service by the entity; and (b) Meets the solvency standards of 42CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or contractors.

Managed Care Plan - The term "Managed Care Plan" is interchangeable with the terms "Contractor", "Plan", or "HMO/MCO".

Marketing – Any communication approved by SCDHHS, from an MCO to a Medicaid recipient who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to disenroll from, another MCO Medicaid product.

Marketing Materials – Materials that (1) are produced in any means, by or on behalf of an MCO and (2) can be reasonable interpreted as intended to market to potential members.

Mass Media - A method of public advertising that can create plan name recognition among a large number of Medicaid recipients and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Medicaid - The medical assistance program authorized by Title XIX of the Social Security Act.

Medicaid Provider - An institution, facility, agency, person, corporation, partnership, or association approved by SCDHHS which accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medicare - A federal health insurance program for people 65 or older and certain individuals with disabilities.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the Contractor, its subcontractor, or any out of plan providers.

Medically Necessary Service - Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid MCO Program member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of Medicaid MCO Program member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Member or Medicaid MCO Program member - An eligible person(s) who voluntarily enrolls with a SCDHHS approved Medicaid MCO Contractor.

NDC - National Drug Code.

National Practitioner Data Bank - A central repository for adverse action and medical malpractice payments. (1-800-767-6732)

Newborn - A live child born to a member during her membership or otherwise eligible for voluntary enrollment under the Contract.

Non-Contract Provider - Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have not contracted with or are not employed by the Contractor to provide health care services.

Non-Covered Services - Services not covered under the Title XIX SC State Medicaid Plan.

Non-Emergency - An encounter by a Medicaid MCO Program member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.

Non-Participating Physician - A physician licensed to practice who has not contracted with or is not employed by the Contractor to provide health care services.

Non-Risk Contract – A contract under which the contractor—(1) is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42CFR § 447.362; and (2) May be reimbursed by the State at the end of the Contract period on the basis of the incurred costs, subject to the specified limits.

Out-of-Plan Services - Medicaid services not included in the Contractor's Core Benefits and reimbursed fee-for-service by the State.

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the Contractor. For further definition see 42 CFR 455.101 (1992).

Plan - The term "Contractor" is interchangeable with the terms "Plan," "Managed Care Plan" or "HMO/MCO".

Policies - The general principles by which SCDHHS is guided in its management of the Title XIX program, as further defined by SCDHHS promulgations and by state federal rules and regulations.

Post-stabilization services - Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve or resolve the member's condition.

Preventative and Rehabilitative Services for Primary Care Enhancement - A package of services designed to help maximize the treatment benefits/outcomes for those patients who have serious medical conditions and/or who exhibit lifestyle, psycho-social, and/or environmental risk factors.

Primary Care – All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP) - The provider who serves as the entry point into the health care system for the member. The PCP is responsible for including, but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care.

Prior Authorization - The act of authorizing specific approved services by the Contractor before they are rendered.

Program - The method of provision of Title XIX services to South Carolina recipients as provided for in the Title XIX SC State Medicaid Plan and SCDHHS regulations.

Provider – Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Managed Care Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Quality – As it pertains to external quality review, means the degree to which an MCO increases the likelihood of desire health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assurance - The process of assuring that the delivery of health care services provided to members are appropriate, timely, accessible, available and medically necessary.

Recipient - A person who is determined eligible in receiving services as provided for in the Title XIX SC State Medicaid Plan.

Referral Services - Health care services provided to Medicaid MCO Program members outside the Contractor's designated facilities or its subcontractors when ordered and

approved by the Contractor, including, but not limited to out-of-plan services which are covered under the Medicaid program and reimbursed at the Fee-For-Service Medicaid Rate.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another.

RHC - A South Carolina licensed rural health clinic is certified by the CMS and receives Public Health Services grants. An RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically under served area.

Risk - A chance of loss assumed by the Contractor which arises if the cost of providing core benefits and covered services to Medicaid MCO Program members exceeds the capitation payment by SCDHHS to the Contractor under the terms of the Contract.

Risk Corridor – A risk sharing mechanism in which States and Contractors share in both profits and losses under the Contract outside predetermined threshold amounts, so that after an initial Corridor in which the Contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

Routine Care - Is treatment of a condition which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

Service Area - The geographic area in which the Contractor is authorized to accept enrollment of eligible Medicaid MCO Program members into the Contractor's plan. The service area must be approved by SCDOI.

SCDOI - South Carolina Department of Insurance.

SCDHHS - South Carolina Department of Health and Human Services

SCDHHS Appeal Regulations - Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 at S.C. Code Regs. 126-150 et seq. and S.C. Code Ann. §§1-23-310 et seq. (1976, as amended).

SSA - Social Security Administration.

SSI - Supplemental Security Income.

Screen or Screening - Assessment of a member's physical or mental condition to determine evidence or indications of problems and the need for further evaluation or services.

Social Security Act - Title 42, United States Code, Chapter 7, as amended.

Social Services - Medical assistance, rehabilitation, and other services defined by Title XIX, SCDHHS regulations, and SCDHHS regulations.

South Carolina State Plan for Medical Assistance - A plan, approved by the Secretary of SCDHHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to recipients pursuant to Title XIX.

Subcontract - A written Contract agreement between the Contractor and a third party to perform a specified part of the Contractor's obligations as specified under the terms of the Contract.

Subcontractor - Any organization or person who provides any functions or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to SCDHHS under the terms of the Contract.

Targeted Case Management - Services which assist individuals in gaining access to needed medical, social, educational, and other services. Services include a systematic referral process to providers.

Termination - The member's loss of eligibility for the S.C. Medicaid MCO Program and therefore automatic disenrollment from the Contractor's plan.

Third Party Resources - Any entity or funding source other than the Medicaid MCO Program member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care provided to a Medicaid MCO Program member.

Third Party Liability (TPL) - Collection from other parties who may be liable for all or part of the cost of items or health care services provided to a Medicaid MCO Program member.

Title XIX - Title 42, United States Code, Chapter 7, subchapter XIX, as amended. (42 U.S.C.A. § 1396 et seq.)

UB-92 - A uniform bill for inpatient and outpatient hospital billing. The required form is the UB-92 HCFA 1450.

Urgent Care - Medical conditions that require attention within forty eight (48) hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

Validation – The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Well Care - A routine medical visit for one of the following: EPSDT visit, family planning, routine follow-up to a previously treated condition or illness, adult and/or any other routine visit for other than the treatment of an illness.

WIC - The Supplemental Food Program for Women, Infants, and Children which provides nutrition counseling, nutrition education, and nutritious foods to pregnant and postpartum women, infants, and children up to the age of two or children deemed nutritional deficient are covered up to age five who have a low income and who are determined to be at nutritional risk.

Appendix 1

Members' and Potential Members' Bill of Rights

Each Member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information—enrollment notices, informational materials, instructional materials, available treatment options and alternatives, etc.—in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and the Contractor in understanding the requirements and benefits of the MCO plan.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.

- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and the Contractor's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the Contractor's services, to include, but not limited to:

    - Benefits covered.
    - Procedures for obtaining benefits, including any authorization requirements.
    - Any cost sharing requirements.
    - Service area.
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals.
    - Any restrictions on member's freedom of choice among network providers.

  - Providers not accepting new patients.
  - Benefits not offered by the Contractor but available to members and how to obtain those benefits, including how transportation is provided.

- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:

  - What constitutes an emergency medical condition, emergency services, and post-stabilization services.
  - That Emergency Services do not require prior authorization.
  - The process and procedures for obtaining Emergency services.
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
  - Member's right to use any hospital or other setting for emergency care.
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c).

- To receive the Contractor's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way the Contractor, its providers or SCDHHS treat the members.

Appendix 2

PROVIDERS' BILL OF RIGHTS

Each Health Care Provider who contracts with DHHS or subcontracts with the MCO Contractor to furnish services to the members shall be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    - Any information the member needs in order to decide among all relevant treatment options.
    - The risks, benefits, and consequences of treatment or non-treatment.
    - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.
- To have access to the Contractor's policies and procedures covering the authorization of services.
- To be notified of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, on behalf of the Medicaid members, the denial of coverage of, or payment for, medical assistance.
- The Contractor's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification

Appendix 3

Transportation Broker Listing and Contact Information

Broker: <u>Medical Transportation Management (MTM)</u> If you live in one of these counties call: **1-866-831-4130** **Region 1** Abbeville Anderson Greenville Greenwood Laurens Oconee Pickens	**Broker: <u>Medical Transportation Management (MTM)</u>** If you live in one of these counties call: **1-866-831-4130** **Region 2** Cherokee Chester Lancaster Spartanburg Union York	Broker: LogistiCare If you live in one of these counties call: **1-866-431-9635** Region 3 McCormick Edgefield Saluda Newberry Lexington Fairfield Richland
Broker: LogistiCare If you live in one of these counties call: **1-866-445-6860** **Region 4** Aiken Allendale Barnwell Bamberg Orangeburg Calhoun Clarendon Kershaw Lee Sumter	Broker: LogistiCare If you live in one of these counties call: **1-866-445-8915** **Region 5** Georgetown Horry Marion Marlboro Williamsburg Chesterfield Darlington Dillon Florence	Broker: LogistiCare If you live in one of these counties call: **1-866-445-9954** Region 6 Berkeley Beaufort Charleston Colleton Dorchester Jasper Hampton

Appendix 4

State of South Carolina
Department of Health and Human Services

2008 Medicaid Managed Care Data Book

Prepared By:

Deloitte Consulting LLP

Jim Whisler, FSA, MAAA
Shannon Krygiel, FSA, MAAA
Dan Feucht, FSA, MAAA
Taylor Pruisner, FSA, MAAA

January 17, 2008

Table of Contents

Exhibits

I. Introduction

This Data Book is intended to provide historical fee-for-service (FFS) data on cost and utilization for the benefit of health plans, their actuaries, and other consultants. It provides all interested parties with the underlying FFS data that will be used to calculate HMO capitation rates effective April 1, 2008 – March 31, 2009 for those Managed Care Organizations (MCOs) contracting with the South Carolina Department of Health and Human Services (DHHS). Deloitte Consulting LLP (Deloitte Consulting) produced the Data Book on behalf of the DHHS.

Deloitte Consulting's objective is to provide a clear explanation of the FFS cost and utilization data provided herein.

The findings contained in the Data Book are based on information and data supplied by DHHS. Although Deloitte Consulting's analysis included a reasonableness review of the data received (both of the FFS and MCO encounter data), a separate audit or verification of the accuracy of the data supplied was not performed and it has been relied upon in arriving at conclusions.

The claims, enrollment, and utilization data presented in the next sections are based upon FFS experience of the South Carolina Medicaid Program during state fiscal years 2005, 2006, and 2007. The claims and utilization information has been summarized from the State's claims database. The claim information in this Data Book was included based on the criteria given to Deloitte Consulting by the State. The demographic information was captured from the State's eligibility files. The Data Book does not contain claims and utilization data for those recipients covered by MCOs.

Not all Medicaid recipients are eligible to enroll in the MCO Program. In addition, not all FFS claims and member months are applicable to MCO ratesetting. Coverage limits and parameters of the FFS program differ from that required for MCO coverage for some services. Adjustments to the FFS claims and exposures to account for these items were made. Specifics regarding the adjustments are described in this document.

FFS claims were adjusted for FFS program changes that occurred during or after the data period since MCOs must meet or exceed the current program benefit level. The claims were also adjusted for FFS provider reimbursement changes that were made during and subsequent to the historical data period. These specific adjustments are also outlined in this document.

II. Claim and Member Month Data Provided

DHHS provided Deloitte Consulting with three state fiscal years of claims and eligibility data.

The FFS claims data included claims incurred during the state fiscal years 2005, 2006, and 2007. The following claim files were provided for each of the years indicated:

- UB92 claims
- HCFA 1500 Form claims
- Nursing Home claims
- Prescription Drug claims

The Managed Care claims data includes encounters incurred during state fiscal years 2005, 2006, and 2007. This data is not part of this Data Book, and includes the MCO program and the PEP (PCCM) program. The following claim files were provided for each of the years indicated:

- Hospital Services encounters
- Ambulatory Services encounters
- Prescription Drug encounters

The recipient data includes both FFS and Managed Care enrollment during state fiscal years 2005, 2006, and 2007. The following recipient files were provided for the years indicated:

- Eligibility for Medicaid
- Eligibility for participating in one or more of the Recipient Special Programs (RSP)

The data sets provided by DHHS were generated by a data extraction from their historical data collection. Eligibility data was based upon eligibility for one month or more in any of state fiscal years 2005-2007. Claim data was based upon incurral dates in any of state fiscal years 2005-2007. For institutional claims, date of discharge was the basis for claim inclusion.

III. Data for Capitation Rate Development (Data Book Exhibits)

Exhibit A shows the claims and exposure data that were used in the development of MCO capitation rates.

Section IV of this document provides an overview of the adjustments and modifications applied to the raw claim and exposure data which resulted in the amounts in Exhibit A.

The data book includes data that reflects supplemental physician teaching payments. These payments represent approximately 35% of billed charges and are paid to participating physicians determined by DHHS.

There is a separate additional payment for newborns. The "Newborn Kicker Payment" (NKP) was developed and priced to cover the costs incurred by newborns during the month of birth. The regular Under Age 1 monthly capitation rate is not paid during the month of birth. MCOs will receive the Under Age 1 monthly capitation rate for subsequent months of newborn coverage. The NKP will not be paid if a baby is not delivered into the MCO.

Through a reinsurance arrangement, the FFS program takes financial responsibility for all hospital costs for those newborns spending more than 15 days in the hospital.

The Data Book exhibits reflect these modifications.

IV. Data Adjustments

Deloitte Consulting applied adjustments to the claims and enrollment data in order to modify FFS claims and exposures to use as a basis for the MCO capitation rate development.

Exhibit B contains the detailed logic and supporting tables utilized by Deloitte Consulting to extract claims and member months for inclusion into this Data Book. The criteria applied are as follows:

- Claims and member months were excluded for FFS recipients who were not eligible for the MCO Program,
- Claims were excluded for services that are outside the scope of the MCO Program.

Retroactive Eligibility Periods and Enrollment Lag

Recipient enrollment in the FFS program can and does occur retroactively. When an individual applies and qualifies for Medicaid coverage, DHHS reimburses claims which occurred during the retroactive qualification period prior to their application. The State backdates the eligibility of the individual to accommodate the retroactive coverage.

There is a lag between the first date of eligibility and the date of enrollment in a managed care plan. Factors which contribute to this lag include the fact that MCO enrollment is voluntary and Medicaid eligibility is always on the first day of the month in which the application was received. Once a Medicaid recipient signs up for an MCO, they will be enrolled on the first day of the subsequent month.

The retroactive enrollment period is not covered by the MCO. Retroactive exposure and claims were included in the data provided to Deloitte Consulting by the DHHS. They were removed for the purposes of this Data Book and subsequent capitation calculations using the following criteria:

If Payment Category in…	Retroactive/Lag is…
88	5 months
Any category other than 88	2 months

Exceptions to the retroactive eligibility month exclusion described above are cases where recipients have continuing coverage from the previous eligibility period (i.e. no lapse in eligibility). In these instances, all eligible months are used (even if the previous eligibility period corresponds with a Payment Category that is being excluded). Newborns are not subject to retroactive adjustments; therefore, their enrollment and costs were counted from the month of birth.

Adjustments for Differences between the FFS Data and Managed Care Programs

There are several differences between the FFS Medicaid data and the Managed Care programs with respect to covered benefits, limit thresholds, and reimbursement methods and levels. Adjustments were made to the FFS data to account for these differences to make the data appropriate for MCO rate setting.

- ***Federally-Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)***

  Under the FFS Medicaid Program, FQHCs and RHCs are paid on a per-encounter basis for all services provided during a visit. The raw claims experience reflects this payment difference from other providers. The claims data is adjusted so that FQHC and RHC payment levels are on a "per-claim" basis, making them equivalent to payment levels to other providers. Codes S4437 – S4440 and T1015 are re-priced to approximate the payment of 99213 plus $10 for other ancillary services provided during a visit. Codes 99381 – 99384 and 99391 – 99394 (EPSDT) were re-priced to FFS levels as well. The repricing only affected claims which were paid a greater amount than those shown below. The following shows the weighted cost for each of the three years:

Codes S4437 – S4440, T015

State Fiscal Year	Re-Priced Amount
2005	$44.88
2006	49.46
2007	51.81

EPSDT

Procedure Code	SFY05	SFY06	SFY07
99381	$52.00	$75.00	$78.75
99391	52.00	60.00	63.00
99382, 99383, 99384,99385	47.00	75.00	78.75
99392, 99393, 99394	47.00	60.00	63.00

- ***HOP Claims***

  The HOP Program was terminated in October 2005. No adjustment has been made to claims for the HOP program.

- ***Long-Term Care Coverage***

  The MCO Program covers the first 30 Long-Term Care (LTC) days per confinement. Once an enrollee reaches this limit they are released from the MCO plan. The FFS data contains all LTC days without limits. We adjust the data to account for this limit. Swing bed claims are included in the Data Book.

- ***Administrative Days***

  Payments to hospitals for Administrative Days are made periodically outside of the Medicaid claims payment system. Therefore, these payments must be added into the rates through an adjustment. These payments are added to the inpatient facility claims for the SSI eligibility category only.

- ***Graduate Medical Expense Payments***

  Graduate Medical Expense (GME) payments have been removed from inpatient hospital claims in the data.

- ***Mental Health Assessments Limited***

  Certain mental health assessments are limited to two sessions per calendar year after the claims period used to develop these rates. The CPT/HCPCS codes to be limited to two sessions each are CPTs 90801 and 90802. Dollars associated with sessions that exceeded the limit of two were removed from the data book to reflect this limitation.

- ***Audiology Claims***

  Several audiology services are covered under the MCO contract up to the limits specified below. Any services exceeding these limits have been removed.

Code/Modifier	Frequency
92552	6 every 12 months
92557	1 every 12 months
92557/52	6 every 12 months
92567	6 every 12 months
92584	1 per implant
92585	No limit
92585/52	No limit
92587	No limit
92588	No limit
92590	6 every 12 months
92592	6 every 12 months
92592/52	6 every 12 months
92626	10 per year
V5011	6 every 12 months
V5090	6 every 12 months
V5275/RT	6 every 12 months
V5275/LT	6 every 12 months

Incurred But Not Reported (IBNR) Claims

The claims data provided by DHHS includes claims that were incurred July 1, 2004 through June 30, 2007. Payments on these incurred claims are through September 30, 2007. According to DHHS personnel, all FFS claims must be submitted within one year following incurral in order for payment to be made. Therefore, an IBNR adjustment for claims incurred prior to July 1, 2006 was not made.

An IBNR study was performed as of June 30, 2007 for inpatient facility, outpatient facility and physician services in order to complete state fiscal year 2007 incurred claims. The adjustments that are applied to the state fiscal year 2007 claim information by service category are shown in the table below.

Service Category	SFY07 IBNR Adjustment
Facility – Inpatient	1.0294
Facility – Outpatient	1.0177
Facility – Emergency Room	1.0177
Professional – Primary Care	1.0304
Professional – Specialist	1.0304
Pharmacy	1.0000
Other Services	1.0304

Treatment of Deliveries and Family Planning Services

Newborn delivery claims and exposures are summarized separately so that a Maternity Kicker Payment (MKP) and Newborn Kicker Payment (NKP) can be calculated.

The MKP includes all facility and professional claims associated with newborn deliveries. The facility charges for deliveries that include sterilization are included in the MKP only for the Standard Rates. The MKP for ethically limited MCOs is slightly larger than the MKP for non-limited plans since the ethically limited MCOs will provide prenatal physician services to all women, but only collect a MKP for women who do not receive sterilization.

The NKP is the only payment a MCO will receive for the month a baby is born. The regular capitation rate for less than one-year-olds will be paid for subsequent months. The NKP includes all facility claims associated with newborn hospital stay of fewer than 15 days. Additionally, all physician and pharmacy claims within 15 days of the date of birth (regardless of the length of the hospital stay) are aggregated and placed into the Data Book under the category “Newborn Kicker.”

Newborns in the hospital for 15 days or more have their facility claims aggregated and placed in the Data Book under the Reinsurance category. Reinsurance covers all hospital services of newborns whose hospital admission is within 3 days of birth and whose length of stay is 15 or more days. Each hospital stay is counted separately, so a hospital transfer will be counted as two stays. Reinsurance covers only the hospital costs of the inpatient stay, excluding physician charges and charges after discharge.

Family planning services are summarized separately. These services are covered under standard rates but are excluded from ethically limited rates.

Other Data-Related Comments

Inpatient claims in the data set do not include payments to Disproportionate Share Hospitals (DSH). DHHS continues to pay applicable DSH payments to hospitals outside of the MCO reimbursement.

Large Claims are examined to determine if any smoothing of data is needed. It was determined that no smoothing adjustments are needed outside of newborn reinsurance.

The data reported in the data book is broken out into different service categories. Exhibit D outlines the definitions for those service categories.

Reimbursement Adjustments

July 1, 2005 Physician Fee Adjustment

Effective July 1, 2005 DHHS increased physician reimbursement. The State's physician fees changed to reflect 80% of the 2005 South Carolina Medicare RBRVS Fee Schedule. The impact of this fee adjustment was determined using CY04 claims data and the claims in the data book prior to 7/1/2005 were adjusted to reflect the expected impact. The percentage change by age band is shown below.

Aid Category	Physician Claim Impact
Family, Under Age 1, Male and Female	13.9%
Family, Age 1 – 6, Male and Female	18.4%
Family, Age 7 – 13, Male and Female	22.8%
Family, Age 14 – 18, Male	21.7%
Family, Age 14 – 18, Female	15.7%
Family, Age 19 – 44, Male	15.5%
Family, Age 19 – 44, Female	15.0%
Family, Age 45 and Older, Male and Female	16.2%
OCWI, Female	8.0%
SSI and SSI Related	18.1%

September 1, 2006 Physician Fee Adjustment

On September 1, 2006 a similar physician fee schedule change was made. Fees were increased from 80% of the 2005 South Carolina Medicare RBRVS Fee Schedule to 85% of the 2006 South Carolina Medicare RBRVS Fee Schedule. The impact of this fee adjustment was determined using CY05 claims data and the claims in the data book prior to 9/1/2006 were adjusted to reflect the expected impact. The percentage change by age band is shown below.

Aid Category	Physician Claim Impact
Family, Under Age 1, Male and Female	5.9%
Family, Age 1 – 6, Male and Female	5.6%
Family, Age 7 – 13, Male and Female	5.6%
Family, Age 14 – 18, Male	5.5%
Family, Age 14 – 18, Female	5.9%
Family, Age 19 – 44, Male	5.0%
Family, Age 19 – 44, Female	5.3%
Family, Age 45 and Older, Male and Female	4.2%
OCWI, Female	6.7%
SSI and SSI Related	4.5%

October 1, 2007 Inpatient/Outpatient/Physician Fee Adjustment

Effective October 1, 2007, DHHS implemented changes to their inpatient hospital, outpatient hospital, and physician FFS fee schedules. As a result, claims in the data book were revised to reflect these fee changes.

The inpatient claims were re-priced for state fiscal years 2005-2007 using the updated reimbursement levels effective October 1, 2007 provided by DHHS. The updated reimbursement rates were trended to the appropriate calendar year using a cost trend of 4% and a charge trend of 8.5%. These trended rates were then used to determine reimbursement for each inpatient admission based on DRG, hospital facility, and the charge level of the claim. Inpatient hospital outlier payment policies were revised as well as day/cost outlier thresholds, average length of stay, and relative weights effective October 1, 2007. The impact of these changes resulted in an aggregate inpatient increase of approximately 26.3%.

DHHS increased the outpatient facility fee schedule by 135% for all services. Since there were no methodology changes to outpatient payments, all outpatient facility claims were increased by 135% in the data book.

Similar to what was done in 2005 and 2006; DHHS updated their physician fee schedule from 85% of 2006 RBRVS to 86% of 2007 RBRVS. Using CY05 claim data, the estimated impact of this change on physician claims was determined. The percentage change to each age band is shown in the table below.

Aid Category	Physician Claim Impact
Family, Under Age 1, Male and Female	-2.10%
Family, Age 1 – 6, Male and Female	1.34%
Family, Age 7 – 13, Male and Female	0.77%
Family, Age 14 – 18, Male	1.18%
Family, Age 14 – 18, Female	0.80%
Family, Age 19 – 44, Male	1.95%
Family, Age 19 – 44, Female	1.29%
Family, Age 45 and Older, Male and Female	2.15%
OCWI, Female	-1.74%
SSI and SSI Related	2.12%

Baby Net and Sickle Cell Claims Removed

Claims relating to Baby Net and Sickle Cell services are removed from the databook because they are not covered under the MCO program.

Baby Net Claims were identified as follows: S7800, X7800, and T1016

Sickle cell claims were identified as follows: S1515, S1597, S1300, S1301, S1302, S0315, and S0316

Claim Criteria Changes

The following criteria adjustments were made in determining which claims to include in the Data Book:

- Codes were updated to account for HIPAA changes. Both the old and new code were used in the criteria to capture claims with either code
- Outpatient and Physician Dental services
- Physician Audiology services
- RSP/Payment Category Eligibility changes

The current criteria for claims to be included can be found in Exhibit B.

Exhibits

A. Data Book (Claims and Exposures)
B. Managed Care In-Rate Data Criteria
C. Coverage Grid
D. Service Category Grouping
E. Significant Reimbursement Changes In The South Carolina Medicaid Program

Exhibit B
(1 of 10)

State of South Carolina Department of Health and Human Services

Data Adjustment Specifications

STANDARD MANAGED CARE - In-Rate Criteria

Provider Type	Provider Specialty	Claim Type	Criteria
Non-Family Planning Services			
		A, D, G, Z	Recipient Payment Category Not = (10,15,33,41,42,43,48,49,50,52,53,54,55,56,70,90,92)
		A, D, G, Z	Age < 65 on date of service
		A, D, G, Z	Not enrolled in Medicare
	For HMO	A, D, G, Z	RSP-Pgm-Ind Not = (X,A,M,L,F,J,V,Q,S,T,G,K,R,U,W,N,Y,1,2,3,4)
00		G	Last 2 bytes of Provider Number = SB
01 or 02		Z	Provider Control Facility not = (010 OR 011)
01		Z	Provider Number Not = TR0001
01		Z	Provider Category of Service = 01 AND DRG not = (424 thru 437 OR 521 thru 523)
02		Z	Provider Number Not = TR0002
02		Z	Principal Diagnostic Class Code not = C
02		Z	Principle Surg Procs Not = (96.54 OR 23.00 through 24.99)
02		Z	Reimbursement = 1 AND Surg Proc not = (D0120 thru D9999 OR 41800 thru 41899)
		A	Procedure Code not = (S7800, X7800, T1016) – BabyNet Services AND Not = (H0002, H0031) – Mental Health Assessments, AND Not = (S1515, S1597, S1300, S1301, S1302, S0315, S0316) – Sickle Cell Services AND Procedure Code does not begin with a "D" – Dental Service
19	04, 06, 25, 86, 99	A	Procedure Code Not = S3260 OR (99420 with ('TG', '0TG' modifiers)) Audiology Services (19/04) subject to CPT AND CPT limits defined on page 8
21		A	Pay to Provider Number Not = TR0003
20 or 21		A	Provider Control Facility not = (010 OR 011)
20 or 21		A	Procedure Code Not = (S0150, S0151, S0152, S0153, 90882, 99371, S3260, (90853 with ('52', '052', 'HN', '0HN', 'HO','0HO', 'HP','0HP', '00', '000' modifiers)), (90847 with ('HN','0HN', 'HO','0HO','HP','0HP','HQ','0HQ', '00', '000' modifiers)), (99402 with ('HQ', '0HQ' modifiers)), (99403 with ('HQ', '0HQ' modifiers)), (99404 with ('HQ', '0HQ' modifiers)), (90804 with ('HN','0HN', 'HO','0HO', 'HP','0HP', '00', '000' modifiers)), (90806 with ('HN','0HN', 'HO','0HO', 'HP','0HP', '00', '000' modifiers)), (99420 with ('TG', '0TG' modifiers)))
20	31	A	Procedure Codes not =(92002, 92004, 92012, 92014, 92015, 92018, 92019, 92340, (99420 with ('TG', '0TG' modifiers)))
20 or 21		A	Only Procedure Codes = 90801, 90802 – limit of 2 / year

Exhibit B
(2 of 10)

State of South Carolina Department of Health and Human Services

Data Adjustment Specifications
Family Planning - In-Rate Criteria

Provider Type	Provider Specialty	Claim Type	Criteria
20 or 21	All specialties Except 48 or 49	A	All Other Procedure Codes
22	95,96,51,21,50,58, 93,94,97,98	A	Procedure Codes not = (X2040, X2041, S3260, (T1002, T1003), 99420 with ('TG', '0TG' modifiers))
22	95	A	First 2 bytes of Provider Number Not = SD OR Provider Control Facility not = (010 , 011, 021)
22	96	A	Provider Number not = MC0015 AND (Procedure Code not = S0700 thru S0703, inclusive, OR (99241-99245 with ('TF', '0TF' modifiers)), OR (S0315, S3016, 99204, 99213, 99214, 99215 AND Provider Number = MC0008, MC0009, MC0010, MC0011, MC0021, MC0040))
22	51	A	Prim Diag not in COMDHEC table AND (Proc code not = (99420 with ('TG', '0TG' modifiers)) OR Proc code not (T1017 OR T1027) with Provider Number from DHEC01 through DHEC46 OR DHEC59)
80		A	Provider Control Facility not = 017 AND Primary Diagnosis not in COMDHEC table
35, 36, 60, 76, 81, 82		A	All claims
70		D	All Claims

Non-Family Planning Services

		A, Z	Fund Code not in Family Planning Table
		A	Fund Code not = BE
70		D	All Claims except those with Fund Code in Family Planning Table
01		Z	Fund Code not = CG
01		Z	DRG not = 374 with Fund Code (2) = CF
02		Z	Fund Code not = DE

Exhibit B
(3 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Provider Type Codes

Code	Provider Type
00	NURSING HOME
01	INPATIENT HOSPITAL
02	OUTPATIENT HOSPITAL
10	MENTAL/REHAB
15	BUY-IN
16	EPSDT
19	OTHER MEDICAL PROF
20	PHYSICIAN,OSTEOPATH IND
21	PHYSICIAN,OSTEOPATH GRP
22	MEDICAL CLINICS
30	DENTIST, IND
31	DENTAL, GRP
32	OPTICIANS
33	OPTOMETRIST, IND
34	OPTOMETRIST, GRP
35	PODIATRIST, IND
36	PODIATRIST, GRP
37	CHIROPRACTOR, IND
38	CHIROPRACTOR, GRP
41	OPTICIAN, GRP
60	HOME HEALTH AGENCY
61	CLTC, INDIVIDUAL
62	CLTC, GROUP
70	PHARMACY
76	DURABLE MEDICAL EQUIPMENT
80	INDEPENDENT LABORATORY
81	X-RAY
82	AMBULANCE SERVICE
84	MEDICAL TRANSPORTATION
85	CAP AGENCIES
89	MCCA

Exhibit B
(4 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Provider Specialty Codes

Code	Provider Specialty
AA	PEDIATRIC SUB-SPECIALIST
00	NO SPECIFIC MEDICAL SPECIALTY
01	THERAPIST/MULTIPLE SPECIALTY GROUP
02	ALLERGY AND IMMUNOLOGY
03	ANESTHESIOLOGY
04	AUDIOLOGY
05	CARDIOVASCULAR DISEASES
06	MIDWIFE
07	CHIROPRACTIC
08	DENTISTRY
09	DERMATOLOGY
10	EMERGENCY MEDICINE
11	ENDOCRINOLOGY AND METAB.
12	FAMILY PRACTICE
13	GASTROENTEROLOGY
14	GENERAL PRACTICE
15	GERIATRICS
16	GYNECOLOGY
17	HEMATOLOGY
18	INFECTIOUS DISEASES
19	INTERNAL MEDICINE
20	PVT MENTAL HEALTH
21	NEPHROLOGY/ESRD
22	NEUROLOGY
23	NEUROPATHOLOGY
24	NUCLEAR MEDICINE
25	NURSE ANESTHETIST
26	OBSTETRICS
27	OBSTETRICS AND GYNECOLOGY
28	SC DEPT OF MENTAL HEALTH
29	OCCUPATIONAL MEDICINE
30	ONCOLOGY
31	OPHTHALMOLOGY
32	OSTEOPATHY
33	OPTICIAN
34	OPTOMETRY
35	ORTHODONTICS
36	OTORHINOLARYNGOLOGY
37	HOSPITAL PATHOLOGY
38	PATHOLOGY
39	PATHOLOGY, CLINICAL
40	PEDIATRICS

Exhibit B
(5 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Provider Specialty Codes - Continued

Code	Provider Specialty
41	PEDIATRICS, ALLERGY
42	PEDIATRICS, CARDIOLOGY
43	PEDODONTICS
44	INDEPENDENT LAB - PRICING ONLY
45	PHYSICAL MEDICINE & REHABILITATION
46	XRAY - LAB - PRICING ONLY
47	PODIATRY
48	PSYCHIATRY
49	PSYCHIATRY, CHILD
50	FEDERALLY QUALIFIED HEALTH CLINICS
51	SC DEPT OF HEALTH & ENVIRON CONTROL
53	NEONATOLOGY
54	RADIOLOGY
55	RADIOLOGY, DIAGNOSTIC
56	RADIOLOGY, THERAPEUTIC
57	RHEUMATOLOGY
58	FEDERALLY FUNDED HEALTH CLINICS (FF
59	SUPPLIER (DME)
60	HOME HEALTH - PRICING ONLY
61	SURGERY, CARDIOVASCULAR
62	SURGERY, COLON AND RECTAL
63	SURGERY, GENERAL
64	AMBULANCE - PRICING ONLY
65	SURGERY, NEUROLOGICAL
66	SURGERY, ORAL (DENTAL ONLY)
67	SURGERY, ORTHOPEDIC
68	SURGERY, PEDIATRIC
69	SURGERY, PLASTIC
70	SURGERY, THORACIC
71	SURGERY, UROLOGICAL
72	CLINIC SCREENERS - PRICING ONLY
73	PHYSICIAN SCREENERS - PRICING ONLY
74	PROSTHETICS & ORTHOTICS PRICE ONLY
75	INDIVIDUAL TRANS - PRICING ONLY
76	CAP - PRICING ONLY
77	CLTC
78	MULTIPLE SPECIALTY GROUP
79	PHYSICIAN ASSISTANT (ENCOUNTER DAT
80	OUTPATIENT-PRICING ONLY
81	OUTPATIENT-ALTERNATE PRICING SPECIA
82	PSYCHOLOGIST
83	SOCIAL WORKER

Exhibit B
(6 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Provider Specialty Codes - Continued

Code	Provider Specialty
84	SPEECH THERAPIST
85	PHYSICAL/OCCUPATIONAL THERAPIST
86	NURSE PRACTITIONER
87	OCCUPATIONAL THERAPIST
88	HOSPICE
89	CORF
90	ALCOHOL & SUBSTANCE ABUSE
91	MENTAL RETARDATION
92	SC CONTINUUM OF CARE
93	AMBULATORY SURGERY
94	DIABETES EDUCATOR
95	DEVELOPMENTAL REHABILITATION
96	FAMILY PLANNING, MATERNAL & CHILD H
97	RURAL HEALTH CLINICS (RHC)
98	PRIVATE DUTY NURSING
99	PEDIATRIC NURSE PRACTITIONER

Exhibit B
(7 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Claim Type Codes

Code	Claim Type
A	HCFA 1500 Form Claims
C	Medical Transportation Claims
D	Prescription Drug Claims
G	Nursing Home Claims
Z	UB92 Claims

Exhibit B
(8 of 10)

State of South Carolina Department of Health and Human Services

Data Adjustment Specifications
Recipient Payment Categories

Code	Payment Category
10	MAO (NURSING HOMES)
11	MAO (EXTENDED TRANSITIONAL)
12	OCWI (INFANTS UP TO AGE 1)
13	MAO (FOSTER CARE/SUBSIDIZED ADOPTION)
14	MAO (GENERAL HOSPITAL)
15	MAO (CLTC WAIVERS)
16	PASS-ALONG ELIGIBLES
17	EARLY WIDOWS/WIDOWERS
18	DISABLED WIDOWS/WIDOWERS
19	DISABLED ADULT CHILD
20	PASS-ALONG CHILDREN
30	AFDC (FAMILY INDEPENDENCE)
31	TITLE IV-E FOSTER CARE
32	AGED, BLIND, DISABLED
33	ABD NURSING HOME
40	WORKING DISABLED
41	REINSTATEMENT
42	Silver Card and SLMB
43	Silver Card and S2 SLMB
48	S2 SLMB
49	S3 SLMB
50	QUALIFIED WORKING DISABLED (QWDI)
51	TITLE IV-E ADOPTION ASSISTANCE
52	SLMB
54	SSI NURSING HOMES
55	FAMILY PLANNING
56	COSY/ISCEDC
57	KATIE BECKETT CHILDREN - TEFRA
58	FAMILY INDEPENDENCE SANCTIONED
59	LOW INCOME FAMILIES
60	REGULAR FOSTER CARE
68	FI-MAO WORK SUPPLEMENTATION
70	REFUGEE ENTRANT
71	BREAST AND CERVICAL CANCER
80	SSI
81	SSI WITH ESSENTIAL SPOUSE
85	OPTIONAL SUPPLEMENT
86	OPTIONAL SUPPLEMENT & SSI
87	OCWI (PREGNANT WOMEN and INFANTS)
88	OCWI (CHILDREN UP TO AGE 19) PHC
90	QUALIFIED MEDICARE BENEF (QMB)
91	RIBICOFF CHILDREN
92	SILVERCARD

Exhibit B
(9 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Provider Category of Service

Code	Provider Category of Service
01	INPATIENT HOSP GEN
03	INPATIENT HOSP MENTAL
04	RESIDENTIAL TREAT FAC
06	CLIN SVCS-MENTL/REHAB
07	OUTPATIENT HOSP GEN
08	HMO
10	NH-INST MNTAL DISEASE
11	SKILLED NURSING FAC
12	SNF TB
13	ICF-MENTAL RETARDTION
16	INTERMED CARE FAC-ICF
19	CLTC SERVICE
20	HOME HEALTH SVCS
22	BUY-IN
23	(INDEP) LAB/X-RAY
27	FAMILY PLANNING SVCS
30	PRESCRIBED DRUGS
32	DURABLE MEDICAL EQUIP
37	AMBULANCE SERVICE
40	EPSDT SCREENING
41	EPSDT DIAG & TREAT
43	PHYS & OSTEO SVCS
45	DENTAL SVCS
47	OPTOMETRIC SVCS
55	PODIATRISTS SVCS
57	CHIROPRACTIC SVCS
61	MEDICAL TRANS
70	CLINICAL SVCS
71	PARAPROF SVCS
72	MISCELLANEOUS
99	OTHER

Exhibit B
(10 of 10)

State of South Carolina Department of Health and Human Services
Data Adjustment Specifications
Waiver Program Codes (RSP Codes)

Code	RSP IND	Description
CLTC	A	COMMUNITY LONG TERM CARE ELDERLY DISABLED
HRHI	B	AT RISK PREGNANT WOMEN - HI
CHPC	C	CHILDRENS PERSONAL CARE AID
HRLO	D	AT RISK PREGNANT WOMEN - LOW
COSY	E	EMOTIONALLY DISTURBED CHILDREN IN BEAUFORT
HIVA	F	CLTC HIV AIDS
MCPP	G	PHYSICIANS ENHANCED PROGRAM
HREX	H	AT RISK PREGNANT WOMEN - EX
ISED	I	EMOTIONALLY DISTURBED CHILDREN
PSCA	J	PALMETTO SENIOR CARE
MCHS	K	HOSPICE
DMRN	L	DEPT OF RETARDATION WAIVER NEW
DMRE	M	DEPT OF RETARDATION WAIVER ESTABLISHED
MCHM	N	HEALTH MAINTENANCE ORGANIZATION
ALVG	Q	CLTC ASSISTED LIVING WAIVER
MCRH	R	RURAL BEHAVIOR HEALTH SERVICES
HSCE	S	HEAD AND SPINAL CORD ESTABLISHED
HSCN	T	HEAD AND SPINAL CORD NEW
MCFC	U	MEDICALLY FRAGILE CHILDREN'S PROGRAM
VENT	V	CLTC VENTILATOR WAIVER
MCNF	W	MEDICALLY FRAGILE NON-FOSTER CARE
MCPA	X	PEP ASTHMA
ASTH	Y	NON PEP ASTHMA
MCPC	Z	INTEGRATED PERSONAL CARE SERVICE CRCF RECIPS
MCPL	1	PEP LEAD
LEAD	2	NONPEP LEAD
SCCH	3	SOUTH CAROLINA CHOICE
NHTR	4	NURSING HOME TRANSITION
MCCM	5	MEDICAL HOME LOCAL NETWORK

Exhibit C
(1 of 2)

State of South Carolina Department of Health and Human Services
Coverage Grid
Fee-For-Services Program and Managed Care Program Benefits

Service	FFS Program	HMO Program with Ethical Limitations	HMO Program without Ethical Limitations
Inpatient	Covered, no limits	Covered, referral required, newborn reinsurance applies	Covered, referral required, newborn reinsurance applies
Outpatient	Covered, no limits	Covered, referral required	Covered, referral required
Physician Services	Adults: limited to 12 visits per year; Children < 21: unlimited	Adults: limited to 12 visits per year; Children < 21: unlimited	Adults: limited to 12 visits per year; Children < 21: unlimited
Maternity Services	Covered, no limits	Covered, no limits	Covered, no limits
Family Planning	Covered	Not covered (paid FFS)	Covered
Communicable Disease Services	Covered, no limits	Covered, no limits	Covered, no limits
Independent Lab and X-Ray	Covered, no limits	Covered, no limits	Covered, no limits
DME	Covered, no limits	Covered, no limits	Covered, no limits
Prescription Drugs	Adults: limited to 4 prescriptions per month (some drugs exempted); Children < 21: unlimited	Adults: limited to 4 prescriptions per month (some drugs exempted); Children < 21: unlimited	Adults: limited to 4 prescriptions per month (some drugs exempted); Children < 21: unlimited
Prescription drug copayment	$3.00	$3.00	$3.00
Podiatry	No limit	No limit	No limit

Exhibit C
(2 of 2)

State of South Carolina Department of Health and Human Services
Coverage Grid
Fee-For-Services Program and Managed Care Program Benefits

Service	FFS Program	HMO Program with Ethical Limitations	HMO Program without Ethical Limitations
Transportation	Covered if medically necessary, non-emergency coordinated through DSS	Covered if delivered via ambulance, non-ambulance is paid FFS	Covered if delivered via ambulance, non-ambulance is paid FFS
Home Health Services	75 visits per member per year	75 visits per member per year	75 visits per member per year
Institutional Long term Care/Nursing home Care	Covered, no limits	First 30 days covered, remainder paid FFS	First 30 days covered, remainder paid FFS
Mental Health/Substance Abuse	Covered, No limits	Only assessments (specified in HMO contract) covered, remainder paid FFS	Only assessments (specified in HMO contract) covered, remainder paid FFS
Vision Care	Vision test: one per 12 months; Glasses: Children 1 pair and 1 replacement per 12 months, adults only following cataract or detached retina services	Not covered (paid FFS)	Not covered (paid FFS)
Dental Services	Routine: only < age 21 Emergency covered	Not covered (routine <21 paid FFS)	Not covered (routine <21 paid FFS)
Chiropractic Services	Limited to 12 visits per year	Not covered (paid FFS)	Not covered (paid FFS)

Exhibit D

Service Category Grouping

ACTUARY SERVICE DESCRIPTION	DHHS DESCRIPTION	TECHNICAL DESCRIPTION/COMMENTS
1. Facility - Inpatient (Excluding Delivery and Family Planning)	Inpatient hospital services excluding delivery with sterilization No delivery services No family planning services Includes Swing bed services	Provider type = 01 • DRG not = 370 - 373, 375 (delivery) • Fund Code not = Family Planning Provider type = 00 and last 2 bytes of provider number = SB **Note: Does not include DRG 374 delivery with sterilization.**
2. Facility - Outpatient (Excluding Delivery and Family Planning)	Outpatient hospital services Ambulatory Surgery Centers ESRD Centers No Outpatient ER services No delivery services No family planning related services	Provider type = 02 and not = ER(reimbursement type =5 and revenue code = 450) • Primary diagnosis code not = v27.0 - v27.9, 650, (651.01 - 669.92 with a 5th digit = 1 or 2) and reimbursement type = 1 • Fund Code not = Family Planning Provider type/practice specialty = 22/93(ASC) Provider type/practice specialty = 22/21(ESRD)
3. Facility - Emergency Room (Excluding Delivery and Family Planning)	Outpatient ER services No family planning related services	Provider Type = 02 and reimbursement type = 5 with revenue code 450 • Fund Code not = Family Planning
4. Professional - Primary Care (Excluding Delivery and Family Planning)	Physician/Primary Care OB/GYN FQHC RHC FFHC DHEC	Provider type = 20/21 w/ practice specialty 12(Family Practice), 14(General Practice), 32(Osteopathy), 40(Pediatrics),19(Internal medicine), 16(Gynecology), 26(Obstetrics),27(Obstetrics & Gynecology) Provider type = 22/50(FQHC) Provider type = 22/51(DHEC) Provider type = 22/58(FFHC)

ACTUARY SERVICE DESCRIPTION	DHHS DESCRIPTION	TECHNICAL DESCRIPTION/COMMENTS
	Nurse Midwife Nurse Practitioner No delivery services No family planning related services	Provider type = 22/97(RHC) Provider type = 19/06(Nurse Midwife) Provider type = 19/86(Nurse Practitioner) • Procedure code not = delivery • Fund Code not = Family Planning
5. Professional - Specialist (Excluding Delivery and Family Planning)	Physician/Specialist Certified Registered Nurse Anesthetist No delivery services No family planning related services	Provider type = 20/21 w/ practice specialty not = 12(Family Practice), 14(General Practice), 32(Osteopathy), 40(Pediatrics),19(Internal medicine), 16(Gynecology), 26(Obstetrics),27(Obstetrics & Gynecology) Provider type = 19/25 (CRNA) • Procedure code not = delivery • Fund Code not = Family Planning
6. Pharmacy - Family Planning (Including family planning services only)	Family planning pharmacy services only.	Provider Type = 70 • Fund Code = family planning
7. Pharmacy - All Other (Excluding Family Planning)	Pharmacy Services No family planning related services	Provider Type = 70 • Fund Code not = family planning **Comment:** For pharmacy claims, costs shown are net of copays. Managed Care enrollees will be expected to pay the same copay level as FFS Medicaid.
8. Maternity - Delivery (Excluding Deliveries with Sterilizations)	Inpatient hospital delivery services excluding delivery with sterilization. Outpatient hospital delivery services Outpatient ER delivery services	Provider type = 01 • DRG= 370 - 373, 375 (delivery) Provider type = 02 • Primary diagnosis code = v27.0 - v27.9, 650, (651.01 - 669.92 with a 5th digit = 1 or 2) and reimbursement type = 1 Provider type = 20/21

ACTUARY SERVICE DESCRIPTION	DHHS DESCRIPTION	TECHNICAL DESCRIPTION/COMMENTS
	Professional-Primary Care delivery services Professional - Specialist delivery services	Provider type = 22/50(FQHC) Provider type = 22/51(DHEC) Provider type = 22/58(FFHC) Provider type = 22/97(RHC) Provider type = 19/06(Nurse Midwife) Provider type = 19/86(Nurse Practitioner) • Procedure code = delivery (see Attachment A) **Note: Maternity kicker for non-ethically limited plans includes DRG 374 with sterilization (fund code = CA/CF)**
9. Family Planning	Family Planning Services	Fund Code = Family Planning Fund Code
10. All Other Services	Home Health DME Ambulance Transportation Podiatry Lab and X-ray Diabetes Education Private Duty Nursing Developmental Rehabilitation Clinic Maternal and Child Health Clinic Mental Health Assessments By Clinics	Provider type not = 01(inpatient) Provider type not = 02(outpatient) Provider type not = 20/21 Provider type not = 70(pharmacy) Provider type not = 22/93 (ASC) Provider type not = 22/21(ESRD) Provider type not = 22/50(FQHC) Provider type not = 22/51(DHEC) Provider type not = 22/58(FFHC) Provider type not = 22/97 (RHC) Provider type not = 19/06(nurse midwife) Provider type not = 19/86 (nurse practitioner) Provider type not = 19/25(CRNA)

Exhibit E

Significant Reimbursement Changes In The South Carolina Medicaid Program

Effective Date of Program Change	Description of Program Change	Aid Category Affected
January 2002	DME: Non-coverage of procedure codes: L3000-L3003, L3010, L3020. L3030, L3040, L3050, L3060, L3080, L3090, L3100. L3140, L3150, L3170, L3201-L3204, L3206-L3209, L3211, L3216-L3218, L3221-L3223, L3230, L3250-L3252, L3257, L3260, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3350, L3360, L3380, L3390, L3400, L3530, L3540, L3550, L3560, L3570, L3580, L3590, S1835, S1860, S1869, S1877-S1879, S1888, S1889, S1928-S1930, S1941, S1943, S1948, S1952, S1969, S1984, S1926, S1944, S1979.	All
	Increase HMO rates	All
	Increase Pediatric Sub-specialist Rate for certain CPT codes.	Family age < 19; SSI w/out Medicare
February 2002	Rate increase for vaginal and Cesarean deliveries	Family and OCWI Women age 14-44
May 2002	Eliminate 150% lump sum payment adjustment for SC non-state government owned or operate hospitals	All
July 2002	Increase Pharmacy Dispensing Fee from $2.00 to $4.05	All
	Increase Emergency Basic Life Support, Advanced Life Support, Wheelchair Ambulance Transportation Services	All

Effective Date of Program Change	Description of Program Change	Aid Category Affected
	Increase reimbursement for Rabies Vaccine and add coverage for Rabies Immune Globulin	All
September 2002	Ortho Patch added as a reimbursable family planning service	Family and OCWI Women age 14-44
October, 2002	Reinstate Psychological Services under the supervision of a Physician	All
	Physician (Primary and Specialty Care Providers) rate increase	All
	Nuva Ring added as a reimbursable family planning service	Family and OCWI Women age 14-44
	Redefine high volume adjuster payments to include the un-reimbursed Medicaid outpatient cost of the high volume hospitals	All
	Swing bed rate increase of 11.14%	All
	Administrative day rate increase of 10.50%	All
	Cost avoidance claims processing replaces “pay and chase” in COB for pharmacy claims	All
January, 2003	Laboring Epidural rate increase	Family and OCWI Women age 14-44
	Added coverage for Diabetic Testing Strips	All

Effective Date of Program Change	Description of Program Change	Aid Category Affected
	Annual retrospective inpatient and outpatient public hospital cost settlements. This change eliminates the high volume adjustment payments.	All
April, 2003	DME fee schedule updated	All
	The Medicare inpatient and outpatient hospital crossover payment methodology was amended to reflect the SCDHHS payment as the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible.	All
July, 2003	Nursing reimbursement to include LPN services added in 2003. Expenditures for School Based nursing services (fund code TD) were $258,628 for FY'03 vs. $617,083 for YTD 7/03-12/03.	All School Based Services
	HMO rate increase effective July 1, 2003	HMO recipients
October, 2003	Swing Bed Rate increased from $107.97 to $116.13. Administrative Day Regular Rate Increased from $115.08 to $123.57 Administrative Day Intensive Rate Increased from $180.00 to $188.00	Primarily SSI and SSI-Related
	Annual retrospective inpatient and outpatient hospital cost settlements for private disproportionate share hospitals (DSH)	All
	Outpatient Hospital lump sum payment adjustments for public disproportionate share hospitals eliminated. Adjustments originally added in October 2001.	All
	Family Planning rate increases effective 10/16/03	FP recipients

Effective Date of Program Change	Description of Program Change	Aid Category Affected
January 2004	Maximum Quantity Limits program implemented by Pharmacy Services.	All
	Prescription Limit Override Restrictions	All
February, 2004	DMH added a new service, Peer Support Services (H0038) at a rate of $11.00 per unit, with a maximum of sixteen 15 minute unites per day.	All
March, 2004	DAODAS added a new service, Caregiver Group (H2017) at a rate of $4.00 per 15-minute unit, with a maximum of 24 units per day.	All
	Implemented Copays for the following services: • Physician Office Visits ($2.00 copay) • DME ($3.00 copay) • Optometrist ($2.00 copay) • Chiropractor ($1.00 copay) • Podiatrist ($1.00 copay) • Home Health ($2.00) • FQHC's ($2.00) • RHC's ($2.00) • Ambulatory Surgical Clinic ($2.00) • Dentist ($3.00) • Pharmacy (now applies to 19 and above instead of 21 and above) ($3.00 copay) • Inpatient Hospital ($25.00 copay) • Outpatient Hospital (Non ER) ($3.00 copay) • Nurse Practitioner / Midwife ($2.00)	• Age 19 + • Non-waiver recipients • Non-pregnancy related • Non-emergency

Effective Date of Program Change	Description of Program Change	Aid Category Affected
May 2004	Preferred Drug List (PDL) phase-in begins with soft editing; hard editing implemented July 2004	All
July 2004	Increase in reimbursement rates for Orthodontic services	Recipients <21 years old
	Increase in the reimbursement rate for the Pediatric Day Treatment (Wonder Center) at Greenville Hospital System DEC from $116/day to $173/day	Recipients <21 years old
	Decrease in reimbursement rate for Medical Management Support at DDSN from $46.50/day to $46.00/day	Adults
	Contractual Transportation Rate Changes, based on cost projections submitted by providers	All
	Special Needs Transportation rate increase from $15.96 to $17.78 per diem (rate increase based on cost settlement)	Recipients <21 years old
	Genetics Service Coordination added as a DDSN Medicaid-billable service from the DDSN Administrative contract activities	All
September 2004	New managed care program, PCCM or Medical Homes Program, began operations. Payments include a Per Member Per Month (PMPM) payment for a regional board, a PMPM for primary care physician overseeing patient's care, and enhanced reimbursement rates for primary care physician.	All
October 2004	Coverage of tobacco cessation products	All
	Swing Bed rate increase from $116.13 to $121.92 Admin Day Regular rate increase from $123.57 to $129.75 Admin Day Intensive rate increase from $188.00 to $197.00	Primarily SSI & SSI Related

Effective Date of Program Change	Description of Program Change	Aid Category Affected
November 2004	State Plan Private Duty Nursing Service rates increased. LPN rate increased from $20/hour to $23/hour; RN increased from $30/hour to $31/hour	Recipients < 21 who meet medical criteria
	Home and Community-Based (HCB) waiver Nursing Service rates increased. LPN rate increased from $20/hour to $23/hour; RN rate increased from $30/hour to $31/hour.	Waiver recipients in Vent, HIV/Aids, MR/RD, HASCI
December 2004	DME fee schedule updated	All
January 2005	Home and Community-Based waiver Adult Day Health Care Service rate increased from $38/day to $40/day.	Waiver recipients in E/D and MR/RD
	Pharmacy prior authorization of growth hormone products	All
	Increase in capitated reimbursement rate for Palmetto Senior Care Program of All-inclusive Care for the Elderly (PACE) from $2,246 to $2,304	PACE recipients
April 1, 2005	Tooth Bundling: For single surface billings billed on same tooth on same DOS, reimbursement will be at a bundled rate instead of individual surface rates	Recipients < 21 and MR/RD waiver recipients
	Rate reduction for Preventive/Rehab Services for Primary Care enhancement (PRSPCE)	All
May 2005	Implemented two new Administrative Service Organizations (ASO) for the PCCMs. ASOs will be paid a PMPM.	PCCM recipients
July 1, 2005	Physician fee schedule updated to 80% of Medicare fee schedule	All

Effective Date of Program Change	Description of Program Change	Aid Category Affected
	Rate increase for Medically Fragile Children's Program	MFCP recipients
	MAPPS rate change and programmatic changes limit the amount of service each recipient may receive.	Recipients < 21
	Changes for family planning counseling and education codes to prohibit the use of these codes in addition to family planning office visit codes on the same day .	FP recipients
	Programmatic changes to P/RSPCE services limit the amount of service each recipient may receive.	All
	Discontinue reimbursement for Pregnancy / Newborn Risk Assessments (Form 204)	Pregnant Women and Newborns
	Contractual Transportation provider rate adjustments of 6 to 8 cents per passenger mile	All
	Procedure code A0431 Rotary (helicopter) Ambulance rate increase from $400 / transport to $2,000 / transport and omission of procedure code A0436 Rotary Ambulance Air Mileage	All
	Division of Preventive and Ancillary Health Services: School-Based Services (SBS) Unit increased the SBS Rehabilitative Therapy rates (to 100% of Medicare) for the Local Education Agencies (LEAs). The Rehabilitative Services include Physical Therapy, Occupational Therapy, Speech Language Pathology and Audiology.	Children 0-21 receiving school-based services
October 1, 2005	Swing Bed rate increase from $121.92 to $129.16 Admin Day Regular rate increase from $129.75 to $136.99 Admin Day Intensive rate increase from $197.00 to $206.00	Primarily SSI & SSI-related

Effective Date of Program Change	Description of Program Change	Aid Category Affected
	Payments to trauma hospitals and trauma professionals from a Trauma Fund	All
	A $214.5 million increase in the hospital tax. All SC general hospitals can participate in the Disproportionate Share Hospital Program. This adds 11 non-public hospitals that can be reimbursed for their uninsured patients and receive Medicaid inpatient and outpatient cost settlement payments. The amounts reflected as the "Estimated Financial Impact" represent Medicaid IP and OP cost settlement payment amounts only.	All
	Prospective and retrospective Private DSH hospitals' IP and OP Medicaid cost settlements will be reimbursed at 100% instead of 90%.	All
	HOP program discontinued effective October 1, 2005 due to the Physician fee schedule change bringing the reimbursement schedule up to 80% of Medicare. No financial advantage in continuing the program for HOP providers.	HOP providers only
January 1, 2006	Implementation of Medicare Part D Prescription Drug Programs	All dual eligibles
	Termination of SILVERxCARD Program	Pay Cat 92
	Termination of the Alternate Reimbursement Methodology (ARM) Program	Nursing home patients residing in facilities served under ARM
February, 2006	CMS authorized the expansion of the Pediatric Sub-specialist program. Affiliation with the Children's Hospital Collaborative is no longer necessary.	Pediatric Sub-specialist

Effective Date of Program Change	Description of Program Change	Aid Category Affected
July 1, 2006	DSS announcement not to renew BHS Case Management Services for Adults 18+ in Protective Services and Children 0-21 in Foster Care contract #C6 3668 M	Adults 18+ in protective svcs.; Foster care children 0-21
	DSS announcement not to renew BHS Purchase and Provision of Case Management (ISCEDC) contract #C6 3008 M	DSS MTS clients
	Integrated Personal Care (IPC) rate increase from $12.80 to $14.80 per day.	Adults 18+ who are unable to live independently and require assistance with activities of daily living who receive OSS
	Optional State Supplementation (OSS) rate increase from $900 to $985 maximum payment facilities are paid.	Adults 18+ who are unable to live independently who reside in a licensed CRCF that participate in the OSS program
	Hospice rate increase (Annual change in Medicaid rates as issued by CMS)	All
	Home Health included Medical Social Services within State plan	All
	Home and Community-Based Waiver Personal Care II Service rate increased from $12.80 to $14.80 per hour.	Children's Personal Care and Waiver Recipients in the MR/RD, VENT, HIV/AIDS and CC waivers

Effective Date of Program Change	Description of Program Change	Aid Category Affected
	State Plan Plan Private Duty Nursing Service rates increased. LPN rate increased from $23/hour to $24/hour; RN increased from $31/hour to $32/hour	Recipients <21 who meet medical criteria
	Home and Community-Based (HCB) waiver Nursing Service rates increased. LPN rate increased from $23/hour to $24/hour; RN rate increased from $31/hour to $32/hour.	Waiver recipients in the VENT, HIV,MR/RD and HASCI waivers
	Home and Community-Based waiver Adult Day Health Care Service rate increased from $40/day to $42/day.	Waiver recipients in CC and MR/RD
	Part D PACE rate update: Rate increase from $3,301.00 to $3,668.00 for Medicaid only participants and from $1,934.00 to $2,246.00 for dual eligible participants. (Pending CMS approval)	PACE participants
September 1, 2006	Physician fee schedule updated from 80% to 85% of Medicare fee schedule	All
	Home and Community-Based waiver Personal Care I Service rate increased from $10.10/hour to $11.10/hour	Waiver recipients in CC,HIV,VENT and MR/RD
	Home and Community-Based waiver Attendant Care Service rate increased from $11/30/hour to $12.30/hour	Waiver recipients in CC,HIV,VENT,MR/RD, and HASCI waivers
	Home and Community-Based waiver meals rate increased from $4.75/meal to $5.00/meal	Waiver recipients in CC, and HIV waivers
	Home and Community-Based waiver companion rate increased from $7.00/hour to $8.00/hour for company companion and from $7.80/hour to $8.80/hour for individual companion.	Waiver recipients in CC, and HIV waivers.
October 1, 2006	Trauma Payments Funding no longer included in SCDHHS budget	All

Effective Date of Program Change	Description of Program Change	Aid Category Affected
October 15, 2006	Synagis® may be billed to Medicaid by either physician or pharmacy providers, regardless of whether the drug was administered in a physician's office or other clinical setting	Children < 24 months old
	Increase Synagis® Injection to AWP – 15%	All
November 1, 2006	Increase EPSDT rates by 5%	Children

Appendix 5

South Carolina 2007 Managed Medicaid Rate Setting Assumptions
Rates effective 4/1/2008 – 3/31/2009

This document serves as a bridge between the data book and the final rates as calculated by Deloitte Consulting and the South Carolina Department of Health and Human Services (DHHS). The assumptions and adjustments used in the final rate setting are discussed with and approved by DHHS. These rates are updated from the October 1, 2007 rates based on updated claims data and assumptions. The rates are effective for the period April 1, 2008 through March 31, 2009.

	Rates Effective 4/1/2008 and 10/1/2007 Rates			
	Universe (Ethically Ltd)		Universe (Standard)	
	10/1/07 Rate	4/1/08 Rate	10/1/07 Rate	4/1/08 Rate
Under Age 1, Male and Female	$355.68	**$316.69**	$355.68	**$316.69**
Age 1 - 6, Male and Female	$105.86	**$98.95**	$105.89	**$98.95**
Age 7 - 13, Male and Female	$88.44	**$83.85**	$93.38	**$85.69**
Age 14 - 18, Male	$87.66	**$85.12**	$91.58	**$86.90**
Age 14 - 18, Female	$116.20	**$113.66**	$130.47	**$122.34**
Age 19 - 44, Male	$203.89	**$209.24**	$204.10	**$209.35**
Age 19 - 44, Female	$275.45	**$266.20**	$285.20	**$273.80**
Age 45+, Male and Female	$456.29	**$458.13**	$456.83	**$458.67**
OCWI	$346.57	**$359.91**	$362.66	**$372.53**
SSI and SSI Related	$524.35	**$698.38**	$525.94	**$699.54**
Maternity Kicker Payment	$5,487.08	**$5,468.17**	$5,402.37	**$5,411.20**
Newborn Kicker Payment	$1,756.33	**$1,575.70**	$1,756.33	**$1,575.70**

Administration Expense

The administration expense allowances included in the calculation of the rates are shown below. The administrative load is based on public insurance filings as well as a review of comparable Medicaid programs. This load is calculated as a percentage of total revenue, not as a percentage of claims.

Administrative Expense Load	13.0%

Trend Rates

The trend rates shown below were calculated using fee-for-service (FFS) data and the expected impact of future budget allocations. These trend assumptions have been approved by SC DHHS.

The trends reflect per member per month cost changes including changes due to utilization, mix of services, and unit cost changes. Assumed trend rates for state fiscal year 2007 to the rating period are based on market experience and state historical trends. The trending period corresponds to rates for April 1, 2008 - March 31, 2009.

Trend Rates	Medical	RX
Non-SSI Non-Family Planning	5.0%	9.0%

SSI Non-Family Planning	9.0%	9.0%
Family Planning Services	5.0%	9.0%

Pharmacy Rebate

A pharmacy rebate assumption of 32.0% was used in the rate setting. This figure represents average rebates received by the State for CY 2005 and 2006 from the Federal Rebate Program. The rebate percentage assumes that the HMO cost is on par with what the State would pay.

Pharmacy Rebate Percentage	32.0%

Managed Care Savings Assumptions

The following shows the managed care savings assumptions used in the rate setting. The savings is based on market experience and industry studies for a well-managed HMO.

Managed Care Savings Reduction

	Fac – IP	Fac – OP	Fac - ER	Prof – PC	Prof - SC	Pharm	Other Services
All rate cells	20.0%	15.0%	30.0%	-5.0%	15.0%	10.0%	20.0%

Risk Adjustment Application

An adverse selection adjustment to account for the difference in health status was not applied.

Third Party Liability (TPL)

The rates were adjusted to reflect the actual amount of pay-and-chase TPL in the FFS Medicaid program. The HMO is expected to pursue their own TPL, and their recoveries will flow directly to their bottom line. Cost-avoidance TPL savings are reflected in the claims data, therefore no additional adjustment was made.

	SFY05	SFY06	SFY07
TPL Recoveries	0.41%	0.38%	0.31%

Investment Income

The rates were adjusted to reflect the impact of investment income. The assumed lag was 1.5 months at an interest rate of 3.5%. There was no investment income adjustment made to maternity or newborn kicker payments.

Investment Income Adjustment	0.9958

Actuarial Certification

State of South Carolina, Department of Health and Human Services
Managed Care Capitation Rates
Actuarial Certification

I, Shannon Keller, am a senior manager with the firm Deloitte Consulting LLP (Deloitte Consulting). I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. The South Carolina Department of Health and Human Services (DHHS) retained Deloitte Consulting to perform an actuarial review and certification of the Managed Care Data Book and rate development. The Data Book presents historical fee-for-service claims experience for the non-managed care Medicaid program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

The capitation rates provided with this certification are considered "actuarially sound" according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices; and
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract

I have reviewed the development of the following components shown in the data book:

- Illustrations of incurred claims, utilization, average reimbursement, and per member per month costs for the fee-for-service population; and
- Age / gender / aid category cost relationships.

Based upon my review, the development of the information presented in the managed care capitation rates and the data book are consistent with sound actuarial principles.

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the South Carolina Department of Health and Human Services. The capitation rates associated with this certification are effective for the twelve month period beginning April 1, 2008.

The capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates.

I have relied upon data and information provided by the DHHS. I reviewed the data for reasonableness and consistency where practical. I relied upon the DHHS for the claim payment files, eligibility files, encounter data experience, and certain adjustments.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

Shannon Keller, FSA
Member, American Academy of Actuaries
January 17, 2008
Deloitte Consulting LLP