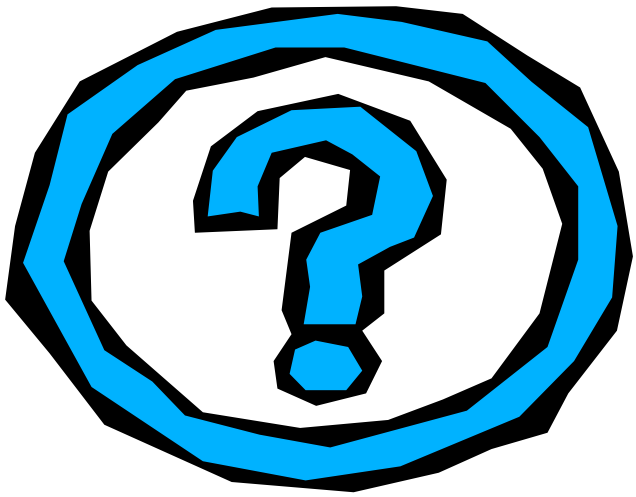
South Carolina Medicaid Managed Care Program

Policy and Procedure Guide
for
Managed Care Organizations



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MANAGED CARE ORGANIZATIONS

INTRODUCTION

The Department of Health and Human Services (DHHS) 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 DHHS for the provision of medical services for eligible persons in accordance with the South Carolina State Plan for Medical Assistance.

The DHHS 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 DHHS 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 re: 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 South Carolina Department of Health and Human Services (DHHS) for Managed Care Organizations (MCO) wishing to do business in South Carolina.

The Department of Managed Care, located within the Division of Care Management, Bureau of Health 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

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 the DHHS. DHHS will furnish potential contractors with a copy of the model MCO contract upon request. 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.

DHHS will enter into a risk-based contract with any qualified MCO that has been issued a Certificate of Authority to operate 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.state.sc.us.

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, DHHS will verify the license and date of issue with the DOI. Upon confirmation, DHHS 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 (see page 4). The Department of Managed Care will review the Required Submissions internally. DHHS will notify the MCO of any changes or re-submissions that must be made prior to approval. Upon DHHS's approval, the signed contract will be forwarded to CMS for approval. At the same time DHHS 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 Corrective Action Plan (CAP) to DHHS. The time frames given for correcting the deficiencies will be based on the severity and scope of the deficiencies. The DHHS staff will monitor the MCO's progress with its Corrective Action Plan.

Once the Readiness Review has been completed and the EQRO has submitted its final report to DHHS, the Managed Care staff will schedule a time to review the county networks in which the MCO wishes to begin operation to determine the network adequacy, to review all signed subcontracts and to review the signed "Hold Harmless" agreements and any applicable approved amendments (See page 6 for detailed information on the county network approval process).

The MCO will be able to begin enrolling members within thirty (30) days following the approval of the network.

Activities and Potential Time Frames

- Review of Required Submissions (see page 4) — Up to 120 days
- Review of Contract by CMS — Up to 45 days
- Readiness Review (not including scheduling time) — 2 to 3 days
- Readiness Review Report Completed — Within 30 days of site visit
- Network Adequacy Desk Review — Submitted upon passing of Readiness Review
- Network Approval (including signature of Hold Harmless Agreements) — ASAP
- Sign-up of first members — Within 30 days following Network Approval
- Enrollment of first members — See Enrollment Process, page 20

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 copy of listing of network provider/subcontractors. (This should only include executed contracts). (CONTRACT SECTION 4.11.2, 3.1.2.2)/See Reports, pages 98-99.

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 thru 4.1.3, 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, Page 67.)

14. A copy of PCP selection procedures and forms. (CONTRACT SECTION 4.11.3, 8.2)

D. Quality Assurance

15. A copy of QA Plan (Written description, credentialing, disciplining, and recredentialing policies and procedures). (CONTRACT SECTION 3.2 and See Quality Assurance and Utilization Review, page 67 and Quality Indicators, page 77.)

E. Marketing

16. The Contractor's maximum Medicaid member enrollment (projected) levels. (CONTRACT SECTION 6.11)

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, page 82)

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 have been reviewed and approved by the Managed Care staff. The MCO is scored against a set of standards that represent DHHS' expectations for successful operation within the South Carolina Medicaid Program. DHHS 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 DHHS. 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, beginning on page 9. 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 DHHS. 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.

2. The Department of Managed Care Program Manager verifies that the MCO network providers are eligible to participate in the Medicaid/Medicare program. In addition, information received from the Attorney General's Office/Centers for Medicare and Medicaid Services (CMS) on sanctioned/terminated providers is checked. If a network provider is found to be ineligible for participation, the Department of Managed Care will notify the MCO via letter. The MCO is responsible for ensuring that non-Medicaid enrolled providers are eligible to participate in the Medicaid Program.

3. Using the Provider Network Listing Spreadsheet and other appropriate provider listings by county (State Health Plan Provider Directory), the Department of Managed Care examines the listing for the inclusion & availability of provider types for the following categories of service:

   Inpatient Hospital Services
   Outpatient Services
   Physician Services
   Maternity Services
   Family Planning and Communicable Disease Services
   Independent Laboratory and X-Ray Services
   Durable Medical Equipment
   Prescription Drugs
   Podiatry Services
   Emergency Transportation
   Home Health Services
   Institutional Long Term Care Facilities/Nursing Homes
   Mental Health and Alcohol and Other Drug Assessment Services

4. The adequacy of each of these provider types is evaluated based on the MCO's projected maximum member enrollment for that county, as indicated in the MCO's Medicaid contract.

5. As appropriate, DHHS program 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.

6. DHHS reports are analyzed to determine normal service patterns for specific groupings of providers (examples: children 18 and under and primary care providers, emergency room hospital services and hospitals in and around the

submitted county).

7. 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.

8. If DHHS 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.

9. If DHHS determines that the MCO has submitted an adequate network for that county, the Department of Managed Care will perform a site review at the MCO to review provider subcontracts, including any applicable approved amendments, and Hold Harmless Agreements. The subcontracts and Hold Harmless Agreements are reviewed to determine whether the language in the subcontracts has been previously approved by DHHS and to ensure that **all** agreements are properly executed.

10. If DHHS determines that the language in the subcontracts has been previously approved by DHHS and that the agreements are properly executed then:

    - The MCO is notified in writing of the approval and of the effective date of enrollment.

    - Training on managed care options is provided to Medicaid eligibility workers within the local county offices as needed.

    - MMIS is notified to modify the "Counties Served" indicator in the provider record to allow member enrollments to be processed.

    - Transportation is also notified to post a notice on the MMIS/ Transportation subsystem.

11. In the event that an MCO submits a county network that uses existing (approved) providers, DHHS 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	1	MCO must describe how service will be provided (contractual / non-contractual relationships)
Durable Medical Equipment	1	
Orthotics/Prostetics	1	
Home Health	1	
Infusion Therapy	1	See Proximity Guidelines for Specialty Care Services
Laboratory/X-Ray	1	
Obstetrical Home Services	1	See Proximity Guidelines for Specialty Care Services
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	Must have Fam/Gen Prac or Int Medicine
Internal Medicine	1	Must have Fam/Gen Prac or Int Medicine
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	1	
Audiology	1	
Cardiology	1	
Chiropractor	2	
Dermatology	1	
Emergency Medical	1	May be included in hospital contract
Endocrinology and Metab	1	
Gastroenterology	1	
Geriatrics	2	
Hematology/Oncology	1	
Infectious Diseases	1	
Midwife	2	
Neonatology	1	
Nephrology	1	
Neurology	1	
Nuclear Medicine	1	
Nurse Practitioner	2	
Occupational Medicine	1	

Ophthalmology	1	
Optician	1	Service may be provided through optometrist
Optometry	1	
Orthopedics	1	
Osteopathy	2	
Otorhinolryngology	1	
Pathology	1	
Pediatrics, Allergy	1	
Pediatrics, Cardiology	1	
Pediatric Nurse Practitioner	2	
Physical Medicine and Rehab	1	
Physician Assistant	2	
Podiatry	2	
Private Duty Nursing	2	
Private Mental Health	2	Not required but MCO network must delineate how MH/AOD assessments will be provided
Psychiatry	2	Not required but MCO network must delineate how MH/AOD assessments will be provided
Psychiatry, Child	2	Not required but MCO network must delineate how MH/AOD assessments will be provided
Psychology	2	Not required but MCO network must delineate how MH/AOD assessments will be provided
Pulmonary Medicine	1	
Radiology, Diagnostic	1	
Radiology, Therapeutic	1	
Rheumatology	1	
Surgery - General	1	May be same person as Thoracic Surgery
Surgery - Thoracic	1	May be same person as General Surgery
Surgery - Cardiovascular	1	
Surgery - Colon and Rectal	1	
Surgery - Neurological	1	
Surgery - Oral	1	
Surgery - Orthopedic	1	
Surgery - Pediatric	1	
Surgery - Plastic	1	
Surgery - Urological	1	
Urology	1	
CRNA/AA	1	
Speech Therapy	1	
Physical/Occupational Therapy	1	
CORF	2	
AOD	2	Not required but MCO network must delineate how MH/AOD assessments will be provided
Mental Health	2	Not required but MCO network must delineate how MH/AOD assessments will be provided
Long Term Care	2	

Hospice	2	
	1=Required **2=Optional**	
Proximity Guidelines		
* Primary Care Physicians should be within 30 miles		
* Specialty Care Physicians should be within 50 miles.		
*In cases where a service is not available within the above "Proximity Guidelines", the MCO network should follow the utilization trends of the regular Medicaid Fee-For-Service system. DHHS may grant exceptions to the above "Proximity Guidelines" on a county by county basis.		

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 Department of Health and Human Services (DHHS) 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 Department of Health and Human Services.

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) – Effective July 1, 2005, 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 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. DHHS 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, his 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.

Sponsored Medicaid Worker Program (SMWP)

The Sponsored Medicaid Worker Program was developed in response to new Medicaid initiatives being implemented by DHHS in order to meet the medical needs of uninsured and underinsured South Carolina residents. The SMWP provides a means for medical facilities and other entities where Medicaid may be a source of revenue to pay the state match (50%) to assist in the hiring of Medicaid workers and/or support staff. The federal government pays for the other 50% of the cost for the worker and other administrative expenditures. In return, Medicaid eligibility workers are placed on site where the client presents themselves for Medicaid services. The Medicaid application process becomes more convenient for the patient and/or his representative, in most instances eliminating the necessity for referrals to another location.

The usual defined duties of a SMW may include, but are not limited to the following:

- ✓ Interviewing persons seeking assistance through Medicaid.
- ✓ Assisting these individuals in completing their application.
- ✓ Obtaining information regarding the family health and finances.
- ✓ Verifying information through secondary sources.
- ✓ Computing a budget to determine eligibility.
- ✓ Maintaining case files according to Federal and State regulations.
- ✓ Data entry of the client's information for Medicaid eligibility.

The benefits of the Sponsored Medicaid Worker Program include:

- ✓ A knowledgeable staff on site to address Medicaid matters.
- ✓ Medicaid applications taken on site.
- ✓ Medicaid determinations made on site.
- ✓ Inquiry capability, which verifies eligibility for billing purposes.

Workers employed through the Sponsored Medicaid Worker program are DHHS employees. They are hired, trained, and supervised by DHHS. DHHS assumes

employer-related liability for the workers including errors that may be made in the eligibility determination process, as well as federal sanctions that may be applied as a result of eligibility errors. Medicaid eligibility worker benefits include all state employee benefits including medical and dental insurance, optional life insurance and holidays recognized by the State.

If the MCO is interested in participating in the SMWP and/or interested in obtaining additional information, please forward a written request to Mr. Charles Johnson in the Bureau of Eligibility Processing. The MCO should also notify the Department of Managed Care that it intends to pursue this option. Once the process has been initiated, DHHS will begin discussions with you regarding the protocol for the worker sponsored by the MCO. Items for discussion may include the number of workers to be sponsored, the location of the worker; supplies and equipment the worker may need. The MCO may be requested to adjust the budget by adding additional matching funds for extra equipment, furniture and supplies that may be needed to make the Sponsored Worker more efficient in the performance of his/her duties.

For further information on eligibility or income and resource requirements, please see the DHHS website at www.DHHS.state.sc.us.

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.

Enrollment Process

SCDHHS intends to implement an auto-assignment enrollment process throughout the state. Newly eligible Medicaid beneficiaries and beneficiaries going through the yearly eligibility re-determination process will be informed of their various managed care choices and given thirty (30) days in which to choose a plan. If the beneficiary does not choose within the thirty (30) days, the beneficiary will be auto-assigned to a plan. Recipients who reside in auto-assignment counties may not enroll directly with the MCO. These recipients must contact their local Eligibility Office or the Department of Beneficiary Services in order to enroll or to change plans. As the auto-assignment process rolls out across the state, the Enrollment Process may change. The Contractor will be notified of changes as they occur and will be provided instructions and clarifications to the process.

Enrollment Forms, generated by the Contractor in ***non-auto-assign counties***, must be submitted to the Department of Beneficiary Services by the DHHS-established cutoff date, *generally* the third (3rd) Friday of each month. DHHS will supply the Contractor with a list of the established cutoff dates annually. All information on the enrollment application will be verified, especially the beneficiary's eligibility. If the beneficiary is approved to become an MCO member and the individual is entered into the system before the DHHS internal cut-off date, the new member will appear on the MCO's member listing for the subsequent month. If the beneficiary is approved to become an MCO member and the individual is entered into the system after the DHHS internal cut-off date, the new member will appear on the MCO's member listing for the following month.

If the beneficiary is not approved to become an MCO member for any reason, the enrollment form will be returned to the MCO. The MCO may resubmit the enrollment form within ninety (90) days of the DHHS received date which shall be stamped on the form. This form will become invalid on the ninety-first (91) day and a new enrollment form must be generated for the beneficiary.

For non MCO generated enrollment forms received by the 10th of the month, enrollment of eligibles shall be guaranteed to be no later than the first day of the following month, provided no request for change of enrollment has been received by SCDHHS.

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 will contain 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) DHHS 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. A new enrollment form will have to be completed and submitted to SCDHHS for processing. The effective date of enrollment will be as specified in Section 6.4 of the contract.

Recipients currently enrolled with another managed care plan must use the "SC Medicaid Managed Care Plan Change Form" (see page 180) 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 MCO's enrollment form or by completing the Change Plan form. If the MCO chooses to use its own form, the MCO must indicate the reason for the recipient's disenrollment from the original plan using one of the following codes:

- 30: Beneficiary for cause, moved out of service area
- 31: Beneficiary for cause, poor quality care
- 32: Beneficiary for cause, access to care issues (ex. Doctor or pharmacy too far away; doctor will not schedule appointment in timely manner)
- 33: Beneficiary for cause, not able to get the care needed
- 34: Beneficiary for cause, lack of access to services covered under the contract
- 35: Beneficiary for cause, doctor or pharmacy not part of network
- 36: Beneficiary for cause, lack of access to providers experienced with member's health care needs
- 37: Beneficiary for cause, entering a waiver program (CLTC or MFCP)
- 38: Beneficiary for cause, entering hospice or nursing home care (MCOs must pay for first 30 days)
- 39: Beneficiary for cause, Not able to get the medicines I was able to get in regular Medicaid
- 41: Beneficiary for cause, other
- 50: Beneficiary, dissatisfaction with plan (other than for cause reason)
- 51: Beneficiary, dissatisfaction with doctor (other than for cause reason)
- 52: Beneficiary, member changed their mind
- 53: Beneficiary, no reason given

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 DHHS 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.
- Other

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 (see page 180) 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, page 21).

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. Effective January 1, 2007, the capitation rates have been risk adjusted using calendar year 2005 data. These rates will be further updated for risk adjustment periodically using updated encounter data as reflected in the schedule detailed in **§12.2 Payment of Capitated Rate** of the contract.

Some payments, however, may be paid to the MCO through an adjustment. If the adjustment processed by the SC DHHS 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 DHHS 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 once a month payment for all deliveries in the preceding month. The MCO should complete the appropriate forms (see page 201). Target date for submission of these payment requests should be the 15th of each month. These reports should be submitted to the MCO's DHHS Program Manager in Excel. This may be sent as an e-mail attachment provided that it is password protected. 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.

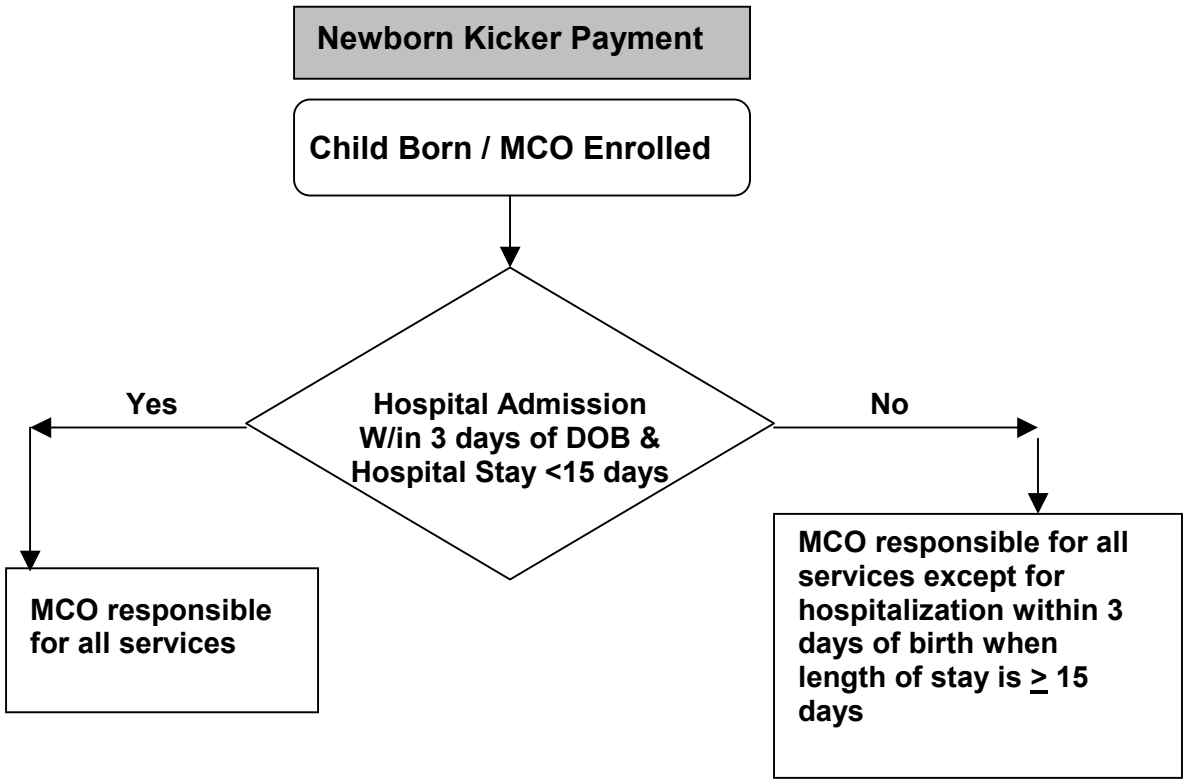
Newborn Kicker Payment – The Newborn Kicker Payment is the only payment the MCO will receive for the month a baby is born. The NKP is priced to cover the costs for the month of birth. Newborns must be enrolled in the MCO for the month of birth in order for the MCO to receive the NKP. The NKP includes 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 page 192) and submit it to the Program Manager.

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 DHHS 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. DHHS 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 DHHS staff will calculate any appropriate credit/debit adjustments due to/from the MCO.

Sanctions: The preferred method for enforcing monetary sanctions imposed by DHHS is via the debit adjustment process. Reasons for sanctions are defined in {Sanction Section reference}.

Capitation/Premium Payment Adjustment: When it is determined by DHHS 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 DHHS 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 DHHS website at http://www.dhhs.state.sc.us.

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 counseling or referral 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.

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 rendered in excess of 72 hours prior to the event,
- Post-Transplant follow-up services, and
- 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.

Hospital claims meeting the criteria above will be paid through Fee-For-Service.

Please see Newborn Kicker Payment flowchart on page 28.

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.

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.

Mental Health, Alcohol And Other Drug Abuse Assessment Services

The Contractor is required to pay mental health and alcohol and other drug abuse assessment services as follows:

90801 Psychiatric Diagnostic Interview Exam (All Providers)

T1015 Alcohol and Drug Screen by Medical Doctor/Nurse Practitioner to Determine Treatment Needs (DAODAS Only)

H0031 Mental Health Assessment, by Non-Physician (DMH Only)

90802 Interactive Psychiatric Interview (Private Psychiatrist only)

H0002 Behavioral Health Screening (Private Psychiatrist only)

Service Requirements: 5 Assessments per member per State fiscal year. The Contractor may authorize additional assessments at their discretion. 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 for children under the age of (21).*

Early & Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child - Preventive health care such as the EPSDT program provides comprehensive and preventive health services to children through the month of their 21st birthday through periodic medical screenings. The basic screening package includes a comprehensive health and developmental history, assessment of physical and

mental development, a comprehensive unclothed physical examination, age-appropriate immunizations, appropriate laboratory tests and health education. Screenings should be provided according to the schedule recommended by the American Academy of Pediatrics (AAP) Guidelines for Health Supervision (Pre-1995 recommendations) and the required standards established by CMS (42 CFR 441.50 - 441.62). The MCO is responsible for assuring that children through the month of their 21st birthday are screened according to this schedule and that the diagnostic and treatment services found medically necessary as a part of EPSDT, yet not covered by the Title XIX SC State Medicaid Plan, are provided.

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.

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. However, eligible recipients have the freedom to receive family planning services from any appropriate Medicaid providers without any restrictions. 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 ***(Standard Contract Only)***

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.

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*

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:

L8619	Cochlea Processor
L8614	Cochlear Head Piece
L8699	Cochlear Implant Repair
L9900	Cochlear Supplies
V5264	Ear Mold right, Ear Mold left, Ear mold (one unspecified)
V5265	Ear mold/insert, disposable, any type
V5030	Hearing Aid, Monaural, Body worn, Air Conduction
V5040	Hearing Aid, Monaural, Body Worn, Conduction
V5050	Hearing Aid, Monaural, Behind the Ear
V5060	Hearing Aid, Monaural, In the Ear
V5267	Hearing Aid Supplies/Accessories
V5170	Hearing aid, CROS, in the ear

V5180 Hearing aid, CROS, behind the ear
V5190 Hearing aid, CROS, glasses
V5210 Hearing aid, BICROS, in the ear
V5220 Hearing aid, BICROS, behind the ear
V5230 Hearing aid, BICROS, glasses
V5242 Hearing aid, analog, monaural, CIC (complete in the ear canal)

V5243 Hearing aid, analog, monaural, ITC (in the canal)
V5244 Hearing aid, digitally programmable analog, monaural, CIC
V5245 Hearing aid, digitally programmable analog, monaural, ITC
V5246 Hearing aid, digitally programmable analog, monaural, ITE
V5247 Hearing aid, digitally programmable analog, monaural, BTE
V5248 Hearing aid, analog, binaural, CIC
V5249 Hearing aid, analog, binaural, ITC
V5250 Hearing aid, digitally programmable analog, binaural, CIC
V5251 Hearing aid, digitally programmable analog, binaural, ITC
V5252 Hearing aid, digitally programmable, binaural, ITE
V5253 Hearing aid, digitally programmable, binaural, BTE
V5254 Hearing aid, digital, monaural, CIC
V5255 Hearing aid, digital, monaural, ITC
V5256 Hearing aid, digital, monaural, ITE
V5257 Hearing aid, digital, monaural, BTE
V5258 Hearing aid, digital, binaural, CIC
V5259 Hearing aid, digital, binaural, ITC
V5260 Hearing aid, digital, binaural, ITE
V5261 Hearing aid, digital, binaural, BTE
V5262 Hearing aid, disposable, any type, monaural
V5263 Hearing aid, disposable, any type, binaural
V5014 Hearing Aid Repair Right Ear, Hearing Aid Repair Left Ear, Hearing Aid Repair (One Unspecified)
V5266 Battery for use in hearing device (billed per pack)

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 (prescription) and most non-legend (over-the-counter) 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 (excluding insulin and those injectable products used to treat erectile dysfunction); aerosolized pentamidine; clozapine therapy; and family planning pharmaceuticals and devices. For pharmaceuticals that are not exempted from the prescription limit, an override billing process allows the monthly prescription limit to be exceeded under

certain circumstances. Medicaid pays for a maximum 34-day supply of medication per prescription or refill for non-controlled substances. 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 pays for most generic products; most brand name products for which generics are available
require prior authorization. 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.

In those cases where an MCO plan utilizes a formulary, the formulary must be shared with Medicaid members and providers. 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.

Podiatry Services

Podiatry services are those services responsible and necessary for the diagnosis and treatment of foot conditions. Services are limited to specialized care of the foot as outlined under the laws of the State of South Carolina. Services include podiatric surgical procedures and routine foot care. Podiatry care can be rendered to patients in nursing or rest home facilities, provided that the service is medically necessary. Routine foot care includes the cutting or removal of corns, calluses, trimming of nails, or other hygienic and preventive maintenance care. Additional services are considered routine when they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

Current Medicaid Service Limitations: *None*

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. DHHS 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. 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.

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 page 190) 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 page 193) 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 which may be found on page 185.

**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 page 189) 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
59840	69.01	635.0 – 635.9
59841	69.51	636.9
59850	69.93	638.0 – 638.9
59851	74.91	
59852	75.0	
59855		
59856		
59857		

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

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 DHHS 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/RT	Ear impression, each- Right	1 ear mold	6 every 12 months
V5275/LT	Ear impression, each- Left	1 ear mold	6 every 12 months
92557/52	Comprehensive audiometry threshold evaluation and	1	6 every 12 months

	speech recognition (92553 and 92556 combined)	reevaluation	
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	6 every 12 months
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	1 test	No limit
92588	Comprehensive or diagnostic evaluatioin (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. After the first 30 days, payment for services will be reimbursed fee-for-service by the Medicaid program for Medicaid enrolled providers.

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 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) except the assessment codes detailed on page 33**;**
- Services provided by the Department of Mental Health (DMH) except the assessment codes detailed on page 33;
- Psychiatric services except the assessment codes detailed on page 33.

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. All assessment codes listed on page 33 are the

responsibility of the MCO. See Exhibit A for a complete list of DRG, Diagnosis and Procedure Codes that are the responsibility of SCDHHS.

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. It may be necessary for a Medicaid MCO member to require non-emergency transportation to receive medical services from a provider located in a county other than the member's county of residence if the MCO does not have that provider type as part of its network. Since prior approval for non-emergency transportation is required by SCDHHS, the MCO will be responsible for faxing or telephoning the request for transportation and authorization for services to the SCDHHS county transportation office/Regional transportation provider. SCDHHS workers will follow their guidelines for providing non-emergency transportation to recipients.

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

Recipients under the age of 21 and those enrolled in the Mental Retardation/Related Disabilities waiver (MRD) receive one comprehensive eye examination every 365 days. 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.

For recipients 21 and over, but under 65 years of age and who are not in the waiver program, can qualify for eyewear if the patient has had cataract surgery. (Only cataract surgery is authorized.) If medically necessary, a replacement pair of eyeglasses will be provided for those with cataract surgery every two years thereafter. If the patient is 65 or over and on Medicare and Medicaid, the first pair of eyewear must be filed to Medicare. After the initial pair from Medicare and if it's medically necessary, Medicaid will provide the eyewear, every two years. Replacement of eyewear is the same as the under 21 year of age.

Dental Services

Routine dental services are available to recipients under the age of 21 and adults enrolled in the Mental Retardation/Related Disabilities (MR/RD) waiver. Routine dental services include any diagnostic, rehabilitative, or corrective procedure, supplies and preventive care furnished or administered under the supervision of a dentist.

Emergency dental services are available to all recipients. These are services necessary to repair traumatic injury, to relieve acute severe pain, to control acute infectious processes, and emergency services necessary due to a catastrophic medical condition. 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 have 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 Transplants

Transplant Services are not included in the core benefits. Transplant services are limited to the actual transplant event and testing done within seventy-two hours of the event. Donor services rendered at the time of the transplant event, or within the seventy-two hours preceding the event, are considered transplant services.

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

- Corneal Transplants,
- Pre-Transplant services rendered in excess of 72 hours prior to the event,
- Post-Transplant follow-up services,
- Post-Transplant pharmaceutical services.

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.

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, Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997.)

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, Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997.)

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,* Fourth Edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 1997, (as revised and updated) 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

Until recently, DHEC has traditionally provided the majority of immunizations to the citizens of South Carolina. Recent efforts to promote the concept of a medical home for each child has resulted in a decrease in the percentage of SC children receiving immunizations in DHEC clinics, and an increase in immunizations provided by the private physician. This trend will continue for families covered by a Managed Care Organizations, where the MCO is responsible for providing immunizations to its members. However, many families continue to present to the DHEC clinics for a variety of reasons. A review of the immunization status often indicates that the child is due or past due for an immunization.

To assure “no missed opportunities” to immunize, a policy that has been effective in making SC immunization rates the highest in the nation, Medicaid MCOs are encouraged to develop cooperative arrangements with DHEC. Arrangements may include: sharing data, sharing immunization histories, promoting medical homes, making referrals, and billing the MCO for administration costs.

Immunization Policy

The administration of immunizations is a required component of EPSDT screening services. An assessment of the child's immunization status should 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 should be documented in the child's record. An appointment should be given to return for administration of immunization at a later date.

Immunization of children should be provided according to the guidelines recommended by the South Carolina Department of Health and Environmental Control, the Centers for Disease Control – Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), The American Academy of Pediatrics, and South Carolina State Law.

If a provider does not routinely administer immunizations as part of his/her practice, he/she should refer to 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. The following indicators shall be used: The rates of receipt by Medicaid enrollees of all age-appropriate DTaP, IPV, MMR, Hep B, Hib, PCV and Varicella immunizations in the first two years of life.

2. Identifying criteria:

Type of Immunizations	Criteria for Being up to date for First Birthday	Criteria for Being Up to date for Second Birthday
DTaP	Three doses	Four doses
- IPV	Three doses	Three doses
MMR	One dose (12-15 months)	One dose
Hep B	Three doses	Three doses
Hib	Three doses	Four doses
Varicella	One dose (12-18 months)	One dose (12-18 months)
PCV	Three doses	Four doses

3. 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

National health care goals include creating community-based, family-centered care for children with special health problems. In the past, some states carved this population out of managed-care- planning, relying on categorical sub-specialty groups to implement all health services for children with chronic and disabling conditions. However, recent consensus is that children with a variety of diagnostic labels are more similar than different and their special health problems are as a whole far more generic than as perceived in the past. A child develops and is socialized in a family setting, therefore, it could be argued, that their health care may be best rendered by a family centered, health maintenance organization.

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

For several years South Carolina Medicaid has encouraged close collaboration between all disciplines serving children with chronic conditions. The goals were to develop a service continuum that was accessible and family friendly. Today, best practice policies include holistic, family centered health care delivery, and the provision of case coordination services has emerged as the catalyst facilitating this systems change.

As the comprehensive medical home for children with (or at risk of developing) serious disabling conditions, MCOs should 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 target population is any Medicaid eligible recipient with Diabetes.

Prevention And Management Of Sexually Transmitted Diseases

The MCO should follow the Centers for Disease Control and Prevention (CDC) program guidelines on the prevention, treatment and management of Sexually Transmitted Diseases (STD) and should coordinate with the local health departments when members are identified as having contracted or been exposed to an STD.

STD prevention programs exist in highly diverse, complex, and dynamic social and health service settings. There are significant differences in availability of resources and range and extent of services among different project areas. These differences include the level of various STDs and health conditions in communities, the level of preventive health services available, and the amount of financial resources available to provide STD services. Therefore, the CDC guidelines should be adapted to local area needs. The CDC has given broad, general recommendations that can be used by all program areas. However, each must be used in conjunction with local area needs and expectations. All STD programs should establish priorities, examine options, calculate resources, evaluate the demographic distribution of the diseases to be prevented and controlled, and adopt appropriate strategies. The success of the program will depend directly upon how well program personnel carry out specific day to day responsibilities in implementing these strategies to interrupt disease transmission and minimize long term adverse health effects of STDs.

For more information, please visit the CDC website at http://www.cdc.gov/std/program.

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

The S.C. Department of Health and Human Services (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, CHAMPUS, 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.

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

PROVIDER CERTIFICATION AND LICENSING

Medical service providers must meet certification and licensing requirements. 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 HHS, 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 state 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 the state 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.scmca.org/download/UCA2004.pdf. The Contractor is also free to use its own credentialing application.

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).

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 Department of Labor, Licensing and Regulations, and/or appropriate medical boards in other states.

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 to practice as a registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations, and certified as a nurse midwife by the Division of Competency Assessment. Services are limited by practice protocol. The Department of Health and Environmental Control (DHEC) must license a midwife.

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, or the appropriate medical board in other states. 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 - No license or certification required.

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, or the appropriate medical board in other states. 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.

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).

QUALITY ASSURANCE AND UTILIZATION REVIEW REQUIREMENTS

All MCOs that contract with the SCDHHS to provide Medicaid MCO Program Services must have a Quality Assurance (QA) and Utilization Review (UR) 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 assurance system that (as required in **§11** of the Contract):

   (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 Assurance program which includes at least the following elements (as required in **§§ 3, 11** of the Contract):

   (a) A quality assurance 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 effort should be health outcome orientated 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 have adequate and appropriate experience for 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 required in Standard 8 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: 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: 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.

(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. (as required in **§§ 4, 12** of the Contract)

   At a minimum, required quality of care studies will include indicators for prenatal care, newborns, childhood immunizations and EPSDT examinations. Quality Indicator Reports must be submitted to SCDHHS on a quarterly basis. Refer to Quality Indicators, page 77.

   The MCO agrees to provide such outcome - based clinical reports quarterly to SCDHHS and to report the HEDIS Reporting Measures as outlined on page 81.

4. Assist the SCDHHS in its quality assurance activities. (as required in **§§ 3; 11; 12** of the Contract)

   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 (as required in **§ 3** of the Contract).

   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: (as required in **§4** of the Contract)

   (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, as required in **§§ 4, 11** of the Contract, 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 UR activities and provides adequate medical and other clinical data required for QA/UR.

(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 page 98 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 review policies and procedures that include at a minimum (as required in **§ 4** of the Contract):

(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 *(Standard Contract only)* comply with 42 CFR 441 subpart E-Abortions, and that hysterectomies and sterilizations *(Standard Contract only for sterilizations)* comply with 42 CFR 441 subpart F-Sterilizations.

Refer to page 39 for further information on Hysterectomies, Sterilizations and Abortions.

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: (as required in **§§ 6; 7; 8** of the Contract)

    (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: (as required in **§§9**; **10** of the Contract)

    (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 **§9.5** of 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 monthly 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, (as required in **§§ 4, 9, 10, 11, 13** of the Contract):

    (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 prior to implementation.

    (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 indicator reports. The quality indicator data 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 Corrective Action Plan and monitor the MCOs progress with the corrective action plan developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective action.

13. External Quality Assurance Review. The SCDHHS will provide for an independent review of services provided or arranged by the MCO. The review will be conducted annually by the External Quality Review Organization (EQRO) under contract with the SCDHHS, as required in **§11** of the Contract. External quality assurance evaluation and EQRO responsibilities shall include:

    (a) 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 Corrective Action Plan.

    (b) Technical assistance with quality of care studies and study designs for prenatal care, newborns, childhood immunizations and EPSDT examinations.

(c) Validate the quality of care study designs to assure that the data to be abstracted during the quality of care studies of childhood immunizations, prenatal care, newborns and EPSDT examinations is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis.

(d) Assist 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.

(e) With SCDHHS or EQRO 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.

(f) SCDHHS will evaluate the MCOs compliance with the QA standards through an annual comprehensive QA evaluation. The Medicaid Managed Care External Review Services Manual 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, 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 and EPSDT examinations.

The EQRO will compare findings of quality care studies with findings of the MCOs internal QA programs. The EQRO 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 and 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.

(g) An MCO summation meeting will be held to discuss the QA evaluation findings.

(h) 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 after SCDHHS reviews the draft report.

A draft statewide report will be issued 30 calendar days after all individual MCO reports have been finalized. A final report will be issued after the draft has been approved 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 with respect to indicators in item 13(f);
- ✓ 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.

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

(j) At a minimum annually a meeting with the MCO will be conducted by SCDHHS staff in order to monitor progress with the MCO's Corrective Action Plan developed as a result of the annual QA evaluation. The frequency for the corrective action plan meetings shall be determined by the SCDHHS based in the findings of the annual QA evaluation, and as specified in the Notice of Corrective Action.

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

Quality Indicators

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 indicators 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 indicators, criteria are necessary to promote collection of comparable and reliable data. Indicators 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	Row Percentage Delivered in Level I Hospitals	Number Delivered in Level II Hospitals	Row Percentage Delivered in Level II Hospitals	Number Delivered in Level III Hospitals	Row 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 Contractor shall report, at a minimum, the following measures:

- Prenatal and Postpartum Care
- Frequency of Ongoing Prenatal Care
- Weeks of Pregnancy at Time of Enrollment in the MCO
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
- Adolescent Well-Care Visits
- Frequency of Selected Procedures
- Inpatient Utilization-General Hospital/Acute Care
- Ambulatory Care
- Discharges and Average Length of Stay—Maternity Care
- Births and Average Length of Stay, Newborns
- Outpatient Drug Utilization

The Contractor is encouraged to collect, utilize and report on Effectiveness of Care measures as well.

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 enrollment into 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. 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.

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 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. (See page 12 for Eligibility information)

- 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 (network provider sites are excluded).

- 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 DHHS. MCOs can conduct marketing/enrollment activities at DSS county offices with the approval of the DSS County Director **and** the DHHS 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 DHHS 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, program or procedures 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 marketing/enrollment activities must be in accordance with these requirements, 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 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.

- The Contractor may not use information on the postcards previously used by potential/existing Medicaid eligibles to request managed care information, for the purpose of contacting potential/existing Medicaid eligibles to offer enrollment, unless the postcard specifically indicates a desire for follow up by the Contractor either through home visit or other methods. The post card must also provide a choice for the eligible to decline further contact by the Contractor.

- 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 DHHS 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 DHHS, that is site specific, MCO videos which incorporate DHHS's video can be shown in doctors' waiting rooms or other approved marketing/enrollment events.

- MCOs can 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 DHHS written prior approval.

- With prior written approval of DHHS, 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 DHHS approved marketing and educational materials within its service areas (i.e. countywide). Mass mailings directed to only Medicaid recipients are prohibited.

- MCOs' Medicaid enrolled network providers can use DHHS's model letters to inform recipients about their participation status in the Medicaid Program and the MCO. DHHS's model 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 network or out of network provider. In addition, the use of the model letters must be in accordance with SCDOI's policy.

Enrollment Form

- The Contractor cannot conduct enrollment activities in auto-assignment counties.

- 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.

- 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. The Contractor may offer a SCDHHS approved over-the-counter expanded drug benefit. Such benefits shall be limited to nonprescription drugs containing a National Drug Code (NDC) number, first aid supplies, and must be offered through the Contractor's pharmacy (or the Contractor's subcontract with a pharmacy) and paid directly to the pharmacy.

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

Marketing And Educational Materials And Activities

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.)

- 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, WIC, and well child process/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 primary care providers and facilities. It shall also include a map or description of the Contractor's service area and information on the participating specialty providers, medical facilities (e.g. hospitals, labs.)

- 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 advanced 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 DHHS and with DHHS's written prior approval. Each specific marketing and/or enrollment event/site, including activities in contracted providers' offices, must be prior approved by DHHS. DHHS'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. 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 including Department of Social Services (DSS) county offices, with prior written approval from DHHS. No enrollment activities can occur at focus groups.

- Show Vans: Show vans or similar vehicles can be used in various locations to distribute DHHS approved Medicaid managed care educational, marketing, and enrollment materials with DHHS 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 DHHS. 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 also 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.

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 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 [see (6) above] for the previous contract year to the SCDHHS three (3) months after the end of the contract 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(l) 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 REPORTS AND FORMS

With the exception of Yearly Reports, all reports are due within 30 calendar days after the end of the reporting period. Yearly reports are due 90 days after the end of the calendar year. All reports may be submitted in a SCDHHS approved e-file.

Report	Frequency	Report Format	Medium *
Network Providers and Subcontractors Listing	Monthly	See pages 100	Hard copy 2 copies or DHHS approved E-file
MCO Insured's Policy Number Report	Monthly	See page 102	File
Third Party Liability Report	Monthly	See page 104	File
Individual Encounter Report	Monthly	See page 106-135	File
Grievance & Appeal Logs with Summary Information	Monthly	See page 136-137	Hard Copy 1 copy or DHHS approved E-file
Institutional LTC/Nursing Home Placement	At initial placement & at end of 30th day	Use Member Plan Change Form – See page 180	Hard Copy 1 copy or DHHS approved E-file
Member Plan Change Form	Upon completion	Form - See page 180	Hard copy 3 copies or DHHS approved E-file
Newborn Notice	Upon completion	See page 192	Hard copy or DHHS approved E-file
Quality Assurance (QA) A. QA Plan	As required	See Contract §11 See Contract §11	Hard copy or DHHS

Report	Frequency	Report Format	Medium *
B. QA Corrective Action Plan C. Quality Indicators D. HEDIS Reporting Measures	As required Quarterly Yearly	See Contract §11 See page 77 See page 81	DHHS approved E-file 1 copy
Member Satisfaction Survey	Annually	Instrument and Survey Results	Hard copy 1 copy or DHHS approved E-file
Medicaid Enrollment Capacity by County Report	The first of each month	See page138	Hard copy 2 copies or DHHS approved E-file
MCO Provider Identification Records for Non-Medicaid Providers	Monthly	See page 141	File Records for Non-Medicaid Providers
Performance Standards – Claims Time to Pay Report	Monthly	Determined by MCO	Hardcopy or DHHS approved E-file
Summary of Claim Turnaround Report	Monthly	Determined by MCO	Hardcopy or DHHS approved E-file

- Number of copies indicated in this column must be submitted by the Contractor to SCDHHS, Bureau of Information Systems or Division of Care Management, as appropriate

Note: For all reports, MCO name and provider number must be indicated.

PROVIDER NETWORK LISTING REQUIREMENTS

Utilizing the DHHS-developed spreadsheet, please provide the following on your 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 code using the attached listing.

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.

11. 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 101.

Please provide a composite listing of all new and terminated providers for the month.

COUNTY LISTING

01 ABBEVILLE
02 AIKEN
03 ALLENDALE
04 ANDERSON
05 BAMBERG
06 BARNWELL
07 BEAUFORT
08 BERKELEY
09 CALHOUN
10 CHARLESTON
11 CHEROKEE
12 CHESTER
13 CHESTERFIELD
14 CLARENDON
15 COLLETON
16 DARLINGTON
17 DILLON
18 DORCHESTER
19 EDGEFIELD
20 FAIRFIELD
21 FLORENCE
22 GEORGETOWN
23 GREENVILLE
24 GREENWOOD
25 HAMPTON
26 HORRY
27 JASPER
28 KERSHAW
29 LANCASTER
30 LAURENS
31 LEE
32 LEXINGTON
33 MCCORMICK
34 MARION
35 MARLBORO
36 NEWBERRY
37 OCONEE
38 ORANGEBURG
39 PICKENS
40 RICHLAND
41 SALUDA
42 SPARTANBURG
43 SUMTER
44 UNION
45 WILLIAMSBURG
46 YORK

MCO INSURED'S POLICY NUMBER REPORT

ELEMENTS	DATA ELEMENT DEFINITION	DATA ELEMENT JUSTIFICATION	DATA ELEMENT REQUIREMENTS
Recipient/Member Number	A State assigned number that uniquely identifies an individual eligible for Medicaid benefits	Link to State eligibility and enrollment files	Required
Recipient/Member Name	Name of the recipient	Link to State eligibility and enrollment files	Required
Recipient/Member Date of Birth	Date of birth of the recipient	Link to State eligibility and enrollment files	Required
Insured's Policy Number	The number assigned by the managed care plan that uniquely Identifies an individual in a managed care plan	Link to managed care plan enrollment files	Required
Managed Care Plan's (MCP) Medicaid Provider Number	A State assigned number that uniquely identifies an MCO as eligible to participate as a Medicaid managed care provider	Link to State eligibility provider enrollment files	Required

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
RECORD LAYOUT FOR HMO INSURED'S POLICY NUMBER REPORT

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	RECIPIENT-MEDICAID-NUM		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.	INSURED-POLICY-NUMBER	15	51	65	C	HMO assigned number that uniquely identifies the recipient in the managed care plan
7.	HMO-NUMBER	6	66	71	C	Managed care plan number
8.	PCP-LAST-NAME	25	72	96	C	Preferred Provider last name
9.	PCP-FIRST-NAME	10	97	106	C	
10.	PCP-MIDDLE-INITIAL	1	107	107	C	
11.	PCP-ENITY-CODE	1	108	108	C	Is preferred provider individual or group Value = 1 – individual = 2 – group
12.	PCP-RELATIONSHIP	1	109	110	C	Relationship between preferred provider and recipient Value = Y – established N – new Space – unknown
13.	FILLER	41	110	150	C	
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						

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 TPL REPORT

ELEMENTS	DATA ELEMENT DEFINITION	DATA ELEMENT JUSTIFICATION	DATA ELEMENT REQUIREMENTS
Recipient/Member Number	A State assigned number that uniquely identifies an individual eligible for Medicaid benefits	Link to State eligibility and enrollment files	Required
Recipient/Member Name	Name of the recipient	Link to State eligibility and enrollment files	Required
Recipient/Member Date of Birth	Date of birth of the recipient	Link to State eligibility and enrollment files	Required
Managed Care Plan's (MCP) Medicaid Provider Number	A State assigned number that uniquely identifies an MCO as eligible to participate as a Medicaid managed care provider	Link to State eligibility provider enrollment files	Required
Third Party: Carrier Name	Name of insured's carrier	Needed for recipient record	Required
Third Party: Group Name (if applicable)	Name of insured's group	Needed for recipient record	Required
Third Party: Carrier's Insured Policy Number	A number assigned by a third party payer that uniquely identifies an insured individual	Needed for recipient record	Required
Third Party: Insured's Name	Name of the individual in whose name the insurance is carried	Needed for recipient record	Required
Third Policy: Policy Effective Date	Date third party went into effect	Needed for recipient record	Required
Third Party: Policy Lapse Date (if applicable)	Date third party coverage was terminated	Needed for recipient record	Required

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
25.	RECIPIENT-MEDICAID-NUM	10	1	10	N	
26.	RECIP-LAST-NAME	17	11	27	C	
27.	RECIP-FIRST-NAME	14	28	41	C	
28.	RECIP-MIDDLE-INITIAL	1	42	42	C	
29.	RECIPIENT-DATE-OF-BIRTH	8	43	50	C	Mask: CCYYMMDD
30.	MCO-NUMBER	6	51	56	C	Managed care plan number
31.	TPL-INFO	544	57	600		Third party payer information (occurs 3 times)
32.	CARRIER-NAME	50	57	106	C	Preferred Provider last name
33.	CARRIER-GROUP-NAME(if applicable)	50	107	156	C	
34.	CARRIER-POLICY-NUMBER	25	157	181		
35.	INSURED-NAME	25	182	213	C	
36.	INSURED-LAST-NAME	17	182	198	C	
37.	INSURED-FIRST-NAME	14	199	212	C	
38.	INSURED-MIDDLE-INITIAL	1	213	213	C	
39.	POLICY EFFECTIVE DATE	8	214	221	C	Mask: CCYYMMDD
40.	POLICY LAPSE DATE (if applicable)	8	222	229	C	
41.	FILLER	25	576	600	C	
42.						
43.						
44.						
45.						

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

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.

REQUIRED ENCOUNTER DATA ELEMENTS - AMBULATORY ENCOUNTERS*

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Date Submitted by MCO	Julian date representing date of submission by MCO.	Needed to link document date of submission.	Required
Encounter Type	The State designation "A" for ambulatory encounters.	Needed to document type of encounter.	Required
TPL Recovery Indicator	A code that designates third party recoveries are being reported for a previously submitted encounter. Use value "R" to indicate a previously submitted encounter.	Needed to link to a previously submitted encounter.	Required, if applicable
Resubmit Indicator	A code that designates that an encounter is being resubmitted as a corrected encounter. Use value "C" to indicate a corrected encounter; value "D" to delete a previous submission.	Needed to document a corrected encounter.	Required, if applicable
MCO Payment Denied Indicator	A code that designates that payment for the encounter was denied by the managed care plan. Use value "D" for denied encounter.	Needed for QA reviews.	Required, if applicable
Adjustment Indicator	A code that designates the adjustment of a previously submitted encounter. Use value "V" to void/cancel a previously approved encounter.	Needed to identify replacements for previous encounters.	Required, if applicable
Client Recipient Number	A State assigned number that uniquely identifies an individual eligible for Medicaid benefits.	Link to State eligibility and enrollment files.	Required
Client ID Number	A number assigned by the managed care plan that uniquely identifies an individual in a managed care plan.	Link to managed care plan's enrollment files	Required
Managed Care Plan's (MCP) Medicaid Provider Number	A State assigned number that uniquely identifies an MCO as eligible to participate as a Medicaid managed care provider.	Needed to identify responsible plan	Required
Third Party Carrier Code	Code identifying any third party carrier on the encounter claim.	Needed to determine capitation rates	Required, if applicable

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Third Party Policy Number	A number assigned by the third party payer that uniquely identifies the insured.	Needed to determine capitation rates	Required, if applicable
Third Party Insured's Name	The name of the individual in whose name the insurance is carried.	Needed to determine capitation rates	Required, if applicable
Third Party Amount Paid	The amount paid by the third party payer.	Needed to determine capitation rates	Required, if applicable
Referring Provider ID Number	A State assigned number that uniquely Identifies the referring provider of service as eligible to participate as a Medicaid provider. If the referring provider is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters.	Needed to identify the referring provider.	Required, if applicable
Principal Diagnosis	The ICD-9 diagnosis code of the principal condition.	Needed for QA reviews and utilization profiling.	Required, except for lab and DME providers
Other Diagnosis	The ICD-9 diagnosis code of any condition other than the principal condition. (Up to 3 Diagnoses)	Needed for QA reviews and utilization profiling.	Required, if applicable
LINE ITEM DETAIL			
Procedure Code	The CPT procedure code or the State assigned procedure code identifying the medical procedure performed.	Needed for QA reviews and utilization profiling.	Required
Procedure Code Modifier	The CPT code or the State assigned code identifying the modifying circumstances of a procedure.	Needed for QA reviews and utilization profiling.	Required, if applicable
Units/Miles	A quantitative measure of services by procedure category.	Needed for QA reviews and utilization profiling.	Required
First Date of Service	The date when the procedure was rendered.	Needed for QA reviews and utilization profiling.	Required
Last Date of Service	The last date when the procedure was rendered over a range of days.	Needed for QA reviews and utilization profiling.	Required, if applicable

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Place of Service	The code that indicates where the service was rendered.**	Needed for QA reviews and utilization profiling.	Required
Performing Provider ID Number	A State assigned number that uniquely identifies the performing provider as eligible to participate as a Medicaid provider. If the performing provider is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters.	Needed to identify the performing provider of service.	Required
Performing Provider Group ID Number	A State assigned number that uniquely identifies the group in which the performing provider is eligible to participate as a Medicaid provider. If the group is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters	Needed to link performing provider to a group provider.	Required, if applicable
EPSDT Indicator	The indicator that the procedure is for a well child visit and a problem was identified that requires follow-up or referral. Use value "Y" to designate the procedure code that required follow-up or referral.	Needed to comply with Federal reporting requirements.	Required, if applicable
Reimbursement Indicator	Code that identifies the managed care plan's method of reimbursement to the provider of service. Use value "C" for capitated; value "F" for fee for service.	Needed for audit purposes and to determine capitation rates.	Required
Dollar Amount Billed	The amount billed by the provider for services rendered for this encounter. If the encounter is not paid fee for service, it is the amount the provider would have billed for the service.	Needed for audit purposes and to determine capitation rates.	Required
Dollar Amount Paid	The amount paid by the managed care plan for services rendered for this encounter.	Needed for audit purposes and to determine capitation rates.	Required, if managed care plan reimbursed on a fee for service basis
MCO Own Reference Number	The unique reference number assigned to identify the encounter by the managed care plan.	Link to the managed care plan's encounter processing system.	Required

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Enhanced Encounter Number	The State assigned encounter number that uniquely identifies an encounter.	Needed to identify a re-submitted encounter.	Required, if applicable

*** Ambulatory Encounters**
Physicians, Other Practitioners = Nurse Practitioner, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Podiatrist
Clinics = FQHC, RHC, ASC, ERSD, Mental Health, Alcohol and Substance Abuse, Infusion Centers
Other Capitated Services = Independent Lab, Radiology, DME, Home Health , Ambulance

**Place of Service Valid Values

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgical Center (ASC)
25 Birthing Center
26 Military Treatment Center
31 Skilled Nursing Facility (NF)
32 Nursing Facility (NF)
33 Custodial Care Facility
34 Hospice
41 Ambulance Land
42 Ambulance Air or Water
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center (CMHC)
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse treatment Facility
56 Psychiatric Residential Treatment Facility
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State of Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
46.	JULIAN-SUBMISSION-DATE	7	1	6	N	Mask CCYYDDD
47.	CLAIM-TYPE	1	8	8	C	HCFA-7500-DATA VALUE 'A'
48.	TPL-RECOVERY-IND	1	9	9	C	Use 'R' in the indicator if claim represents recovery from TPL by the HMO
49.	RE-SUBMIT-IND	1	10	10	C	Indicates encounter is a re-submit Corrected encounter value 'C' Delete previous submission value 'D'
50.	HMO-PAYMENT-DENIED-INDICATOR	1	11	11	C	Denied encounter value 'D'
51.	ADJUSTMENT-INDICATOR	1	12	12	C	Adjustment of a previously approved encounter VOID-CANCEL value 'V'
52.	MISC-IND-7	1	13	13	C	Future use
53.	MISC-IND-2	1	14	14	C	Future use
54.	MISC-IND-3	1	15	15	C	Future use
55.	MISC-IND-4	2	16	17	C	Future use
56.	RECIPIENT-MEDICAID-NUM	10	18	27	N	Client Medicaid number
57.	INSURED-POLICY-NUMBER	15	28	42	C	HMO Client ID number
58.	HMO-NUMBER	6	43	48	C	Managed Care plan number
59.	TPL-INFO-1	71				THIRD PARTY INSURANCE INFORMATION
60.	CARRIER-CODE-1	5	49	53	C	
61.	CARRIER-POLICY-NUM-1	25	54	78	C	
62.	INSURED-NAME-1.	32			C	
63.	INSURED-LAST-NAME-1	17	79	95	C	
64.	INSURED-FIRST-NAME-1	14	96	109	C	
65.	INSURED-MIDDLE-INIT-1	1	110	110	C	
66.	TPL-AMOUNT-PAID-1	9	111	119	N	999999999 Assumed 2 decimal places
67.	TPL-INFO-2	71				THIRD PARTY INSURANCE I NFORMATION
68.	CARRIER-CODE-2	5	120	124	C	
69.	CARRIER-POLICY-NUM-2	25	125	149	C	
70.	INSURED-NAME-2	32			C	
71.	INSURED-LAST-NAME-2	17	150	166	C	
72.	INSURED-FIRST-NAME-2	14	197	180	C	
73.	INSURED-MIDDLE-INIT-2	1	181	181	C	
74.	TPL-AMOUNT-PAID-2	9	182	190	N	Mask: 9999999V99
75.	TPL-INFO-3	71				THIRD PARTY INSURANCE NFORMATION
76.	CARRIER-CODE-3	5	191	195	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
77.	CARRIER-POLICY-NUM-3	25	196	220	C	
78.	INSURED-NAME-3	32			C	
79.	INSURED-LAST-NAME-3	17	221	237	C	
80.	INSURED-FIRST-NAME-3	14	238	251	C	
81.	INSURED-MIDDLE-INIT-3	1	252	252	C	
82.	TPL-AMOUNT-PAID-3	9	253	261	N	Mask: 9999999V99
83.	REFERRING-PROVIDER	6	262	267	C	Provider who referred patient for service
84.	PRINCIPAL-DIAGNOSIS	6	268	273	C	Diagnosis code for principal condition
85.	OTHER-DIAGNOSIS-7	6	274	279	C	Diagnosis other than principal
86.	OTHER-DIAGNOSIS-2	6	280	285	C	Diagnosis other than principal
87.	OTHER-DIAGNOSIS-3	6	286	291	C	Diagnosis other than principal
88.	LINE-ENCOUNTER-DATA-1		292	348		Data line for up to eight procedures
89.	PROCEDURE-CODE-1	5	292	296	C	
90.	FILLER	1	297	297	C	
91.	MODIFIER-1	2	298	299	C	
92.	UNITS-MILES-1	3	300	302	N	
93.	FIRST-DATE-OF-SERV-1		303	310		
94.	FIRST-DATE-CENTURY-1	2	303	304	N	
95.	FIRST-DATE-YEAR-1	2	305	306	N	
96.	FIRST-DATE-MONTH-1	2	307	308	N	
97.	FIRST-DATE-DAY-1	2	309	310	N	
98.	LAST-DATE-OF-SERV-1		311	318		
99.	LAST-DATE-CENTURY-1	2	311	312	N	
100.	LAST-DATE-YEAR-1	2	313	314	N	
101.	LAST-DATE-MONTH-1	2	315	316	N	
102.	LAST-DATE-DAY-1	2	317	318	N	
103.	PLACE-OF-SERVICE-1	2	319	320	C	See PLACE OF SERVICE table for values
104.	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
105.	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
106.	EPSDT-INDICATOR-1	1	333	333	C	Indicates this is a well child visit that needs

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						follow up or referral. VALUE 'Y'
107.	REIMBURSE-IND-1	1	334	334	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
108.	AMOUNT-BILLED-1	7	335	341	N	Amount billed by provider of service Mask: 99999V99
109.	AMOUNT-PAID-1	7	342	348	N	Amount paid by HMO plan for service Mask: 99999V99
110.	LINE-ENCOUNTER-DATA-2		349	405		
111.	PROCEDURE-CODE-2	5	349	353	C	
112.	FILLER	1	354	354	C	
113.	MODIFIER-2	2	355	356	C	
114.	UNITS-MILES-2	3	357	359	N	
115.	FIRST-DATE-OF-SERV-2		360	367		
116.	FIRST-DATE-CENTURY-2	2	360	361	N	
117.	FIRST-DATE-YEAR-2	2	362	363	N	
118.	FIRST-DATE-MONTH-2	2	364	365	N	
119.	FIRST-DATE-DAY-2	2	366	367	N	
120.	LAST-DATE-OF-SERV-2		368	375		
121.	LAST-DATE-CENTURY-2	2	368	369	N	
122.	LAST-DATE-YEAR-2	2	370	371	N	
123.	LAST-DATE-MONTH-2	2	372	373	N	
124.	LAST-DATE-DAY-2	2	374	375	N	
125.	PLACE-OF-SERVICE-2	2	376	377	C	See PLACE OF SERVICE table for values
126.	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
127.	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
128.	EPSDT-INDICATOR-2	1	390	390	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
129.	REIMBURSE-IND-2	1	391	391	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
130.	AMOUNT-BILLED-2	7	392	398	N	Amount billed by provider of service Mask: 99999V99
131.	AMOUNT-PAID-2	7	399	405	N	Amount paid by HMO plan for service Mask: 99999V99
132.	LINE-ENCOUNTER-DATA-3		406	462		
133.	PROCEDURE-CODE-3	5	406	410	C	
134.	FILLER	1	411	411	C	
135.	MODIFIER-3	2	412	413	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
136.	UNITS-MILES-3	3	414	416	N	
137.	FIRST-DATE-OF-SERV-3		417	424		
138.	FIRST-DATE-CENTURY-3	2	417	418	N	
139.	FIRST-DATE-YEAR-3	2	419	420	N	
140.	FIRST-DATE-MONTH-3	2	421	422	N	
141.	FIRST-DATE-DAY-3	2	423	424	N	
142.	LAST-DATE-OF-SERV-3		425	432		
143.	LAST-DATE-CENTURY-3	2	425	426	N	
144.	LAST-DATE-YEAR-3	2	427	428	N	
145.	LAST-DATE-MONTH-3	2	429	439	N	
146.	LAST-DATE-DAY-3	2	431	432	N	
147.	PLACE-OF-SERVICE-3	2	433	434	C	See PLACE OF SERVICE table for values
148.	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
149.	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
150.	EPSDT-INDICATOR-3	1	447	447	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
151.	REIMBURSE-IND-3	1	448	448	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
152.	AMOUNT-BILLED-3	7	449	455	N	Amount billed by provider of service Mask: 99999V99
153.	AMOUNT-PAID-3	7	456	462	N	Amount paid by HMO plan for service Mask: 99999V99
154.	LINE-ENCOUNTER-DATA-4		463	467		
155.	PROCEDURE-CODE-4	5	463	467	C	
156.	FILLER	1	468	468	C	
157.	MODIFIER-4	2	469	470	C	
158.	UNITS-MILES-4	3	471	473	N	
159.	FIRST-DATE-OF-SERV-4		474	481		
160.	FIRST-DATE-CENTURY-4	2	474	475	N	
161.	FIRST-DATE-YEAR-4	2	476	477	N	
162.	FIRST-DATE-MONTH-	2	478	479	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	4					
163.	FIRST-DATE-DAY-4	2	480	481	N	
164.	LAST-DATE-OF-SERV-4		482	489		
165.	LAST-DATE-CENTURY-4	2	482	483	N	
166.	LAST-DATE-YEAR-4	2	484	485	N	
167.	LAST-DATE-MONTH-4	2	486	487	N	
168.	LAST-DATE-DAY-4	2	488	489	N	
169.	PLACE-OF-SERVICE-4	2	490	491	C	See PLACE OF SERVICE table for values
170.	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
171.	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
172.	EPSDT-INDICATOR-4	1	504	504	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
173.	REIMBURSE-IND-4	1	505	505	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
174.	AMOUNT-BILLED-4	7	506	512	N	Amount billed by provider of service Mask: 99999V99
175.	AMOUNT-PAID-4	7	513	519	N	Amount paid by HMO plan for service Mask: 99999V99
176.	LINE-ENCOUNTER-DATA-5		520	576		
177.	PROCEDURE-CODE-5	5	520	524	C	
178.	FILLER	1	525	525	C	
179.	MODIFIER-5	2	526	527	C	
180.	UNITS-MILES-5	3	528	530	N	
181.	FIRST-DATE-OF-SERV-5		531	538		
182.	FIRST-DATE-CENTURY-5	2	531	532	N	
183.	FIRST-DATE-YEAR-5	2	533	534	N	
184.	FIRST-DATE-MONTH-5	2	535	536	N	
185.	FIRST-DATE-DAY-5	2	537	538	N	
186.	LAST-DATE-OF-SERV-5		539	546		
187.	LAST-DATE-CENTURY-5	2	539	540	N	
188.	LAST-DATE-YEAR-5	2	541	542	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
189.	LAST-DATE-MONTH-5	2	543	544	N	
190.	LAST-DATE-DAY-5	2	545	546	N	
191.	PLACE-OF-SERVICE-5	2	547	548	C	See PLACE OF SERVICE table for values
192.	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
193.	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
194.	EPSDT-INDICATOR-5	1	561	561	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
195.	REIMBURSE-IND-5	1	562	562	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
196.	AMOUNT-BILLED-5	7	563	569	N	Amount billed by provider of service Mask: 99999V99
197.	AMOUNT-PAID-5	7	570	576	N	Amount paid by HMO plan for service Mask: 99999V99
198.	LINE-ENCOUNTER-DATA-6		577	563		
199.	PROCEDURE-CODE-6	5	577	581	C	
200.	FILLER	1	582	582	C	
201.	MODIFIER-6	2	583	584	C	
202.	UNITS-MILES-6	3	585	587	N	
203.	FIRST-DATE-OF-SERV-6		588	595		
204.	FIRST-DATE-CENTURY-6	2	588	589	N	
205.	FIRST-DATE-YEAR-6	2	590	591	N	
206.	FIRST-DATE-MONTH-6	2	592	593	N	
207.	FIRST-DATE-DAY-6	2	594	595	N	
208.	LAST-DATE-OF-SERV-6		596	603		
209.	LAST-DATE-CENTURY-6	2	596	597	N	
210.	LAST-DATE-YEAR-6	2	598	599	N	
211.	LAST-DATE-MONTH-6	2	600	601	N	
212.	LAST-DATE-DAY-6	2	602	603	N	
213.	PLACE-OF-SERVICE-6	2	604	605	C	See PLACE OF SERVICE table for values
214.	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
215.	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
216.	EPSDT-INDICATOR-6	1	618	618	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
217.	REIMBURSE-IND-6	1	619	619	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
218.	AMOUNT-BILLED-6	7	620	626	N	Amount billed by provider of service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						Mask: 99999V99
219.	AMOUNT-PAID-6	7	627	633	N	Amount paid by HMO plan for service Mask: 99999V99
220.	LINE-ENCOUNTER-DATA-7		634	690		
221.	PROCEDURE-CODE-7	5	634	638	C	
222.	FILLER	1	639	639	C	
223.	MODIFIER-7	2	640	641	C	
224.	UNITS-MILES-7	3	642	644	N	
225.	FIRST-DATE-OF-SERV-7		645	652		
226.	FIRST-DATE-CENTURY-7	2	645	646	N	
227.	FIRST-DATE-YEAR-7	2	647	648	N	
228.	FIRST-DATE-MONTH-7	2	649	650	N	
229.	FIRST-DATE-DAY-7	2	651	652	N	
230.	LAST-DATE-OF-SERV-7		653	660		
231.	LAST-DATE-CENTURY-7	2	653	654	N	
232.	LAST-DATE-YEAR-7	2	655	656	N	
233.	LAST-DATE-MONTH-7	2	657	658	N	
234.	LAST-DATE-DAY-7	2	659	660	N	
235.	PLACE-OF-SERVICE-7	2	661	662	C	See PLACE OF SERVICE table for values
236.	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
237.	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
238.	EPSDT-INDICATOR-7	1	675	675	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
239.	REIMBURSE-IND-7	1	676	676	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
240.	AMOUNT-BILLED-7	7	677	683	N	Amount billed by provider of service Mask: 99999V99
241.	AMOUNT-PAID-7	7	684	690	N	Amount paid by HMO plan for service Mask: 99999V99
242.	LINE-ENCOUNTER-DATA-8		691	747		
243.	PROCEDURE-CODE-8	5	691	695	C	
244.	FILLER	1	696	696	C	
245.	MODIFIER-8	2	697	698	C	
246.	UNITS-MILES-8	3	699	701	N	
247.	FIRST-DATE-OF-SERV-8		702	709		
248.	FIRST-DATE-CENTURY-8	2	702	703	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
249.	FIRST-DATE-YEAR-8	2	704	705	N	
250.	FIRST-DATE-MONTH-8	2	706	707	N	
251.	FIRST-DATE-DAY-8	2	708	709	N	
252.	LAST-DATE-OF-SERV-8		710	717		
253.	LAST-DATE-CENTURY-8	2	710	711	N	
254.	LAST-DATE-YEAR-8	2	712	713	N	
255.	LAST-DATE-MONTH-8	2	714	715	N	
256.	LAST-DATE-DAY-8	2	716	717	N	
257.	PLACE-OF-SERVICE-8	2	718	719	C	See PLACE OF SERVICE table for values
258.	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
259.	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
260.	EPSDT-INDICATOR-8	1	732	732	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
261.	REIMBURSE-IND-8	1	733	733	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service
262.	AMOUNT-BILLED-8	7	734	740	N	Amount billed by provider of service Mask: 99999V99
263.	AMOUNT-PAID-8	7	741	747	N	Amount paid by HMO plan for service Mask: 99999V99
264.	FILLER	520	748	1267		
265.	HMO-OWN-REF-NUMBER	16	1268	1283	C	HMO own reference number
266.	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

REQUIRED ENCOUNTER DATA ELEMENTS - HOSPITAL ENCOUNTERS

DATA ELEMENT	DESCRIPTION/VALUES	POS		JUSTIFICATION	REQUIREMENT
		IP	OP		
Date Submitted by MCO	Julian date representing date of submission by MCO.	X	X	Needed to link document date of submission.	Required
Encounter Type	The State designation "Z" for hospital encounters.	X	X	Needed to document type of encounter.	Required
TPL Recovery Indicator	A code that designates third party recoveries are being reported for a previously submitted encounter claim. Use value "R" to indicate a previously submitted encounter.	X	X	Needed to link to a previously submitted encounter.	Required, if applicable
Resubmit Indicator	A code that designates that an encounter is being resubmitted as a corrected encounter. Use value "C" to indicate a corrected encounter; value "D" to delete a previous submission.	X	X	Needed to document a corrected encounter.	Required, if applicable
MCO Payment Denied Indicator	A code that designates that payment for the encounter was denied by the managed care plan. Use value "D" for denied encounter.	X	X	Needed for QA reviews.	Required, if applicable
Adjustment Indicator	A code that designates the adjustment of a previously submitted encounter. Use value "V" to void/cancel a previously approved encounter.	X	X	Needed to identify replacements for previous encounters.	Required, if applicable
Client Recipient Number	A State assigned number that uniquely identifies an individual eligible for Medicaid benefits.	X	X	Link to State eligibility and enrollment files.	Required
Client ID Number	A number assigned by the managed care plan that uniquely identifies each individual in the plan.	X	X	Link to managed care plan's enrollment files.	Required
Managed Care Plan's (MCP) Medicaid Provider Number	A State assigned number that uniquely identifies and MCO as eligible to participate as a Medicaid managed care provider.	X	X	Needed to identify responsible plan.	Required

DATA ELEMENT	DESCRIPTION/VALUES	POS		JUSTIFICATION	REQUIREMENT
		IP	OP		
Third Party Carrier Code	Code identifying any third party carrier on the encounter.	X	X	Needed to determine capitation rates.	Required, if applicable
Third Party Policy Number	A number assigned by the third party payer that uniquely identifies the insured.	X	X	Needed to determine capitation rates.	Required, if applicable
Third Party Insured's Name	The name of the individual in whose name the insurance is carried.	X	X	Needed to determine capitation rates.	Required, if applicable
Third Party Amount Paid	The amount paid by the third party payer.	X	X	Needed to determine capitation rates.	Required, if applicable
Attending Physician ID Number	A State assigned number that uniquely identifies the attending physician as eligible to participate as a Medicaid provider. If the attending physician is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters.	X	X	Needed to identify the attending physician.	Required
Performing Provider ID Number	A State assigned number that uniquely Identifies the performing provider of service as eligible to participate as a Medicaid provider. If the performing provider of service is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters.	X	X	Required to identify provider of service.	Required
Dollar Amount Billed	The amount billed by the provider for services rendered for this encounter. If the encounter is not paid fee for service, it is the amount the provider would have billed for the service.	X	X	Needed for audit purposes and to determine capitation rates.	Required
Dollar Amount Paid	The amount paid by the managed care plan for services rendered for this encounter.	X	X	Needed for audit purposes and to determine capitation rates.	Required, if managed care plan reimbursed on a fee for service basis

DATA ELEMENT	DESCRIPTION/VALUES	POS		JUSTIFICATION	REQUIREMENT
		IP	OP		
Reimbursement Indicator	Code that identifies the managed care plan's method of reimbursement to the provider of service. Use value "C" for capitated; value "F" for fee for service.	X	X	Needed for audit purposes and to determine capitation rates.	Required
Date of Service (From)	The beginning date of service included on the encounter.	X	X	Needed for QA reviews and utilization profiling.	Required
Date of Service (To)	The ending date of service included on the encounter.	X	X	Needed for QA reviews and utilization profiling.	Required
Date of Admission	The date a recipient was admitted to the medial institution.	X		Needed for QA reviews and utilization profiling.	Required for inpatient encounters
Date of Discharge	The formal release date of the inpatient from the medical institution.	X		Needed for QA purposes and medical record tracking.	Required, if applicable
Patient Status	The code that indicates patient status as of the ending date of service.*	X		Needed for QA reviews and utilization profiling.	Required for inpatient encounters
Admitting Diagnosis Code	The ICD-9 diagnosis code that necessitates the inpatient admission.	X		Needed for QA reviews and utilization profiling.	Required for inpatient encounters
Principal Diagnosis	The ICD-9 diagnosis code for the principal condition.	X	X	Needed for QA reviews and utilization profiling.	Required
Other Diagnosis	The ICD-9 diagnosis code of any condition other than the principal condition. (Up to 8 diagnoses)	X	X	Needed for QA reviews and utilization profiling.	Required, if applicable
Principal Surgical Procedure Code	The ICD-9 principal surgical procedure performed.	X	X	Needed for QA reviews and utilization profiling.	Required, if applicable
Principal Surgical Procedure Code Date	The date the principal procedure was performed.	X	X	Needed for QA reviews and utilization profiling.	Required, if applicable
Other Surgical Procedure Codes	Any ICD-9 surgical procedures performed other than the principal surgical procedure. (Up to 5 surgical procedures)	X	X	Needed for QA reviews and utilization profiling.	Required, if applicable

DATA ELEMENT	DESCRIPTION/VALUES	POS		JUSTIFICATION	REQUIREMENT
		IP	OP		
Other Surgical Procedure Code Dates	The dates of any surgical procedure codes performed other than the principal surgical procedure. (Up to 5 surgical procedures)	X	X	Needed for QA reviews and utilization profiling.	Required, if other surgical procedure is indicated
Diagnosis Related Group (DRG)	The Diagnosis Related Group (DRG) assigned to the encounter.	X		Needed for QA reviews and utilization profiling.	Required for inpatient encounters
LINE ITEM DETAIL					
Revenue Code	The code identifying specific hospital services. (Up to 50 codes)	X	X	Needed for QA reviews and utilization profiling.	Required, if applicable
Procedure Code	The CPT procedure codes applicable to the revenue codes.		X	Needed for QA reviews and utilization profiling.	Required, if applicable
Units	A quantitative measure of services rendered by revenue/procedure category.	X	X	Needed for QA reviews and utilization profiling.	Required, if applicable
MCO Own Reference Number	The unique reference number assigned to identify the encounter by the managed care plan.	X	X	Link to the managed care plan's encounter processing system.	Required
Enhanced Encounter Number	The State assigned encounter number that uniquely identifies an encounter.	X	X	Needed to identify a re-submitted encounter.	Required, if applicable

***Patient Status Valid Values**

01 DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE).
02 DISCHARGED/TRANSFERRED TO ANOTHER SHORT TERM GENERAL HOSPITAL (PPS) FOR INPATIENT CARE.
03 DISCHARGED/TRANSFERRED TO SKILLED NURSING FACILITY (SNF).
04 DISCHARGED/TRANSFERRED TO AN INTERMEDIATE CARE FACILIITY (ICF).
05 DISCHARGED/TRANSFERRED TO ANOTHER TYPE OF INSTITUTION (PPS EXCLUDED HOSPITAL OR DISTINCT PART UNIT) FOR INPATIENT CARE OR REFERRED FOR OUTPATIENT CARE SERVICES TO ANOTHER INSTITUTION.
06 DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF ORGANIZED HOME HEALTH SERVICE.
07 LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE.
08 DISCHARGED/TRANSFERRED TO HOME UNDER CARE OF A HOME IV PROVIDER.

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
267.	JULIAN-SUBMISSION-DATE	7	1	6	N	Mask CCYYDDD
268.	CLAIM-TYPE	1	8	8	C	HCFA-7500-DATA VALUE 'Z'
269.	TPL-RECOVERY-IND	1	9	9	C	Use 'R' in the indicator if claim represents recovery from TPL by the HMO
270.	RE-SUBMIT-IND	1	10	10	C	Indicates encounter is a re-submit Corrected encounter value 'C' Delete previous submission value 'D'
271.	HMO-PAYMENT-DENIED-INDICATOR	1	11	11	C	Denied encounter value 'D'
272.	ADJUSTMENT-INDICATOR	1	12	12	C	Adjustment of a previously approved encounter VOID-CANCEL value 'V'
273.	MISC-IND-7	1	13	13	C	Future use
274.	MISC-IND-2	1	14	14	C	Future use
275.	MISC-IND-3	1	15	15	C	Future use
276.	MISC-IND-4	2	16	17	C	Future use
277.	RECIPIENT-MEDICAID-NUM	10	18	27	N	Client Medicaid number
278.	INSURED-POLICY-NUMBER	15	28	42	C	HMO Client ID number
279.	HMO-NUMBER	6	43	48	C	Managed Care plan number
280.	TPL-INFO-1	71				THIRD PARTY INSURANCE INFORMATION
281.	CARRIER-CODE-1	5	49	53	C	
282.	CARRIER-POLICY-NUM-1	25	54	78	C	
283.	INSURED-NAME-1.	32			C	
284.	INSURED-LAST-NAME-1	17	79	95	C	
285.	INSURED-FIRST-NAME-1	14	96	109	C	
286.	INSURED-MIDDLE-INIT-1	1	110	110	C	
287.	TPL-AMOUNT-PAID-1	9	111	119	N	999999999 Assumed 2 decimal places
288.	TPL-INFO-2	71				THIRD PARTY INSURANCE INFORMATION
289.	CARRIER-CODE-2	5	120	124	C	
290.	CARRIER-POLICY-NUM-2	25	125	149	C	
291.	INSURED-NAME-2	32			C	
292.	INSURED-LAST-NAME-2	17	150	166	C	
293.	INSURED-FIRST-NAME-2	14	197	180	C	
294.	INSURED-MIDDLE-INIT-2	1	181	181	C	
295.	TPL-AMOUNT-PAID-2	9	182	190	N	Mask: 9999999V99
296.	TPL-INFO-3	71				THIRD PARTY INSURANCE INFORMATION

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
297.	CARRIER-CODE-3	5	191	195	C	
298.	CARRIER-POLICY-NUM-3	25	196	220	C	
299.	INSURED-NAME-3	32			C	
300.	INSURED-LAST-NAME-3	17	221	237	C	
301.	INSURED-FIRST-NAME-3	14	238	251	C	
302.	INSURED-MIDDLE-INIT-3	1	252	252	C	
303.	TPL-AMOUNT-PAID-3	9	253	261	N	Mask: 9999999V99
304.	ATTENDING-PHYSICIAN	6	262	267	C	Attending physician
305.	SERVICE-PROVIDER-NUM	6	268	273	C	Provider of the service
306.	AMOUNT-BILLED	9	274	282	N	Amount billed by the service provider
307.	AMOUNT-PAID BY HMO	9	283	291	N	Amount paid by HMO plan for service
308.	REIMBURSE-IND	1	292	292	C	Value 'C' for capitalized Value 'F' for fee for service
309.	FIRST-DATE-OF-SERV-1	8	293	300		
310.	FIRST-DATE-CENTURY-1	2	293	294	N	
311.	FIRST-DATE-YEAR-1	2	295	296	N	
312.	FIRST-DATE-MONTH-1	2	297	298	N	
313.	FIRST-DATE-DAY-1	2	299	300	N	
314.	LAST-DATE-OF-SERV-1		301	308		
315.	LAST-DATE-CENTURY-1	2	301	302	N	
316.	LAST-DATE-YEAR-1	2	303	304	N	
317.	LAST-DATE-MONTH-1	2	305	306	N	
318.	LAST-DATE-DAY-1	2	307	308	N	
319.	ADMISSION-DATE	8	309	316		Admission date
320.	ADMIT-DATE-CENTURY-1	2	309	310	N	
321.	ADMIT-DATE-YEAR-1	2	311	312	N	
322.	ADMIT-DATE-MONTH-1	2	313	314	N	
323.	ADMIT-	2	315	316	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	DATE-DAY-1					
324.	DISCHARGE-DATE	8	317	324		Discharge date
325.	DISCH-DATE-CENTURY-1	2	317	318	N	
326.	DISCH-DATE-YEAR-1	2	319	320	N	
327.	DISCH-DATE-MONTH-1	2	321	322	N	
328.	DISCH-DATE-DAY-1	2	323	324	N	
329.	PATIENT-STATUS	2	325	326	C	See PATIENT STATUS table for values
330.	ADMISSION-DIAGNOSIS	6	327	332	C	
331.	PRINCIPAL-DIAGNOSIS	6	333	338	C	ICD-9 code for principal condition
332.	OTHER-DIAGNOSIS-1	6	339	344	C	ICD-9 diagnoses other than principal
333.	OTHER-DIAGNOSIS-2	6	345	350	C	ICD-9 diagnoses other than principal
334.	OTHER-DIAGNOSIS-3	6	351	356	C	ICD-9 diagnoses other than principal
335.	OTHER-DIAGNOSIS-4	6	357	362	C	ICD-9 diagnoses other than principal
336.	OTHER-DIAGNOSIS-5	6	363	368	C	ICD-9 diagnoses other than principal
337.	OTHER-DIAGNOSIS-6	6	369	374	C	ICD-9 diagnoses other than principal
338.	OTHER-DIAGNOSIS-7	6	375	380	C	ICD-9 diagnoses other than principal
339.	OTHER-DIAGNOSIS-8	6	381	386	C	ICD-9 diagnoses other than principal
340.	PRINCIPAL-SURGERY	14	387	400		
341.	PRIM-SURG-PROC	6	387	392	C	ICD-9 Performed
342.	PRIM-SURG-DATE	8	393	400	N	CCYYMMDD
343.	OTHER-SURGERY-1	14	401	414		
344.	OTHER-SURG-PROC-1	6	401	406	C	ICD-9 Performed
345.	OTHER-SURG-DATE-1	8	407	414	N	CCYYMMDD
346.	OTHER-SURGERY-2	14	415	428		
347.	OTHER-SURG-PROC-2	6	415	420	C	ICD-9 Performed
348.	OTHER-SURG-DATE-2	8	421	428	N	CCYYMMDD
349.	OTHER-SURGERY-3	14	429	442		
350.	OTHER-SURG-PROC-3	6	429	434	C	ICD-9 Performed
351.	OTHER-SURG-DATE-3	8	435	442	N	CCYYMMDD
352.	OTHER-SURGERY-4	14	443	456		
353.	OTHER-SURG-PROC-4	6	443	448	C	ICD-9 Performed
354.	OTHER-SURG-DATE4	8	449	456	N	CCYYMMDD
355.	OTHER-SURGERY-5	14	457	470		
356.	OTHER-SURG-PROC-5	6	457	462	C	ICD-9 Performed
357.	OTHER-SURG-DATE-5	8	463	470	N	CCYYMMDD
358.	DRG	3	471	473	N	
359.	REVENUE-CODE-1	4	474	477	N	Code for specific hospital service
360.	PROCEDURE-CODE-1	5	478	482	C	HCPCS Code applicable to revenue code
361.	UNITS-1	4	483	486	N	
362.	REVENUE-CODE-2	4	487	490	N	Code for specific hospital service
363.	PROCEDURE-CODE-2	5	491	495	C	HCPCS Code applicable to revenue code
364.	UNITS-2	4	496	499	N	
365.	REVENUE-CODE-3	4	500	503	N	Code for specific hospital service
366.	PROCEDURE-CODE-3	5	504	508	C	HCPCS Code applicable to revenue code
367.	UNITS-3	4	509	512	N	
368.	REVENUE-CODE-4	4	513	516	N	Code for specific hospital service
369.	PROCEDURE-CODE-4	5	517	521	C	HCPCS Code applicable to revenue code
370.	UNITS-4	4	522	525	N	
371.	REVENUE-CODE-5	4	526	529	N	Code for specific hospital service
372.	PROCEDURE-CODE-5	5	530	534	C	HCPCS Code applicable to revenue code
373.	UNITS-5	4	535	538	N	
374.	REVENUE-CODE-6	4	539	542	N	Code for specific hospital service
375.	PROCEDURE-CODE-6	5	543	547	C	HCPCS Code applicable to revenue code
376.	UNITS-6	4	548	551	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
377.	REVENUE-CODE-7	4	552	555	N	Code for specific hospital service
378.	PROCEDURE-CODE-7	5	556	560	C	HCPCS Code applicable to revenue code
379.	UNITS-7	4	561	564	N	
380.	REVENUE-CODE-8	4	565	568	N	Code for specific hospital service
381.	PROCEDURE-CODE-8	5	569	573	C	HCPCS Code applicable to revenue code
382.	UNITS-8	4	574	577	N	
383.	REVENUE-CODE-9	4	578	581	N	Code for specific hospital service
384.	PROCEDURE-CODE-9	5	582	586	C	HCPCS Code applicable to revenue code
385.	UNITS-9	4	587	590	N	
386.	REVENUE-CODE-10	4	591	594	N	Code for specific hospital service
387.	PROCEDURE-CODE-10	5	595	599	C	HCPCS Code applicable to revenue code
388.	UNITS-10	4	600	603	N	
389.	REVENUE-CODE-11	4	604	607	N	Code for specific hospital service
390.	PROCEDURE-CODE-11	5	608	612	C	HCPCS Code applicable to revenue code
391.	UNITS-11	4	613	616	N	
392.	REVENUE-CODE-12	4	617	620	N	Code for specific hospital service
393.	PROCEDURE-CODE-12	5	621	625	C	HCPCS Code applicable to revenue code
394.	UNITS-12	4	626	629	N	
395.	REVENUE-CODE-13	4	630	633	N	Code for specific hospital service
396.	PROCEDURE-CODE-13	5	634	638	C	HCPCS Code applicable to revenue code
397.	UNITS-13	4	639	642	N	
398.	REVENUE-CODE-14	4	643	646	N	Code for specific hospital service
399.	PROCEDURE-CODE-14	5	647	651	C	HCPCS Code applicable to revenue code
400.	UNITS-14	4	652	655	N	
401.	REVENUE-CODE-15	4	656	659	N	Code for specific hospital service
402.	PROCEDURE-CODE-15	5	660	664	C	HCPCS Code applicable to revenue code
403.	UNITS-15	4	665	668	N	
404.	REVENUE-CODE-16	4	669	672	N	Code for specific hospital service
405.	PROCEDURE-CODE-16	5	673	677	C	HCPCS Code applicable to revenue code
406.	UNITS-16	4	678	681	N	
407.	REVENUE-CODE-17	4	682	685	N	Code for specific hospital service
408.	PROCEDURE-CODE-17	5	686	690	C	HCPCS Code applicable to revenue code
409.	UNITS-17	4	691	694	N	
410.	REVENUE-CODE-18	4	695	698	N	Code for specific hospital service
411.	PROCEDURE-CODE-18	5	699	703	C	HCPCS Code applicable to revenue code
412.	UNITS-18	4	704	707	N	
413.	REVENUE-CODE-19	4	708	711	N	Code for specific hospital service
414.	PROCEDURE-CODE-19	5	712	716	C	HCPCS Code applicable to revenue code
415.	UNITS-19	4	717	720	N	
416.	REVENUE-CODE-20	4	721	724	N	Code for specific hospital service
417.	PROCEDURE-CODE-20	5	725	729	C	HCPCS Code applicable to revenue code
418.	UNITS-20	4	730	733	N	
419.	REVENUE-CODE-21	4	734	737	N	Code for specific hospital service
420.	PROCEDURE-CODE-21	5	738	742	C	HCPCS Code applicable to revenue code
421.	UNITS-21	4	743	746	N	
422.	REVENUE-CODE-22	4	747	750	N	Code for specific hospital service
423.	PROCEDURE-CODE-22	5	751	755	C	HCPCS Code applicable to revenue code
424.	UNITS-22	4	756	759	N	
425.	REVENUE-CODE-23	4	760	763	N	Code for specific hospital service
426.	PROCEDURE-CODE-23	5	764	768	C	HCPCS Code applicable to revenue code
427.	UNITS-23	4	769	772	N	
428.	REVENUE-CODE-24	4	773	776	N	Code for specific hospital service
429.	PROCEDURE-CODE-24	5	777	781	C	HCPCS Code applicable to revenue code
430.	UNITS-24	4	782	785	N	
431.	REVENUE-CODE-25	4	786	789	N	Code for specific hospital service
432.	PROCEDURE-CODE-25	5	790	794	C	HCPCS Code applicable to revenue code
433.	UNITS-25	4	795	798	N	
434.	REVENUE-CODE-26	4	799	802	N	Code for specific hospital service
435.	PROCEDURE-CODE-26	5	803	807	C	HCPCS Code applicable to revenue code
436.	UNITS-26	4	808	811	N	
437.	REVENUE-CODE-27	4	812	815	N	Code for specific hospital service
438.	PROCEDURE-CODE-27	5	816	820	C	HCPCS Code applicable to revenue code
439.	UNITS-27	4	821	824	N	
440.	REVENUE-CODE-28	4	825	828	N	Code for specific hospital service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
441.	PROCEDURE-CODE-28	5	829	833	C	HCPCS Code applicable to revenue code
442.	UNITS-28	4	834	837	N	
443.	REVENUE-CODE-29	4	838	841	N	Code for specific hospital service
444.	PROCEDURE-CODE-29	5	842	846	C	HCPCS Code applicable to revenue code
445.	UNITS-29	4	847	850	N	
446.	REVENUE-CODE-30	4	851	854	N	Code for specific hospital service
447.	PROCEDURE-CODE-30	5	855	859	C	HCPCS Code applicable to revenue code
448.	UNITS-30	4	860	863	N	
449.	REVENUE-CODE-31	4	864	867	N	Code for specific hospital service
450.	PROCEDURE-CODE-31	5	868	872	C	HCPCS Code applicable to revenue code
451.	UNITS-31	4	873	876	N	
452.	REVENUE-CODE-32	4	877	880	N	Code for specific hospital service
453.	PROCEDURE-CODE-32	5	881	885	C	HCPCS Code applicable to revenue code
454.	UNITS-32	4	886	889	N	
455.	REVENUE-CODE-33	4	890	893	N	Code for specific hospital service
456.	PROCEDURE-CODE-33	5	894	898	C	HCPCS Code applicable to revenue code
457.	UNITS-33	4	899	902	N	
458.	REVENUE-CODE-34	4	903	906	N	Code for specific hospital service
459.	PROCEDURE-CODE-34	5	907	911	C	HCPCS Code applicable to revenue code
460.	UNITS-34	4	912	915	N	
461.	REVENUE-CODE-35	4	916	919	N	Code for specific hospital service
462.	PROCEDURE-CODE-35	5	920	924	C	HCPCS Code applicable to revenue code
463.	UNITS-35	4	925	928	N	
464.	REVENUE-CODE-36	4	929	932	N	Code for specific hospital service
465.	PROCEDURE-CODE-36	5	933	937	C	HCPCS Code applicable to revenue code
466.	UNITS-36	4	938	941	N	
467.	REVENUE-CODE-37	4	942	945	N	Code for specific hospital service
468.	PROCEDURE-CODE-37	5	946	950	C	HCPCS Code applicable to revenue code
469.	UNITS-37	4	951	954	N	
470.	REVENUE-CODE-38	4	955	958	N	Code for specific hospital service
471.	PROCEDURE-CODE-38	5	959	963	C	HCPCS Code applicable to revenue code
472.	UNITS-38	4	964	967	N	
473.	REVENUE-CODE-39	4	968	971	N	Code for specific hospital service
474.	PROCEDURE-CODE-39	5	972	976	C	HCPCS Code applicable to revenue code
475.	UNITS-39	4	977	980	N	
476.	REVENUE-CODE-40	4	981	984	N	Code for specific hospital service
477.	PROCEDURE-CODE-40	5	985	989	C	HCPCS Code applicable to revenue code
478.	UNITS-40	4	990	993	N	
479.	REVENUE-CODE-41	4	994	997	N	Code for specific hospital service
480.	PROCEDURE-CODE-41	5	998	1002	C	HCPCS Code applicable to revenue code
481.	UNITS-41	4	1003	1006	N	
482.	REVENUE-CODE-42	4	1007	1010	N	Code for specific hospital service
483.	PROCEDURE-CODE-42	5	1011	1015	C	HCPCS Code applicable to revenue code
484.	UNITS-42	4	1016	1019	N	
485.	REVENUE-CODE-43	4	1020	1023	N	Code for specific hospital service
486.	PROCEDURE-CODE-43	5	1024	1028	C	HCPCS Code applicable to revenue code
487.	UNITS-43	4	1029	1032	N	
488.	REVENUE-CODE-44	4	1033	1036	N	Code for specific hospital service
489.	PROCEDURE-CODE-44	5	1037	1041	C	HCPCS Code applicable to revenue code
490.	UNITS-44	4	1042	1045	N	
491.	REVENUE-CODE-45	4	1046	1049	N	Code for specific hospital service
492.	PROCEDURE-CODE-45	5	1050	1054	C	HCPCS Code applicable to revenue code
493.	UNITS-45	4	1055	1058	N	
494.	REVENUE-CODE-46	4	1059	1062	N	Code for specific hospital service
495.	PROCEDURE-CODE-46	5	1063	1067	C	HCPCS Code applicable to revenue code
496.	UNITS-46	4	1068	1071	N	
497.	REVENUE-CODE-47	4	1072	1075	N	Code for specific hospital service
498.	PROCEDURE-CODE-47	5	1076	1080	C	HCPCS Code applicable to revenue code
499.	UNITS-47	4	1081	1084	N	
500.	REVENUE-CODE-48	4	1085	1088	N	Code for specific hospital service
501.	PROCEDURE-CODE-48	5	1089	1093	C	HCPCS Code applicable to revenue code

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
502.	UNITS-48	4	1094	1097	N	
503.	REVENUE-CODE-49	4	1098	1101	N	Code for specific hospital service
504.	PROCEDURE-CODE-49	5	1102	1106	C	HCPCS Code applicable to revenue code
505.	UNITS-49	4	1107	1110	N	
506.	REVENUE-CODE-50	4	1111	1114	N	Code for specific hospital service
507.	PROCEDURE-CODE-50	5	1115	1119	C	HCPCS Code applicable to revenue code
508.	UNITS-50	4	1120	1123	N	
509.	FILLER	144	1124	1267	C	
510.	HMO-OWN-REF-NUMBER	16	1268	1283	C	HMO own reference number
511.	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

REQUIRED ENCOUNTER DATA ELEMENTS - PRESCRIBED DRUG ENCOUNTERS

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Date Submitted by MCO	Julian date representing date of submission by MCO.	Needed to link document date of submission.	Required
Encounter Type	The State designation "D" for drug encounters.	Needed to document type of encounter.	Required
TPL Recovery Indicator	A code that designates third party recoveries are being reported for a previously submitted encounter. Use value "R" to indicate a previously submitted encounter.	Needed to link to a previously submitted encounter.	Required, if applicable
Resubmit Indicator	A code that designates that an encounter is being resubmitted as a corrected encounter. Use value "C" to indicate a corrected encounter; value "D" to delete a previous submission.	Needed to document a corrected encounter.	Required, if applicable
MCO Payment Denied Indicator	A code that designates that payment for the encounter was denied by the managed care plan. Use value "D" for denied encounter.	Needed for QA reviews.	Required, if applicable
Adjustment Indicator	A code that designates the adjustment of a previously submitted encounter. Use value "V" to void/cancel a previously approved encounter.	Needed to identify replacements for previous encounters.	Required, if applicable
Client Recipient Number	A State assigned number that uniquely identifies an individual eligible for Medicaid benefits.	Link to State eligibility and enrollment files.	Required
Client ID Number	A number assigned by the managed care plan that uniquely identifies an individual in a managed care plan.	Link to managed care plan's enrollment files.	Required
Managed Care Plan's (MCP) Medicaid Provider Number	A State assigned number that uniquely identifies and MCO as eligible to participate as a Medicaid managed care provider.	Needed to identify responsible plan.	Required

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Third Party Carrier Code	Code identifying any third party carrier on the encounter.	Needed to determine capitation rates.	Required, if applicable
Third Party Policy Number	A number assigned by the third party payer that uniquely identifies the insured.	Needed to determine capitation rates.	Required, if applicable
Third Party Insured's Name	The name of the individual in whose name the insurance is carried.	Needed to determine capitation rates.	Required, if applicable
Third Party Amount Paid	The amount paid by the third party payer.	Needed to determine capitation rates.	Required, if applicable
Performing Provider ID Number	A State assigned number that uniquely Identifies the performing provider of service as eligible to participate as a Medicaid provider. If the performing provider is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters.	Needed to identify the performing provider of service.	Required
Dollar Amount Billed	The amount billed by the provider for services rendered for this encounter. If the encounter is not paid fee for service, it is the amount the provider would have billed for the service.	Needed for audit purposes and to determine capitation rates.	Required
Dollar Amount Paid	The amount paid by the managed care plan for services rendered for this encounter.	Needed for audit purposes and to determine capitation rates.	Required, if managed care plan reimbursed on a fee for service basis
Reimbursement Indicator	Code that identifies the managed care plan's method of payment to the provider of service. Use value "C" for capitated; value "F" for fee for service.	Needed for audit purposes and to determine capitation rates.	Required
Date of Service	The date the drug was dispensed.	Needed for QA reviews and utilization profiling.	Required
National Drug Code (NDC)	National code assigned to all drugs.	Needed for QA reviews and utilization profiling.	Required

DATA ELEMENT	DESCRIPTION/VALUES	JUSTIFICATION	REQUIREMENT
Unit Type	Type of unit based on National Council for Prescription Drug Programs.*	Needed for QA reviews and utilization profiling.	Required
Quantity/Units	A quantitative measure of medication dispensed.	Needed for QA reviews and utilization profiling.	Required
Day's Supply	The number of days for which the prescription is dispensed.	Needed for QA reviews and utilization profiling.	Required
Prescription Number	A unique number assigned by the pharmacy provider to the prescription dispensed.	Needed for QA reviews and utilization profiling.	
Prescribing Physician ID Number	A State assigned number that uniquely identifies the prescribing physician as eligible to participate as a Medicaid provider. If the prescribing physician is not enrolled with Medicaid, the unique number assigned by the managed care plan based on State defined parameters.	Needed to identify the prescribing physician.	Required
New/Refill Indicator	Code that indicates if the prescription is a refill or new prescription.	Needed for QA reviews and utilization profiling.	Required
MCO Own Reference Number	The unique reference number assigned to identify the encounter by the managed care plan.	Link to the managed care plan's encounter processing system.	Required
Enhanced Encounter Number	The State assigned encounter number that uniquely identifies an encounter.	Needed to identify a re-submitted encounter.	Required, if applicable

*** Unit Type Valid Values**

AHF - ANTI-HEMOPHILIC FACTOR INJECTABLES
CAP - CAPSULES
EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE
GM - GRAMS
ML - MILLILITERS
SUP - SUPPOSITORIES
TAB - TABLE
TDP - TRANSDERMAL PATCHES

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
512.	*DEI-CC*	2	1	2	**N**	ENCOUNTER SUBMIT DATE CENTURY
513.	DEI-YY	2	3	4	**N**	ENCOUNTER SUBMIT DATE YEAR
514.	DEI-DDD	3	5	7	**N**	ENCOUNTER SUBMIT DATE DAYS (JULIAN)
515.	DEI-ENC-DOC-TYPE	1	8	8	**C**	RECORD TYPE, DRUG='D'
516.	DEI-TPL-RECOVERY-IND	1	9	9	C	RECOUPMENT = 'R' (CLEMSON USE ONLY)
517.	DEI-RESUBMIT-IND	1	10	10	C	CORRECTED = 'C' DELETE = 'D' (CLEMSON USE ONLY)
518.	DEI-PAYMENT-DENIED-IND	1	11	11	C	DENIED ENCOUNTER = 'D' (CLEMSON USE ONLY)
519.	DEI-ADJUSTMENT-IND	1	12	12		VOID-CANCEL = 'V'
520.	DEI-ENC-IND-1	1	13	13	C	MISC INDICATOR (CLEMSON USE ONLY)
521.	DEI-ENC-IND-2	1	14	14	C	MISC INDICATOR (CLEMSON USE ONLY)
522.	DEI-ENC-IND-3	1	15	15		MISC INDICATOR 'G' =GAPS PDP
523.	DEI-ENC-IND-4	2	16	17	C	MISC INDICATOR (CLEMSON USE ONLY)
524.	DEI-INDIV-NO	10	18	27	N	RECIPIENT MEDICAID NUMBER
525.	DEI-HMO-RECIP-ID	15	28	42	C	HMO RECIPIENT NUMBER
526.	DEI-PROV-NUMBER	6	43	48		SC ASSIGNED PROVIDER NUMBER
527.	DEI-CARRIER-CODE	5	49	53	C	17-22 OCCUR 3X – CARRIER CODE (CLEMSON USE ONLY)
528.	DEI-POLICY-NUMBER	25	54	78	C	POLICY NUMBER (CLEMSON USE ONLY)
529.	DEI-INS-LAST-NAME	17	79	95	C	INSURED LAST NAME (CLEMSON USE ONLY)
530.	DEI-INS-FIRST-NAME	14	96	109	C	INSURED FIRST NAME (CLEMSON USE ONLY)
531.	DEI-INS-MIDDLE-INITIAL	1	110	110	C	INSURED MIDDLE INITIAL (CLEMSON USE ONLY)
532.	DEI-CARRIER-PAID/-INP	9	111	119	N	AMOUNT PAID BY CARRIER / REDEFINES WITHOUT INP (CLEMSON USE ONLY)
533.	DEI-CARRIER-CODE	5	120	124	C	CARRIER CODE (CLEMSON USE ONLY)
534.	DEI-POLICY-NUMBER	25	125	149	C	POLICY NUMBER (CLEMSON USE ONLY)
535.	DEI-INS-LAST-NAME	17	150	166	C	INSURED LAST NAME (CLEMSON USE ONLY)
536.	DEI-INS-FIRST-NAME	14	167	180	C	INSURED FIRST NAME (CLEMSON USE ONLY)
537.	DEI-INS-MIDDLE-INITIAL	1	181	181	C	INSURED MIDDLE INITIAL (CLEMSON USE ONLY)
538.	DEI-CARRIER-PAID/-INP	9	182	190	N	AMOUNT PAID BY CARRIER / REDEFINES WITHOUT INP (CLEMSON USE ONLY)
539.	DEI-CARRIER-CODE	5	191	195	C	CARRIER CODE (CLEMSON USE ONLY)
540.	DEI-POLICY-NUMBER	25	196	220	C	POLICY NUMBER (CLEMSON USE ONLY)
541.	DEI-INS-LAST-NAME	17	221	237	C	INSURED LAST NAME (CLEMSON USE ONLY)
542.	DEI-INS-FIRST-NAME	14	238	251	C	INSURED FIRST NAME (CLEMSON USE ONLY)
543.	DEI-INS-MIDDLE-INITIAL	1	252	252	C	INSURED MIDDLE INITIAL (CLEMSON USE ONLY)

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
544.	DEI-CARRIER-PAID/-INP	9	253	261	N	AMOUNT PAID BY CARRIER / REDEFINES WITHOUT INP (CLEMSON USE ONLY)
545.	FILLER	12	262	273	C	FILLER (CLEMSON USE ONLY)
546.	DEI-SERVICE-PROV-NO	6	274	279	C	SERVICE PROVIDER NUMBER (sc assigned to pharmacy)
547.	DEI-TOT-AMT-HMO-BILLED-INPUT	9	280	288		AMOUNT BILLED BY HMO (AMT BEING BILLED BY PDP) MASK 9999999V99 ZERO FILLED, NO SIGN
548.	DEI-TOT-AMT-HMO-PAID-INPUT	9	289	297	N	AMOUNT PAID BY HMO (CLEMSON USE ONLY)
549.	DEI-REIMBURSE-METHOD	1	298	298	C	FEE FOR SERVICE = 'F' CAPITATED = 'C' (CLEMSON USE ONLY)
550.	DEI-DD-CCYY	4	299	302		DISPENSE DATE CENTURY AND YEAR
551.	DEI-DD-MO	2	303	304	**N**	DISPENSE DATE MONTH
552.	DEI-DD-DA	2	305	306	**N**	DISPENSE DATE DAY OF MONTH
553.	DEI-DRUG-CODE	11	307	317	**C**	NDC DRUG CODE
554.	DEI-UNIT-TYPE	3	318	320	C	TYPE OF UNITS (CLEMSON USE ONLY)
555.	DEI-QUANTITY-DISPENSED-INPUT	6	321	326		QUANTITY DISPENSED
556.	DEI-DAYS-SUPPLY-INPUT	3	327	329	**N**	DAYS SUPPLY DISPENSED
557.	DEI-ENC-PRESCRIPTION-NO	15	330	344	**C**	PRESCRIPTION NUMBER
558.	DEI-PHYSICIAN-NO	6	345	350	**C**	PHYSICAN PROVIDER NUMBER
559.	FILLER	2	351	352	C	FILLER (CLEMSON USE ONLY)
560.	DEI-REFILL-INP	2	353	354	N	NUMBER OF REFILLS (CLEMSON USE ONLY)
561.	DEI-SERV-PROV-NPI	10	355	364		SERVICE PROVIDER (PHARMACY) NPI
562.	DEI-SERV-PROV-NCPDP	7	365	371	**C**	PHARMACY NCPCP (NABP) NUMBER
563.	DEI-SERV-PROV-NAME	25	372	396	**C**	PHARMACY NAME
564.	DEI-PHYSICIAN-NPI	10	397	406	**N**	PRESCRIBING PHYSICIAN'S NPI NUMBER
565.	DEI-PHYSICIAN-DEA	9	407	415	**C**	GAPS PHYSICIAN DEA NUMBER
566.	DEI-PHYSICAN-NAME	25	416	440	**C**	PRESCRIBING PHYSICIAN'S NAME
567.	DEI-RECIP-SSN	9	441	449	**C**	RECEIPIENT SOCIAL SECURITY NUMBER
568.	DEI-GAPS-LAST-NAME	17	450	466	**C**	GAPS MEMBER LAST NAME
569.	DEI-GAPS-FIRST-NAME	14	467	480	**C**	GAPS MEMBER FIRST NAME
570.	DEI-GAPS-MIDDLE-INITIAL	1	481	481	**C**	GAPS MEMBER MIDDLE INITIAL
571.	FILLER	8	482	489	C	FILLER (CLEMSON USE ONLY)
572.	DEI-MEDICARE-ID	15	490	504		15 BYTE MEDICARE NUMBER Mask: XXX-999999999-XXX
573.	DEI-RAILROAD-NUM	**3**	490	492		USED ONLY IF USING THE RAILROAD NUMBER (spaces if not used)
574.	DEI-SSN-MEDICARE-NUM	9	493	501		NUMERIC PORTION OF MEDICARE NUMBER (Typically SSN)
575.	DEI- SUFFIX-MEDICARE-NUM	3	502	504		LAST 3 CHARACTERS OF MEDICARE NUMBER Mask: Characters are left justified Example: value is 'a..', 'b1.', 'c12' (.) indicates space
576.	FILLER	**763**	505	1267		FILLER (CLEMSON USE ONLY)
577.	DEI-HMO-OWN-REF-NUMBER	16	1268	1283		PROVIDER'S OWN REFERENCE NUMBER
578.	DEI-CCN-JULIAN	7	1284	1290	**N**	CCN (7 BYTE JULIAN DATE OF

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
						SUBMISSION DATE)
579.	DEI-CCN-UNIQUE	9	1291	1299		9 BYTE UNIQUE NUMBER
580.	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. It has multiple uses. We have **BOLDED** all the elements needed, to comply with the PDP contract, for the Preferred Drug Provider's submission of encounter data. Not all of these fields will be used by an MCO.

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

Field number 15: DEI-PROV-NUMBER, This is the provider number assigned to you by DHHS.

Field number 36: 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 47: DEI-PHYSICIAN-NO is the SCDHHS physician assigned number. Leave blank if you do not have it.

Field number 54: DEI-PHYSICIAN-DEA it is acceptable to report "NOT FOUND" when unable to report the physician's DEA#

Field number 55: DEI-PHYSICAN-NAME , it is acceptable to report "NOT FOUND" when unable to report the physician's DEA#

Field number 61: 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 62, 63: 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.

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

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: _____

MCO PROVIDER IDENTIFICATION RECORDS FOR NON-MEDICAID PROVIDERS

ELEMENTS	DATA ELEMENT DEFINITION	DATA ELEMENT JUSTIFICATION	DATA ELEMENT REQUIREMENTS
Managed Care Plan's (MCP) Medicaid Provider Number	A State assigned number that uniquely identifies an MCO as eligible to participate as a Medicaid managed care provider	Needed to identify responsible plan	Required
Provider ID Number	Number assigned by the managed care plan using the State defined parameters that uniquely identifies a provider or a provider group that is not enrolled as A Medicaid provider (The first character of this unique number is a State assigned symbol unique to the MCO.)	Required to identify the provider of service	Required
Provider Name	Name of the provider	Needed for provider record	Required
Provider Address	Address of the provider	Needed for provider record	Required
Provider County	County of the provider	Needed for provider record	Required
License Number	License number that uniquely identifies the provider	Needed for provider record	Required, if applicable

EIN (Employee Identification Number)	The EIN (Employee Identification Number) that uniquely identifies the provider	Needed for provider record	Required, if applicable
ELEMENTS	**DATA ELEMENT DEFINITION**	**DATA ELEMENT JUSTIFICATION**	**DATA ELEMENT REQUIREMENTS**
SS# (Social Security Number)	The SS# (Social Security Number) that uniquely identifies the provider	Needed for provider record	Required, if applicable
Pharmacy Permit Number	The permit number that uniquely identifies the pharmacy provider.	Needed for provider record	Required, if applicable
Provider Type	Code indicating the classification of the provider	Needed for provider record	Required
Provider Specialty	Identification of medical specialty or classification of provider	Needed for provider record	Required, if provider type 10, 19, 20, 1,22
Category of Service	Code indicating type of service category of provider	Needed for provider record	Required, if provider type 00, 01

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
581.	HMO-MEDICAID-NUM	6	1	6	C	Managed care plan Medicaid number
582.	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.
583.	PROVIDER-NAME	26	13	38	C	
584.	PROVIDER-CAREOF	26	39	64	C	Provider address line 1
585.	PROVIDER- STREET	26	65	90	C	
586.	PROVIDER-CITY	20	91	110	C	
587.	PROVIDER-STATE	2	111	112	C	
588.	PROVIDER-ZIP	9	113	121	C	
589.	PROVIDER-COUNTY	12	122	133		
590.	PROVIDER-EIN-NUM	10	134	143	C	Employee identification number
591.	PROVIDER-SSN-NUM	9	144	152	C	
592.	PHARMACY-PERMIT-NUM	10	153	162	C	Pharmacy permit number
593.	PROVIDER-TYPE	2	163	164	C	Refer to table for provider types
594.	PROVIDER-SPECIALTY	2	165	166	C	Refer to table for provider specialties
595.	PROVIDER-CATEG-SERV	2	167	168	C	Refer to table for categories of service
596.	PROVIDER-LICENSE-NUMBER	10	169	178	C	
597.	FILLER	22	179	200	C	
598.						
599.						
600.						
601.						
602.						
603.						
604.						
605.						

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

PROVIDER TYPES

01	INPATIENT HOSPITAL
02	OUTPATIENT HOSPITAL
10	MENTAL/REHAB CLINIC
19	OTHER MEDICAL PROFESSIONAL
20	PHYSICIAN, OSTEOPATH IND
21	PHYSICIAN, OSTEOPATH GRP
22	MEDICAL CLINICS
35	PODIATRIST, IND
36	PODIATRIST, GRP
60	HOME HEALTH AGENCY
70	PHARMACY
76	DURABLE MEDICAL EQUIPMENT
80	INDEPENDENT LABORATORY
81	X-RAY
82	AMBULANCE SERVICE

PROVIDER PRACTICE SPECIALTY TABLE

CODE	DESCRIPTION
00	NO SPECIFIC MEDICAL SPECIALTY
01	THERAPIST, MULTIPLE SPECIALTY GROUP
02	ALLERGY AND IMMUNOLOGY
03	ANESTHESIOLOGY
04	AUDIOLOGY
05	CARDIOVASCULAR DISEASES
06	MIDWIFE
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	PRIVATE MENTAL HEALTH
21	NEPHROLOGY/ESRD
22	NEUROLOGY
23	NEUROPATHOLOGY
24	NUCLEAR MEDICINE
25	CERTIFIED REGISTERED NURSE ANESTHETIST/ANESTHETIST ASSISTANT (CRNA/AA)
26	OBSTETRICS
27	OBSTETRICS AND GYNECOLOGY
28	SOUTH CAROLINA DEPT. OF MENTAL HEALTH
29	OCCUPATIONAL MEDICINE
30	ONCOLOGY
31	OPHTHALMOLOGY
32	OSTEOPATHY

33	OPTICIAN
34	OPTOMETRY
36	OTORHINOLARYNGOLOGY
37	HOSPITAL PATHOLOGY
38	PATHOLOGY
39	PATHOLOGY, CLINICAL
40	PEDIATRICS
41	PEDIATRICS, ALLERGY
42	PEDIATRICS, CARDIOLOGY
45	PHYSICAL MEDICINE & REHABILITATION
47	PODIATRY
48	PSYCHIATRY
49	PSYCHIATRY, CHILD
50	FEDERALLY QUALIFIED HEALTH CLINICS
52	SOUTH CAROLINA DEPT. OF HEALTH & ENVIRONMENTAL CONTROL
52	PULMONARY MEDICINE
53	NEONATOLOGY
54	RADIOLOGY
55	RADIOLOGY, DIAGNOSTIC
56	RADIOLOGY, THERAPEUTIC
57	RHEUMATOLOGY
58	FEDERALLY FUNDED HEALTH CLINICS (FFHC)
61	SURGERY, CARDIOVASCULAR
62	SURGERY, COLON AND RECTAL
63	SURGERY, GENERAL
65	SURGERY, NEUROLOGICAL
66	SURGERY, ORAL
67	SURGERY, ORTHOPEDIC
68	SURGERY, PEDIATRIC
69	SURGERY, PLASTIC
70	SURGERY, THORACIC
71	SURGERY, UROLOGICAL
78	MULTIPLE SPECIALTY GROUP
79	PHYSICIAN ASSISTANT
82	PSYCHOLOGIST
83	SOCIAL WORKER

84	SPEECH THERAPIST
85	PHYSICAL/OCCUPATIONAL THERAPIST
86	NURSE PRACTITIONER
87	OCCUPATIONAL THERAPIST
89	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)
90	ALCOHOL & SUBSTANCE ABUSE
93	AMBULATORY SURGERY
95	DEVELOPMENTAL REHABILITATION, INFUSION CENTER
97	RURAL HEALTH CLINICS (RHC)
98	PRIVATE DUTY NURSING
99	PEDIATRIC NURSE PRACTITIONER
AA	PEDIATRIC SUB-SPECIALIST

CATEGORY OF SERVICE

01	Inpatient Hospital - General
03	Inpatient Hospital - Institution for Mental Disease
10	Nursing Home - Institution for Mental Disease
11	Skilled Nursing Facility
13	ICF - Mental Retardation
16	ICF - General

Assistance Payment Categories

Code	Description
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)
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	Medicaid reinstatement
48	S2 SLMB
19	S3 SLMB
50	Qualified working disabled (QWDI)
51	Title IV-E adoption assistance
52	SLMB (SPF low income Medicare beneficiary)
53	Not currently being used
54	SSI nursing homes
55	Family Planning
56	COSY/ISCEDC
57	Katie Beckett Children – Tefra
58	FI-MAO (Temp assist for needy)
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)

Code	Description
88	OCWI (children up to age 19) PHC
90	Qualified Medicare beneficiary (QMB)
91	RIBICOFF children
92	Eligible for GAPS; not Medicaid eligible

Last updated in MMIS 01/01/06
Last updated in this directory 01/20/06

REPORTS FURNISHED TO MCOs BY DHHS

DHHS will furnish the MCOs with the following reports.

Managed Care Member Listing Report
Managed Care Members with Third Party Liability Report

Provider Information Record

Enhanced Encounter Data
- **Prescribed Drugs**
- **Ambulatory**
- **Hospital**

EPSDT Immunization Records

Eligibility Re-determination Listing

In addition, DHHS will provide the MCO with a monthly listing of Medicaid recipients who were mailed an Eligibility Re-determination/Review Form during the month. The listing will include the following information:

- Family Number
- Recipient Number
- Name
- Address
- Phone Number
- Date Review Form Mailed.

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
606.	MLE-RECORD-TYPE	1	1	1		Internal, H=HMO, P=PEP, C=MHN, ? = Other
607.	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
608.	MLE-PROV-NO	6	3	8		Physician recipient is enrolled with.
609.	MLE-PROV-NAME	26	9	34		Provider Name
610.	MLE-CAREOF	26	35	60		Provider Address
611.	MLE-STREET	26	61	86		Provider Street
612.	MLE-CITY	20	87	106		City
613.	MLE-STATE	2	107	108		State
614.	MLE-ZIP	9	109	117		Zip code + 4
615.	MLE-RECIP-NO	10	118	127		Recipient identifying Medicaid number.
616.	MLE-RECIP-LAST-NAME	17	128	144		Recipient Last name
617.	MLE-RECIP-FIRST-NAME	14	145	158		Recipient First name
618.	MLE-RECIP-MI	1	159	159		Recipient Middle initial
619.	MLE-ADDR-CARE-OF	25	160	184		Recipient address
620.	MLE-ADDR-STREET	25	185	209		Street
621.	MLE-ADDR-CITY	23	210	232		City
622.	MLE-ADDR-STATE	2	233	234		State
623.	MLE-ADDR-ZIP	9	235	243		Zip code + 4
624.	MLE-ADDR-AREA-CODE	3	244	246		Recipient phone number Area code
625.	MLE-ADDR-PHONE	7	247	253		Recipient phone number
626.	MLE-COUNTY	2	254	255		Recipient county where eligible
627.	MLE-RECIP-AGE	3	256	258		Recipient Age
628.	MLE-AGE-SW	1	259	259		Y=year, M=month, <=less than 1 month, U=unknown
629.	MLE-RECIP-SEX	1	260	260		M =Male, F=Female, U =Unknown
630.	MLE-RECIP-PAY-CAT	2	261	262		Recipient category of eligibility – see Table 01 for values
631.	MLE-RECIP-DOB.	8	263	270		Recipient date of birth CCYYMMDD
632.	MLE-ENROLL-DATE	6	271	276		Managed Care Enrollment Date YYMMDD
633.	MLE-DISENROLL-DATE	6	277	282		Managed Care Disenrollment Date YYMMDD
634.	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
635.	MLE-PR-KEY	3	285	287		Premium Rate Category
636.	MLE-PREMIUM-RATE	9	288	296		Amount of Premium paid
637.	MLE-PREM-DATE.	6	297	302		CCYYMM – Month for which the premium

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						is paid.
638.	MLE-MENTAL-HEALTH-ARRAY	3	303	305		Obsolete
639.	MLE-PREFERRED-PHYS	25	306	330		Recipient's preferred provider
640.	MLE-REVIEW-DATE-CCYYMMDD.	8	331	338		CCYYMMDD – Date recipient will be reviewed for eligibility and/or managed care enrollment.
641.	PREGNANCY-INDICATOR	1	339	339		Pregnancy indicator
642.	MLE-SSN	9	340	348		Member's social security number
643.	*TPL-NBR-POLICIES*	*2*	*349*	*350*		**Number of TPL policies**
644.	**TPL INFORMATION below REPEATS 10 TIMES IF APPLICABLE This occurs only 5 times on the 834**	**4140**	351	4490		
645.	**POLICY-CARRIER-NAME**	50	351	400		Policy carrier name
646.	*POLICY-NUMBER*	25	401	425		Policy number
647.	*CARRIER-CODE*	5	426	430		Code to signify a carrier
648.	*POLICY- RECIP-EFFECTIVE DATE*	8	431	438		Recipient effective date of policy
649.	*POLICY-RECIP-LAST UPDATE*	6	439	444		Last update policy recipient record
650.	*POLICY-RECIP-OPEN DATE*	8	445	452		Recipient policy open date
651.	*POLICY-RECIP-LAPSE DATE*	8	453	460		Recipient lapse date policy
652.	*POLICY-RECIP-PREG-COV-IND*	1	461	461		Pregnancy coverage indicator
653.	*POLICY-TYPE*	2	462	463		Type of policy-health or casualty
654.	*POLICY-GROUP-NO*	20	464	483		Policy group number
655.	*POLICY-GROUP-NAME*	50	484	533		Policy group name
656.	*POLICY-GROUP-ATTN*	50	534	583		Policy group attention
657.	*POLICY-GROUP-ADDRESS*	50	584	633		Policy group address
658.	*POL-GRP-CITY*	39	634	672		Policy group city
659.	*POL-GRP-STATE*	2	673	674		Policy group state
660.	*POL-GRP-ZIP*	9	675	683		Policy group zip code + 4
661.	*POL-POST-PAYREC-IND*	1	684	684		0-cost avoid, 1-no cost avoid
662.	*POLICY-INSURED-LAST NAME*	17	685	701		Insured last name
663.	*POLICY-INSURED-FIRST NAME*	14	702	715		Insured first name
664.	*POLICY-INSURED-MI-NAME*	1	716	716		Insured middle Initial
665.	*POLICY--SOURCE-CODE*	1	717	717		Source of info about policy (ie. champus, highway)
666.	*POLICY--LETTER-IND*	1	718	718		If present, pass group address info
667.	*POL-EFFECTIVE-DATE*	8	719	726		Effective date of policy CCYYMMDD
668.	*POL-OPEN-DATE*	8	727	734		First stored date
669.	*POL-COVER- IND-ARRAY*	30	735	764		1 BYTE FIELDS X 30 What policy will cover
670.	*RECIPIENT-RACE*	2	4491	4492		Race code - Reference Table 13
671.	*RECIPIENT-LANGUAGE*	1	4493	4493		Language code -Reference Table 21
672.	*RECIPIENT-FAMILY--NUM*	8	4494	4501		Family Number
673.	*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
MCO 834 Output Record

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
674.	834-SRC-REC-TYPE	1	1	1	C	* H=header * D=data * T=trailer
675.	834-SRC-PROVIDER-NAME	26	2	27	C	Provider Name
676.	834-SRC-PROV-EMP-ID	9	28	36	C	EIN from Provider record
677.	834-SRC-MLE-CODE	1	37	37	C	* Status in managed care: N=new P=previous C=continuing R=retro enrolled D=disenrolled
678.	834-SRC-MEDICARE-PLAN-CODE	1	38	38	C	* E=no buy-in * A=Part A buyin * B= Part B buyin * C=both A&B
679.	834-SRC-HANDICAP-IND	1	39	39	C	* Y=qual cat 50 or paycat 32,40
680.	834-SRC-INDIVIDUAL-NO	10	40	49	C	* recipient id
681.	834-SRC-GROUP-NUMBER	30	50	79	C	HMO policy number; recip id if no policy number on t
682.	834-SRC-STATUS-INFO-EFF-DATE	6	80	85	C	managed care enroll date unless disenrolled, then disenro Mask YYMMDD
683.	834-SRC-LAST-NAME	17	86	102	C	Recipient Last Name
684.	834-SRC-FIRST-NAME	14	103	116	C	Recipient First Name
685.	834-SRC-MIDDLE-INITIAL	1	117	117	C	Recipient Middle Initial
686.	834-SRC-SOCIAL-SECURITY-NUMBER	9	118	126	C	Recipient Social Security Numb
687.	834-SRC-COMMUNICATION-NUMBER	10	127	136	C	area code + phone number
688.	834-SRC-FAM-RA-ADDR-CARE-OF	25	137	161	C	
689.	834-SRC-FAM-RA-ADDR-LINE-2	25	162	186	C	
690.	834-SRC-SUBSCRIBER-CITY	23	187	209	C	
691.	834-SRC-SUBSCRIBER-STATE-CODE	2	210	211	C	
692.	834-SRC-FAM-RA-ZIP-CODE	9	212	220	C	
693.	834-SRC-COUNTY-WHERE-ELIGIBLE	2	221	222	C	
694.	834-SRC-DATE-OF-BIRTH-8	8	223	230	C	Mask YYYYMMDD
695.	834-SRC-SEX	1	231	231	C	M/F/U
696.	834-SRC-COVERAGE-EFF-DATE	6	232	237		YYMMDD managed care enroll date unless disenrolled, then disenro
697.	834-SRC-PRE-PREM-AMT	9	238	246	N	999999999 Implied 2 decimal p
698.	834-SRC-ENTITY-TYPE-QUAL	1	247	247	C	1=individual preferred provider 2=organization
699.	834-SRC-PCP-LAST-NAME	25	248	272	C	last name of individual or org na
700.	834-SRC-PCP-FIRST-NAME	25	273	297	C	first name of ind preferred prov
701.	834-SRC-PCP-MIDDLE-NAME	25	298	322	C	middle init of ind preferred prov
702.	834-SRC-COB OCCURS 5 TIMES	95	323	417	C	
703.	834-SRC-POLICY-NUMBER	25				
704.	834-SRC-POLAUX-GROUP-TPL-NO	20				
705.	834-SRC-CARRIER-TPL-NAME	50				5-byte carrier code+carrier nam
706.	834-SRC-DATE-TIME-QUAL-COB	3	418	420	C	'344' to indicate pol effective dt '345' to indicate pol lapse dt
707.	834-SRC-COB-EFF-DATE	8	421	428	C	effective or lapse dt depending
708.	834-SRC-LNK-CHAIN-PROV-NUMBER	9	429	437	C	edi mailbox id
709.	834-SRC-PCP-RELATION	2	448	449	C	25=relationship w/pref provider 26=no relationship w/pref provid 72=unknown
710.	834-SRC-PLAN-COVG-DESC	50	450	499	C	pay category+description '** disenrollment**' for disenrolle
711.	FILLER	87	500	587	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
712.						

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

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
713.	PROVIDER-ID-NUMBER	6	1	6	C	Medicaid provider number
714.	PROVIDER-NAME	26	7	32	C	
715.	PROVIDER-CAREOF	26	33	58	C	Provider address line 1
716.	PROVIDER- STREET	26	59	84	C	
717.	PROVIDER-CITY	20	85	104	C	
718.	PROVIDER-STATE	2	105	106	C	
719.	PROVIDER-ZIP	9	107	115	C	
720.	PROVIDER-PHONE-NUMBER	10	116	125	C	
721.	PROVIDER-COUNTY	12	126	137	C	
722.	PROVIDER-TYPE	2	138	139	C	Refer to table for provider types
723.	PROVIDER-SPECIALTY	2	140	141	C	Refer to table for provider specialties
724.	PROV-PRICING-SPECIALTY	2	142	143	C	
725.	FILLER	48	144	191	C	
726.						
727.						
728.						
729.						
730.						
731.						
732.						
733.						
734.						
735.						
736.						
737.						

Special instruction:
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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

ENHANCED ENCOUNTER DATA ELEMENTS - PRESCRIBED DRUG ENCOUNTERS

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Encounter Control Number	The unique number assigned to the encounter by DHHS at the time that the encounter is enhanced. The encounter control number = MCO own reference number + "E" (encounter value indicator) + Managed Care Plan's Medicaid Provider Number.	
Client Recipient Number	The State assigned number that uniquely identifies an individual eligible for Medicaid benefits.	√
Encounter Type	The State designation "D" for drug encounters.	√
Client ID Number	Identification number assigned to the member by the managed care plan.	√
Managed Care Indicator (PEP/MCO Indicator)	The indicator that identifies if the encounter is for the Physician Enhanced Program (PEP) or the Health Maintenance Organization (MCO) plan. (This indicator is for future identification by DHHS for the two types of encounters.)	
Format Indicator	Identifies which format in which the encounter was submitted. Assigned by DHHS to distinguish encounters submitted under different record format requirements.	
Submit Date	Julian date(CCYYDDD) on which the encounter was submitted.	√
Process Date	Date(CCYYMMDD) claim was processed(edited and enhanced) by DHHS in MMIS.	
Encounter Status	Status assigned by DHHS to the encounter after editing. An encounter status of "G" = good encounter, "F" = flawed encounter, "I" = ignore encounter, T= TPL encounter only. This status determines what encounters are identified to be moved to the encounter data base.	
Managed Care Plan's (MCP) Provider Type	Identifies the type of managed care provider. Refer to the provider type table for values.	
Managed Care Plan's (MCP) Name	Name of the managed care plan.	
Recipient Name	Last, First, MI of the recipient in the managed care plan.	
Recipient Date of Birth	The date of birth(CCYYMMDD) of the recipient in the managed care plan.	
Recipient's Sex	The sex of the recipient in the managed care plan. Value 01 = male and 02 = female.	
Recipient's Age	The age of the recipient in the managed care plan.	

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Recipient's Race	The race of the recipient in the managed care plan. The value 01 =White, 02 = Black, 03 = Puerto Rican, 04 = =Mexican, 05 = American Indian, 06 = Cuban, 07 = Asian, 08 = Unknown, and 09 = Refugee/Entrant.	
Recipient's County	The county in which the recipient in the managed care plan resides. Values = 01 - 46.	
Payment Category	The category of payment assigned by DSS to the recipient in the managed care plan.	
Qualifying Category	The status of the recipient in the managed care plan that qualifies the recipient for benefits.	
QMB Indicator	Indicates if the recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level.	
Recipient Special Program Indicator	Indicates the enrollment in special programs.	
Third Party: Carrier Code	Three digit code that identifies any third party carrier associated with the encounter.	√
Third Party: Policy Number	Assigned number that uniquely identifies the individual covered under the third party carrier.	√
Third Party: Insured Name	First, last name and MI of the insured under the third party.	√
Third Party: Amount Paid	The amount paid by third party carrier associated with the encounter.	√
TPL Recovery Indicator	Value "R" indicates a TPL recoupment for a previously submitted encounter.	√
Resubmit Indicator	Identifies the encounter as a corrected resubmitted encounter or a deleted encounter. Value "C" identifies a corrected resubmitted encounter and value "D" identifies an encounter that was submitted in error and does not need to be corrected.	√
Denial Indicator	Identifies encounter as being denied payment by MCO. **For future use.**	√
Adjustment Indicator	Identifies a previously approved encounter as being voided or canceled.	√
Encounter Status Indicator	The value that identifies the status of the encounter after editing. Value "A" indicates the encounter passed the edits and was accepted, value "R" indicates that the encounter was rejected and the encounter needs to be resubmitted, value "D" indicates that the encounter was a duplicate of a previously submitted encounter. Managed care plans would need to identify encounters that are marked with an encounter status of "R" to resubmit.	

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Replaced Encounter Control Number	The encounter control number that uniquely identifies the approved encounter that is being replaced.	√
Error Count	Identifies the number of errors assigned to encounter.	
Error Code Array (Up to 50 Errors)	Identifies the error code assigned and the line of the encounter on which the error occurred.	
Error Code Status	Identified the type of error that occurred on the encounter. Value "C" = critical error, value "N" = non-critical error and value "I" = ignore encounter.	
Performing Provider Number	The ID number of provider that rendered the service. For "D" encounters this would be the State assigned Medicaid provider number of the pharmacy or the unique number assigned by the managed care plan to the pharmacy for non-enrolled Medicaid providers.	√
Performing Provider County	County in which the performing provider is enrolled. Values = 01 - 46.	
National Drug Code(NDC)	National Drug Code(NDC) for the drug prescribed on the encounter.	√
Prescription Number	The prescription number assigned to the drug on the encounter.	√
Dispense Date	The dispense/date of service(CCYYMMDD)of the drug on the encounter.	√
Day's Supply	The number of days for which the prescription was dispensed.	√
Unit Type	The unit type of the drug on the encounter.	√
Quantity /Units	The quantity of the drug dispensed on the encounter.	√
Therapeutic Class	The therapeutic class of the drug on the encounter.	
Reimbursement Indicator	Identifies the managed care plan's method of reimbursement to performing provider. Value "C" indicates a capitated reimbursement and value "F" indicates a fee for service reimbursement.	√
Amount Billed	Amount billed by performing provider to the managed care plan.	√
Amount Paid	Amount paid by the managed care plan for the service rendered.	√
Prescribing Physician Number	The ID number of provider that prescribed the drug on the encounter. For "D" encounters this would be the State assigned Medicaid provider number of the prescribing physician or unique number assigned by the managed care plan to the prescribing physician for non-enrolled Medicaid providers.	√
New/Refill Indicator	Identifies new or number of refills used. A "blank" value indicates a new prescription.	√

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
738.	DEC-ENC-KEY	23	1	23		
739.	DEC-ENC-ID-NO	16	1	16	C	
740.	DEC-ENC-IND	1	17	17	C	Value = 'E'
741.	DEC-PROV-NUMBER	6	18	23	C	State assigned number of MCO
742.	DEC-INDIVIDUAL-NO	10	24	33	C	Recipient Medicaid number
743.	DEC-INDIV-NO-CHECK-DIGIT	1	24	24	C	Check digit
744.	DEC-INDIV-NO	9	25	33	C	Number
745.	DEC-ENC-DOC-TYPE	1	34	34	C	Value 'A' = HIC 'D' = Drug 'Z' = Hospital UB
746.	DEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
747.	DEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
748.	DEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
749.	DEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted Mask: CCYYDDD
750.	DEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS Mask: CCYYMMDD
751.	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
752.	DEC-HMO-PROV-INFO	28	69	96	C	Provider information
753.	DEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
754.	DEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
755.	DEC-ENC-RECIP-INFO	63	97	159		Recipient information
756.	DEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
757.	DEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
758.	DEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
759.	DEC-DOB-8	8	129	136	C	Recipient date of birth Mask: CCYYMMDD
760.	DEC-SEX	1	137	137	C	Sex
761.	DEC-AGE	3	138	140	N	Age in years
762.	DEC-RACE	2	141	142	C	Race code
763.	DEC-COUNTY	2	143	144	C	County Code
764.	DEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
765.	DEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
766.	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
767.	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.
768.	FILLER	4	156	159	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
769.	DEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
770.	DEC-CARRIER-CODE	5	160	164	C	Carrier Code
771.	DEC-POLICY-NUMBER	25	165	189	C	Policy number
772.	DEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
773.	DEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
774.	DEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
775.	DEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
776.	DEC-TPL-RECOVERY-IND	1	373	373	C	Value 'R' = recoupment
777.	DEC-RESUBMIT-IND	1	374	374	C	Identifies the encounter as a re-submit or delete Value 'C' = corrected encounter 'D' = delete encounter
778.	DEC-PAYMENT-DENIED-IND	1	375	375	C	Identifies as being denied payment by HMO Value 'D' = denied encounter
779.	DEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
780.	DEC-ENC-IND-1	1	377	377		Possible future use
781.	DEC-ENC-IND-2	1	378	378		Possible future use
782.	DEC-ENC-IND-3	1	379	379		Possible future use
783.	DEC-ENC-IND-4	2	380	381		Possible future use
784.	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
785.	DEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
786.	DEC-REPORTING-QUARTER	5	400	404	C	Quarter in which encounter reported
787.	DEC-CC	2	400	401	C	Century
788.	DEC-YY	2	402	403	C	Year
789.	DEC-QUARTER	1	404	404	C	Quarter reported ???? Calendar or state fiscal ??? Value '1 – 4'
790.	FILLER	45	405	449		
791.	DEC-ERROR-COUNT	2	450	451		Number of errors on the encounter Mask: S9999 COMP (signed packed EBCDIC)
792.	DEC-ERROR-CODE-ARRAY	300	452	751		This array allows for 50 entries, 6 bytes each
793.	DEC-ERROR-LINE-NO	2	452	453	C	Line on which the error occurred
794.	DEC-ERROR-CODE	3	454	456	C	Error code assigned
795.	DEC-ENC-ERROR-STATUS	1	457	457	C	Type of error Value 'C' = critical 'N' = non critical 'I' = ignore
796.	DEC-PERFORMING-PROV-NO	6	752	757	C	Provider number who rendered service
797.	DEC-PROV-COUNTY	2	758	759	C	Performing provider county
798.	DEC-DRUG-CODE	11	760	770	C	National drug code number
799.	DEC-DRUG-NAME	40	771	810	C	Desi drug name
800.	DEC-ENC-PRESCRIPTION-NO	15	811	825	C	Prescription number
801.	DEC-DISPENSE-DATE-8	8	826	833	C	Date which prescription was dispensed Mask: CCYYMMDD
802.	DEC-DAYS-SUPPLY-INPUT	3	834	836	N	Number of days supply
803.	DEC-UNIT-TYPE	3	837	839	X	
804.	DEC-QUANTITY-DISPENSED	6	840	845	N	Amount dispensed
805.	DEC-THERAPEUTIC-CLASS	6	846	851	C	Therapeutic class from drug record

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
806.	DEC-REIMBURSE-METHOD	1	852	852	C	Indicates type of reimbursement for service Value 'F' = fee for service 'C' = capitated
807.	DEC-TOT-AMT-HMO-BILLED	9	853	861	N	Amount billed for service Mask: S9999999V99 (this is zone signed)
808.	DEC-TOT-AMT-HMO-PAID	9	862	870	N	Amount paid for service rendered Mask: S9999999V99 (this is zone signed)
809.	DEC-PRESC-PROV-NO	6	871	876	C	Prescribing physician number
810.	DEC-REFILL	2	877	878	N	Indicates new RX (blank) or number f refills used
811.	FILLER	1386	879	2264		
812.						

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

ENHANCED ENCOUNTER RECORD DATA ELEMENTS - AMBULATORY ENCOUNTERS

Field Name	Field Description	Input Field
Encounter Control Number	The unique number assigned to the encounter by DHHS at the time that the encounter is enhanced. The encounter control number = MCO own reference number + "E" (encounter value indicator) + Managed Care Plan's Medicaid Provider Number.	
Client Recipient Number	The State assigned number that uniquely identifies an individual eligible for Medicaid benefits.	√
Encounter Type	The State designation "D" for drug encounters.	√
Client ID Number	Identification number assigned to the member by the managed care plan.	√
Managed Care Indicator (PEP/MCO Indicator)	The indicator that identifies if the encounter is for the Physician Enhanced Program (PEP) or the Health Maintenance Organization (MCO) plan. (This indicator is for future identification by DHHS for the two types of encounters.)	
Format Indicator	Identifies which format in which the encounter was submitted. Assigned by DHHS to distinguish encounters submitted under different record format requirements.	
Submit Date	Julian date(CCYYDDD) on which the encounter was submitted.	√
Process Date	Date(CCYYMMDD) claim was processed(edited and enhanced) by DHHS in MMIS.	
Encounter Status	Status assigned by DHHS to the encounter after editing. An encounter status of "G" = good encounter, "F" = flawed encounter, "I" = ignore encounter, T= TPL encounter only. This status determines what encounters are identified to be moved to the encounter data base.	
Managed Care Plan's (MCP) Provider Type	Identifies the type of managed care provider. Refer to the provider type table for values.	
Managed Care Plan's (MCP) Name	Name of the managed care plan.	
Recipient Name	Last Name, First Name, MI of the recipient in the managed care plan.	
Recipient Date of Birth	The date of birth(CCYYMMDD) of the recipient in the managed care plan.	
Recipient's Sex	The sex of the recipient in the managed care plan. Value 01 = male and 02 = female.	
Recipient's Age	The age of the recipient in the managed care plan.	

Field Name	Field Description	Input Field
Recipient's Race	The race of the recipient in the managed care plan. The value 01 =White, 02 = Black, 03 = Puerto Rican, 04 = =Mexican, 05 = American Indian, 06 = Cuban, 07 = Asian, 08 = Unknown, and 09 = Refugee/Entrant.	
Recipient's County	The county in which the recipient in the managed care plan resides. Values = 01 - 46.	
Payment Category	The category of payment assigned by DSS to the recipient in the managed care plan.	
Qualifying Category	The status of the recipient in the managed care plan that qualifies the recipient for benefits.	
QMB Indicator	Indicates if the recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level.	
Recipient Special Program Indicator	Indicates the enrollment in special programs.	
Third Party: Carrier Code	Three digit code that identifies any third party carrier associated with the encounter.	√
Third Party: Policy Number	Assigned number that uniquely identifies the individual covered under the third party carrier.	√
Third Party: Insured Name	First, last name and MI of the insured under the third party.	√
Third Party: Amount Paid	The amount paid by third party carrier associated with the encounter.	√
TPL Recovery Indicator	Value "R" indicates a TPL recoupment for a previously submitted encounter.	√
Resubmit Indicator	Identifies the encounter as a corrected resubmitted encounter or a deleted encounter. Value "C" identifies a corrected resubmitted encounter and value "D" identifies an encounter that was submitted in error and does not need to be corrected.	√
Denial Indicator	Identifies encounter as being denied payment by MCO. **For future use.**	√
Adjustment Indicator	Identifies a previously approved encounter as being voided or canceled.	√
Encounter Status Indicator	The value that identifies the status of the encounter after editing. Value "A" indicates the encounter passed the edits and was accepted, value "R" indicates that the encounter was rejected and the encounter needs to be resubmitted, value "D" indicates that the encounter was a duplicate of a previously submitted encounter. Managed care plans would need to identify encounters that are marked with an encounter status of "R" to resubmit.	

Field Name	Field Description	Input Field
Replaced Encounter Control Number	The encounter control number that uniquely identifies the approved encounter that is being replaced.	√
Error Count	Identifies the number of errors assigned to encounter.	
Error Code Array (Up to 50 Errors)	Identifies the error code assigned and the line of the encounter on which the error occurred.	
Error Code Status	Identified the type of error that occurred on the encounter. Value “C” = critical error, value “N” = non-critical error and value “I” = ignore encounter.	
Referring Provider ID Number	The ID number of the referring provider. For “A” encounters this would be the State assigned Medicaid provider number of the doctor who referred the client or the unique number assigned by the managed care plan to the referring doctor for non-enrolled Medicaid providers.	√
Principal Diagnosis	The ICD-9 diagnosis code for the principal condition.	√
Other Diagnosis	The ICD-9 code for any condition other than the principal condition. (Up to 3 diagnoses)	√
First Date of Service	The beginning date of service(CCYYMMDD) included on the encounter.	√
Last Date of Service	The ending date of service(CCYYMMDD) included on the encounter.	√
Procedure Code	The CPT procedure code or the State assigned procedure code identifying the medical procedure preformed.	√
Procedure Code Modifier	The CPT code or the State assigned code identifying the modifying circumstances of a procedure code.	√
Units	The quantitative measure of services by procedure category.	√
Place of Service	The code that indicates where the service was rendered.	√
Performing Provider Group ID Number	The ID number of the group that rendered the service if the performing provider is enrolled as a group provider. For “A” encounters this would be the State assigned Medicaid provider number of the group who provider the service or the unique number assigned by the managed care plan to group for non-enrolled Medicaid providers.	√
Performing Provider ID Number	The ID number of provider that rendered the service. For “A” encounters this would be the State assigned Medicaid provider number of the doctor’s office who provider the service or the unique number assigned by the managed care plan to the doctor’s office for non-enrolled Medicaid providers.	√
Performing Provider County	County in which the performing provider is enrolled. Values = 01 - 46.	

Field Name	Field Description	Input Field
Performing Provider Type	The provider type for the performing provider. Refer to the provider type table for values.	
Performing Provider Practice Specialty	The provider practice specialty assigned to the performing provider. Refer to the provider practice specialty table for values.	
Performing Provider Category of Service	The category of service assigned to the performing provider. Refer to the category of service table for values.	
Reimbursement Indicator	Identifies the managed care plan's method of reimbursement to the performing provider. Value "C" indicates a capitated reimbursement and value "F" indicates a fee for service reimbursement.	√
EPSDT Indicator	The indicator "Y" that the procedure is for a well child visit and a problem was identified that required follow-up or referral.	√
Amount Billed	The amount billed by the provider for services rendered for the hospital encounter. If the amount is not paid fee for service, it is the amount the provider of service would have billed for the service.	√
Amount Paid	The amount paid by the managed care plan for services rendered for this encounter.	√

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
813.	HEC-ENC-KEY	23	1	23		
814.	HEC-ENC-ID-NO	16	1	16	C	
815.	HEC-ENC-IND	1	17	17	C	Value = 'E'
816.	HEC-PROV-NUMBER	6	18	23	C	State assigned number of MCO
817.	HEC-INDIVIDUAL-NO	10	24	33	C	Recipient Medicaid number
818.	HEC-INDIV-NO-CHECK-DIGIT	1	24	24	C	Check digit
819.	HEC-INDIV-NO	9	25	33	C	Number
820.	HEC-ENC-DOC-TYPE	1	34	34	C	Value 'A' = HIC 'D' = Drug 'Z' = Hospital UB
821.	HEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
822.	HEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
823.	HEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
824.	HEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted Mask: CCYYDDD
825.	HEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS Mask: CCYYMMDD
826.	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
827.	HEC-HMO-PROV-INFO	28	69	96	C	Provider information
828.	HEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
829.	HEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
830.	HEC-ENC-RECIP-INFO	63	97	159		Recipient information
831.	HEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
832.	HEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
833.	HEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
834.	HEC-DOB-8	8	129	136	C	Recipient date of birth Mask: CCYYMMDD
835.	HEC-SEX	1	137	137	C	Sex
836.	HEC-AGE	3	138	140	N	Age in years
837.	HEC-RACE	2	141	142	C	Race code
838.	HEC-COUNTY	2	143	144	C	County Code
839.	HEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
840.	HEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
841.	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

CField Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
842.	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.
843.	FILLER	4	156	159	C	
844.	HEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance I nformation Occurs 3 times
845.	HEC-CARRIER-CODE	5	160	164	C	Carrier Code
846.	HEC-POLICY-NUMBER	25	165	189	C	Policy number
847.	HEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
848.	HEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
849.	HEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
850.	HEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
851.	HEC-TPL-RECOVERY-IND	1	373	373	C	Value 'R' = recoupment
852.	HEC-RESUBMIT-IND	1	374	374	C	Identifies the encounter as a re-submit or delete Value 'C' = corrected encounter 'D' = delete encounter
853.	HEC-PAYMENT-DENIED-IND	1	375	375	C	Identifies as being denied payment by HMO Value 'D' = denied encounter
854.	HEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
855.	HEC-ENC-IND-1	1	377	377		Possible future use
856.	HEC-ENC-IND-2	1	378	378		Possible future use
857.	HEC-ENC-IND-3	1	379	379		Possible future use
858.	HEC-ENC-IND-4	2	380	381		Possible future use
859.	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
860.	HEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
861.	HEC-REPORTING-QUARTER	5	400	404	C	Quarter in which encounter reported
862.	HEC-CC	2	400	401	C	Century
863.	HEC-YY	2	402	403	C	Year
864.	HEC-QUARTER	1	404	404	C	Quarter reported ???? Calendar or state fiscal ??? Value '1 – 4'
865.	FILLER	45	405	449		
866.	HEC-ERROR-COUNT	2	450	451		Number of errors on the encounter Mask: S9999 COMP (signed packed EBCDIC)
867.	HEC-ERROR-CODE-ARRAY	300	452	751		This array allows for 50 entries, 6 bytes each
868.	HEC-ERROR-LINE-NO	2	452	453	C	Line on which the error occurred
869.	HEC-ERROR-CODE	3	454	456	C	Error code assigned

CField Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
870.	HEC-ENC-ERROR-STATUS	1	457	457	C	Type of error Value 'C' = critical 'N' = non critical 'I' = ignore
871.	HEC-PRIMARY-CARE-PROV	6	752	757	C	Primary care physician
872.	HEC-PRIM-DIAG-CODE	6	758	763	C	Primary diagnosis
873.	HEC-OTHER-DIAG-CODE-TABLE	18	764	781		Other diagnoses table contains 3 entries – 6 bytes each
874.	HEC-OTHER-DIAG-CODE	6	764	769	C	Other diagnoses code
875.	HEC-TOTAL-NUM-LINES	2	782	783	N	Total number of encounter lines
876.	HEC-HIC-ENC-LINE	76	784	1391		Information for up to 8 lines (table has 8 entries)
877.	HEC-FDOS-CCYY	4	784	787	C	First date of service full year Mask: CCYY
878.	HEC-FDOS-mm	2	788	789	C	First date of service month Mask: MM
879.	HEC-FDOS-DD	2	790	791	C	First date of service day Mask: DD
880.	HEC-LDOS-CCYY	4	792	795	C	Last date of service full year Mask: CCYY
881.	HEC-LDOS-mm	2	796	797	C	Last date of service month Mask: MM
882.	HEC-LDOS-DD	2	798	799	C	Last date of service day Mask: DD
883.	HEC-PROC-CODE-6	6	800	805		Full 6 byte code
884.	HEC-PROC-BYTE-1	1	800	800	C	For future use
885.	HEC-PROCEDURE-CODE	5	801	805	C	HCPCS code
886.	HEC-PROC-CODE-MODIFIER	3	806	808	C	Procedure code modifier
887.	HEC-UNITS-OF-SERVICE	3	809	811	C	Number of visits or services Mask: S999 (field is zone signed)
888.	HEC-TWO-BYTE-POS	2	812	813	C	Location at which service was rendered Field broke into byte 1 and byte 2
889.	HEC-GROUP-PROV-NO	6	814	819	C	Group provider number, if applicable
890.	HEC-SERVICE-PROV-NO	6	820	825	C	Provider rendering service
891.	HEC-PROV-COUNTY	2	826	827	C	County of service provider
892.	HEC-SERVICE-PROV-TYPE	2	828	829	C	Service provider type
893.	HEC-PRACTICE-SPECIALTY	2	830	831	C	Service provider specialty
894.	HEC-CATEGORY-OF-SERVICE	2	832	833	C	Service provider category of service
895.	HEC-EPSDT-INDICATOR	1	834	834	C	Indicator showing screening follow up needed
896.	HEC-REIMBURSE-METHOD	1	835	835	C	Indicates type of reimbursement for service Value 'F' = fee for service 'C' = capitated
897.	HEC-AMT-BILLED-BY-PROV	7	836	842	N	Amount billed for service Mask: S99999V99 (field is zone signed)
898.	HEC-AMT-PAID-TO-PROV	7	843	849	N	Amount paid for service Mask: S99999V99 (field is zone signed)

CField Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
899.	HEC-HIC-LINE-IND	1	850	850	C	Indicates previous payment for service Value 'D' = duplicate line
900.	FILLER	9	851	859		
901.	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

ENHANCED ENCOUNTER DATA ELEMENTS - HOSPITAL ENCOUNTERS

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Encounter Control Number	The unique number assigned to the encounter by DHHS at the time that the encounter is enhanced. The encounter control number = MCO own reference number + "E" (encounter value indicator) + Managed Care Plan's Medicaid Provider Number.	
Client Recipient Number	The State assigned number that uniquely identifies an individual eligible for Medicaid benefits.	√
Encounter Type	The State designation "Z" for hospital encounters.	√
Client ID Number	Identification number assigned to the member by the managed care plan.	√
Managed Care Indicator (PEP/MCO Indicator)	The indicator that identifies if the encounter is for the Physician Enhanced Program (PEP) or the Health Maintenance Organization (MCO) plan. (This indicator is for future identification by DHHS for the two types of encounters.)	
Format Indicator	Identifies which format in which the encounter was submitted. Assigned by DHHS to distinguish encounters submitted under different record format requirements.	
Submit Date	Julian date(CCYYDDD) on which the encounter was submitted.	√
Process Date	Date(CCYYMMDD) claim was processed(edited and enhanced) by DHHS in MMIS.	
Encounter Status	Status assigned by DHHS to the encounter after editing. An encounter status of "G" = good encounter, "F" = flawed encounter, "I" = ignore encounter, T= TPL encounter only. This status determines what encounters are identified to be moved to the encounter data base.	
Managed Care Plan's (MCP) Provider Type	Identifies the type of managed care provider. Refer to the provider type table for values.	
Managed Care Plan's (MCP) Name	Name of the managed care plan.	
Recipient Name	Last, First, MI of the recipient in the managed care plan.	
Recipient Date of Birth	The date of birth(CCYYMMDD) of the recipient in the managed care plan.	
Recipient's Sex	The sex of the recipient in the managed care plan. Value 01 = male and 02 = female.	
Recipient's Age	The age of the recipient in the managed care plan.	

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Recipient's Race	The race of the recipient in the managed care plan. The value 01 =White, 02 = Black, 03 = Puerto Rican, 04 = =Mexican, 05 = American Indian, 06 = Cuban, 07 = Asian, 08 = Unknown, and 09 = Refugee/Entrant.	
Recipient's County	The county in which the recipient in the managed care plan resides. Values = 01 - 46.	
Payment Category	The category of payment assigned by DSS to the recipient in the managed care plan.	
Qualifying Category	The status of the recipient in the managed care plan that qualifies the recipient for benefits.	
QMB Indicator	Indicates if the recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level.	
Recipient Special Program Indicator	Indicates the enrollment in special programs.	
Third Party: Carrier Code	Three digit code that identifies any third party carrier associated with the encounter.	√
Third Party: Policy Number	Assigned number that uniquely identifies the individual covered under the third party carrier.	√
Third Party: Insured Name	First name, last name and MI of the insured under the third party.	√
Third Party: Amount Paid	The amount paid by third party carrier associated with the encounter.	√
TPL Recovery Indicator	Value "R" indicates a TPL recoupment for a previously submitted encounter.	√
Resubmit Indicator	Identifies the encounter as a corrected resubmitted encounter or a deleted encounter. Value "C" identifies a corrected resubmitted encounter and value "D" identifies an encounter that was submitted in error and does not need to be corrected.	√
Denial Indicator	Identifies encounter as being denied payment by MCO. **For future use.**	√
Adjustment Indicator	Identifies a previously approved encounter as being voided or canceled.	√
Encounter Status Indicator	The value that identifies the status of the encounter after editing. Value "A" indicates the encounter passed the edits and was accepted, value "R" indicates that the encounter was rejected and the encounter needs to be resubmitted, value "D" indicates that the encounter was a duplicate of a previously submitted encounter. Managed care plans would need to identify encounters that are marked with an encounter status of "R" to resubmit.	

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Replaced Encounter Control Number	The encounter control number that uniquely identifies the approved encounter that is being replaced.	√
Error Count	Identifies the number of errors assigned to encounter.	
Error Code Array (Up to 50 Errors)	Identifies the error code assigned and the line of the encounter on which the error occurred.	
Error Code Status	Identified the type of error that occurred on the encounter. Value “C” = critical error, value “N” = non-critical error and value “I” = ignore encounter.	
Attending Physician ID Number	The ID number of the attending physician for the hospital encounter. The attending ID number would be the State assigned Medicaid provider number of the attending physician or the unique number assigned by the managed care plan to the attending physician for non-enrolled Medicaid providers.	√
Performing Provider ID Number	The ID number of provider that rendered the service. For “Z” encounters this would be the State assigned Medicaid provider number of the hospital who provider the service or the unique number assigned by the managed care plan to the hospital for non-enrolled Medicaid providers.	√
Performing Provider Type	The provider type for the performing provider. Refer to the provider type table for values.	
Performing Provider Category of Service	The category of service assigned to the performing provider. Refer to the category of service table for values.	
Performing Provider County	County in which the performing provider is enrolled. Values = 01 - 46.	
Admitting Diagnosis	The ICD-9 diagnosis code that necessitates the inpatient admission on the encounter.	√
Date of Admission	The date(CCYYMMDD) the recipient was admitted to the medical institution.	√
Date of Discharge	The formal release date(CCYYMMDD) of the recipient from the medical institution.	√
Patient Status	The code that indicates the patient status as of the ending date of service. Patient status codes designated on the record layout.	√
Principal Diagnosis	The ICD-9 diagnosis code for the principal condition.	√
Other Diagnosis	The ICD-9 code for any condition other than the principal condition. (Up to 8 diagnoses)	√
Date of Service (From)	The beginning date of service(CCYYMMDD) included on the encounter.	√

NAME OF ENHANCED DATA ELEMENT	DESCRIPTION	INPUT FIELD
Date of Service (To)	The ending date of service(CCYYMMDD) included on the encounter.	√
Principal Surgical Procedure Code	The ICD-9 principal surgical procedure performed.	√
Principal Surgical Procedure Code Date	The date(CCYYMMDD)principal procedure performed.	√
Other Surgical Procedure Codes	Any ICD -9 surgical procedures performed other than the principal surgical procedure.(Up to 5 surgical procedures)	√
Other Surgical Procedure Code Dates	The dates of any surgical procedure codes performed other than the principal surgical procedure. (Up to 5 surgical procedures)	√
Diagnosis Related Grouper(DRG)	The DRG assigned to the encounter.	√
Dollar Amount Billed	The amount billed by the provider for services rendered for the hospital encounter. If the amount is not paid fee for service, it is the amount the provider of service would have billed for the service.	√
Dollar Amount Paid	The amount paid by the managed care plan for services rendered for this encounter.	√
Reimbursement Indicator	Identifies the managed care plan's method of reimbursement to the performing provider. Value "C" indicates a capitated reimbursement and value "F" indicates a fee for service reimbursement.	√
Revenue Code	The code identifying specific hospital services. (Up to 50 codes)	√
Procedure Code	The CPT procedure codes applicable to the revenue codes.	√
Units	The quantitative measure of services rendered by the revenue/procedure category.	√

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
902.	ZEC-ENC-KEY	23	1	23		
903.	ZEC-ENC-ID-NO	16	1	16	C	
904.	ZEC-ENC-IND	1	17	17	C	Value = 'E'
905.	ZEC-PROV-NUMBER	6	18	23	C	State assigned number of MCO
906.	ZEC-INDIVIDUAL-NO	10	24	33	C	Recipient Medicaid number
907.	ZEC-INDIV-NO-CZECK-DIGIT	1	24	24	C	CZECk digit
908.	ZEC-INDIV-NO	9	25	33	C	Number
909.	ZEC-ENC-DOC-TYPE	1	34	34	C	Value 'A' = HIC 'D' = Drug 'Z' = Hospital UB
910.	ZEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
911.	ZEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
912.	ZEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
913.	ZEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted Mask: CCYYDDD
914.	ZEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS Mask: CCYYMMDD
915.	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
916.	ZEC-HMO-PROV-INFO	28	69	96	C	Provider information
917.	ZEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
918.	ZEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
919.	ZEC-ENC-RECIP-INFO	63	97	159		Recipient information
920.	ZEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
921.	ZEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
922.	ZEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
923.	ZEC-DOB-8	8	129	136	C	Recipient date of birth Mask: CCYYMMDD
924.	ZEC-SEX	1	137	137	C	Sex
925.	ZEC-AGE	3	138	140	N	Age in years
926.	ZEC-RACE	2	141	142	C	Race code
927.	ZEC-COUNTY	2	143	144	C	County Code
928.	ZEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
929.	ZEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
930.	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
931.	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.
932.	FILLER	4	156	159	C	
933.	ZEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
934.	ZEC-CARRIER-	5	160	164	C	Carrier Code

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
	CODE					
935.	ZEC-POLICY-NUMBER	25	165	189	C	Policy number
936.	ZEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
937.	ZEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
938.	ZEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
939.	ZEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
940.	ZEC-TPL-RECOVERY-IND	1	373	373	C	Value 'R' = recoupment
941.	ZEC-RESUBMIT-IND	1	374	374	C	Identifies the encounter as a re-submit or delete Value 'C' = corrected encounter 'D' = delete encounter
942.	ZEC-PAYMENT-DENIED-IND	1	375	375	C	Identifies as being denied payment by HMO Value 'D' = denied encounter
943.	ZEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
944.	ZEC-ENC-IND-1	1	377	377		Possible future use
945.	ZEC-ENC-IND-2	1	378	378		Possible future use
946.	ZEC-ENC-IND-3	1	379	379		Possible future use
947.	ZEC-ENC-IND-4	2	380	381		Possible future use
948.	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
949.	ZEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
950.	ZEC-REPORTING-QUARTER	5	400	404	C	Quarter in which encounter reported
951.	ZEC-CC	2	400	401	C	Century
952.	ZEC-YY	2	402	403	C	Year
953.	ZEC-QUARTER	1	404	404	C	Quarter reported ???? Calendar or state fiscal ??? Value '1 – 4'
954.	FILLER	45	405	449		
955.	ZEC-ERROR-COUNT	2	450	451		Number of errors on the encounter Mask: S9999 COMP (signed packed EBCDIC)
956.	ZEC-ERROR-CODE-ARRAY	300	452	751		This array allows for 50 entries, 6 bytes each
957.	ZEC-ERROR-LINE-NO	2	452	453	C	Line on which the error occurred
958.	ZEC-ERROR-CODE	3	454	456	C	Error code assigned
959.	ZEC-ENC-ERROR-STATUS	1	457	457	C	Type of error Value 'C' = critical 'N' = non critical 'I' = ignore
960.	ZEC-PRIMARY-CARE-PROV	6	752	757	C	Primary care physician
961.	ZEC-SERVICE-PROV-NO	6	758	763	C	Provider rendering service
962.	ZEC-SERVICE-PROV-TYPE	2	764	765	C	Service provider type
963.	ZEC-SERVICE-PROV-COS	2	766	767	C	Service provider category of service
964.	ZEC-SERVICE-PROV-COUNTY	2	768	769	C	County of service provider
965.	ZEC-ADMIT-DIAGNOSIS	6	770	775	C	Inpatient admission diagnosis
966.	ZEC-ADMIT-DATE-8	8	776	783	C	Date of hospital admission Mask: CCYYMMDD
967.	ZEC-DISCHARGE-DATE-8	8	784	791	C	Date of discharge from hospital
968.	ZEC-PATIENT-STATUS	2	792	793	C	Status of patient upon discharge
969.	ZEC-PRIM-DIAG-CODE	6	794	799	C	Primary diagnosis
970.	ZEC-OTHER-DIAG-CODE	48	800	847	C	Other diagnoses
971.	ZEC-FROM-DATE-8	8	848	855	C	Date service began Mask: CCYYMMDD

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
972.	ZEC-TO-DATE-8	8	856	863	C	Last date of service Mask: CCYYMMDD
973.	ZEC-PRIN-SURG-CODE	6	864	869	C	Principal surgical code
974.	ZEC-PRIN-SURG-DATE-8	8	870	877	C	Date principal surgical procedure performed
975.	ZEC-OTHER-SURG-DATA	14	878	947	C	Other surgical data (occurs 5 times
976.	ZEC-OTHER-SURG-CODE	6	878	883	C	Other surgical codes
977.	ZEC-OTHER-SURG-DATE-8	8	884	891	C	Date other surgical procedure performed Mask: CCYYMMDD
978.	ZEC-DRG-VALUE	3	948	950	C	DRG assigned to encounter
979.	ZEC-TOT-AMT-HMO-BILLED	9	951	959	N	Amount billed for hospital services Mask S9999999v99 (zone signed)
980.	ZEC-TOT-AMT-HMO-PAID	9	960	968	N	Amount billed for hospital services Mask S9999999v99 (zone signed)
981.	ZEC-REIMBURSE-METHOD	1	969	969	C	Indicates type of reimbursement for service Value = F – fee for service Value = C – capitated
982.	ZEC-TOTAL-NUM-LINES	2	970	971	N	Total number of revenue lines
983.	ZEC-ENC-REV-LINE	1150	972	2121	C	Revenue line (occurs 50 times x 23 bytes)
984.	ZEC-REVENUE-CODE-4	4	972	975	C	Revenue code Mask: X – not used at this time XXX – revenue code
985.	ZEC-PROCEDURE-CODE	5	976	980	C	Procedure code
986.	ZEC-REV92-UNITS-SERV	4	981	984	N	Number of days or units of service
987.	FILLER	10	985	994	C	
988.	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
989.	RECIPIENT-MEDICAID-NUMBER	10	1	10	C	
990.	RECIPIENT-LAST-NAME	17	11	27	C	
991.	RECIPIENT-FIRST-NAME	14	28	41	C	
992.	RECIPIENT-MIDDLE-INITIAL	1	42	42	C	
993.	SERVICE-PROVIDER	6	43	48	C	
994.	PAY-TO-PROVIDER	6	49	54	C	
995.	PAY-TO-PROVIDER-NAME	24	55	80	C	
996.	RECIPIENT-COUNTY	2	81	82	C	
997.	PROCEDURE-CODE	5	83	87	C	
998.	DATE-OF-SERVICE-8	8	88	95	C	Mask: YYYYMMDD
999.	FILLER	1	96	96	C	
1000.	DATE-OF-BIRTH	8	97	104	C	Mask: YYYYMMDD
1001.	FILLER	1	105	105	C	
1002.	AGE-ON-DATE-OF-SERVICE	3	106	108	N	
1003.						
1004.						
1005.						
1006.						
1007.						
1008.						
1009.						
1010.						
1011.						
1012.						
1013.						
1014.						

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 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): following plan (check one):		Please **ENROLL** me in the	
☐ First Choice (HM1000)	☐ South Carolina Solutions (PCM120)	☐ First Choice (HM1000)	☐ S
☐ Unison (HM1600)	☐ Palmetto Medical Home Network (PCM130)	☐ Unison (HM1600)	☐ P
☐ Upstate Carolina Best Care (PCM100)	☐ PEP	☐ Upstate Carolina Best Care (PCM100)	☐ _
☐ ~~PhyTrust of South Carolina (PCM110)~~	☐ _____	☐ ~~PhyTrust of South Carolina (PCM110)~~	☐ R

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 the bottom of this form. If reasons are not given, your request may not be honored.***

eiving poor quality care. (31)	☐ I am not able to get the care I need. (33)	☐ Access to care issues (Plan doctor too me to get to). (32)
ıoved 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 Medicaid. (39)
ering a waiver program. (37) ne: CLTC or MFCP	☐ I need hospice services or am entering a nursing home. (38)	☐ The doctor I was assigned to does understand my health care needs. (36)
ff is rude and won't help me. (41)	☐ I didn't realize what I was signing up for. (52)	☐ It takes too long to get services approve
ppy with the doctor. (51)	☐ I'm unhappy with the plan. (50)	☐ I have changed my mind (1st 90 days or

PRINT THE NAME OF EACH FAMILY MEMBER TO BE DISENROLLED--(LAST, FIRST, MIDDLE INITIAL)	BIRTH DATE	

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

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)

<<MCO Name>>

Monthly Newborn 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	Baby's Medicaid #

<<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

Exhibit 1

EXHIBIT 1

Mental Health and Alcohol/Drug Guidelines for MCO/FFS Payment

UB-92 (Hospital Inpatient)

If the Primary Diagnosis is DRG 424 through 433 or 521 through 523, which are listed below, **FFS Medicaid (not MCO)** is responsible for payment.

Diagnosis Code	Description
424	O.R. procedure with principal diagnosis of mental illness
425	Acute adjustment reaction and psychosocial dysfunction
426	Depressive neuroses
427	Neuroses except depressive
428	Disorders of personality and impulse control
429	Organic disturbances and mental retardation
430	Psychoses
431	Childhood mental disorders
432	Other mental disorder diagnosis
433	Alcohol/drug abuse or dependence, left AMA
521	Alcohol/drug abuse or dependence W CC
522	Alcohol/drug abuse or dependence with rehab therapy w/o CC
523	Alcohol/drug abuse or dependence w/o rehab therapy w/o CC

UB-92 (Hospital Outpatient)

If the Primary Diagnosis is a Class C, which are listed below, **FFS Medicaid (not MCO)** is responsible for payment.

Diagnosis Code	Description
290.0	SENILE DEMENTIA UNCOMP
290.10	PRESENILE DEMENTIA
290.11	PRESENILE DELIRIUM
290.12	PRESENILE DELUSION
290.13	PRESENILE DEPRESSION
290.20	SENILE DELUSION
290.21	SENILE DEPRESSIVE
290.3	SENILE DELIRIUM
290.40	VASCULAR DEMENTIA, UNCOMPLICATED
290.41	VASCULAR DEMENTIA, WITH DELIRIUM
290.42	VASCULAR DEMENTIA, WITH DELUSIONS

290.43	VASCULAR DEMENTIA, WITH DEPRESSED M
290.8	SENILE PSYCHOSIS NEC
Diagnosis Code	**Description**
290.9	SENILE PSYCHOT COND NOS
291.0	DELIRIUM TREMENS
291.1	ALCOHOL-INDUCED PERSIST AMNESTIC DI
291.2	ALCOHOL-INDUCED PERSISTING DEMENTIA
291.3	ALCOHOL-INDUC PSYCHOTIC DISORD W/HA
291.4	PATHOLOGIC ALCOHOL INTOX
291.5	ALCOHOL-INDUC PSYCHOTIC DISORD W/DE
291.81	ALCOHOL WITHDRAWAL
291.82	ALCOHOL INDUCED SLEEP DISORDERS
291.89	OTHR SPEC ALCOHOL-INDUCED MENTAL D
291.9	UNSPEC ALCOHOL-INDUCED MENTAL DISO
292.0	DRUG WITHDRAWAL
292.11	DRUG-INDUCED PSYCHOTIC DISOR W/DELU
292.12	DRUG-INDUCED PSYCHOTIC DISOR W/HALL
292.2	PATHOLOGIC DRUG INTOX
292.81	DRUG-INDUCED DELIRIUM
292.82	DRUG-INDUCED PERSISTING DEMENTIA
292.83	DRUG-INDUCED PERSISTING AMNESTIC DI
292.84	DRUG-INDUCED MOOD DISORDER
292.85	DRUG INDUCED SLEEP DISORDERS
292.89	DRUG MENTAL DISORDER NEC
292.9	DRUG MENTAL DISORDER NOS
293.0	DELIRIUM DUE TO CONDITION CLASSIF EL
293.1	SUBACUTE DELIRIUM
293.81	PSYCHOTIC DISORD W/DELUSIONS IN CC E
293.82	PSYCHOTIC DISORD W/HALLUCINATIONS I
293.83	MOOD DISORD IN CONDIT CLASSIFIED ELS
293.84	ANXIETY DISORD IN CONDIT CLASS ELSEW
293.89	OTHR TRANSIENT MENTAL DISORD DUE TO
293.9	UNSPEC TRANSIENT MENTAL DISORDER IN
294.0	AMNESTIC DISORD IN CONDITIONS CLASS
294.10	DEMENTIA CCE WITHOUT BEHAVIORAL DIS
294.11	DEMENTIA CCE WITH BEHAVIORAL DISTUR
294.8	OTHR PERSISTENT MENTAL DISORD DUE T
294.9	UNSP PERSISTENT MENTAL DISORD DUE T
295.00	SIMPL SCHIZOPHREN-UNSPEC
295.01	SIMPL SCHIZOPHREN-SUBCHR
295.02	SIMPLE SCHIZOPHREN-CHR
295.03	SIMP SCHIZ-SUBCHR/EXACER
295.04	SIMPL SCHIZO-CHR/EXACERB

295.05	SIMPL SCHIZOPHREN-REMISS
295.10	HEBEPHRENIA-UNSPEC
295.11	HEBEPHRENIA-SUBCHRONIC
Diagnosis Code	**Description**
295.12	HEBEPHRENIA-CHRONIC
295.13	HEBEPHREN-SUBCHR/EXACERB
295.14	HEBEPHRENIA-CHR/EXACERB
295.15	HEBEPHRENIA-REMISSION
295.20	CATATONIA-UNSPEC
295.21	CATATONIA-SUBCHRONIC
295.22	CATATONIA-CHRONIC
295.23	CATATONIA-SUBCHR/EXACERB
295.24	CATATONIA-CHR/EXACERB
295.25	CATATONIA-REMISSION
295.30	PARANOID SCHIZO-UNSPEC
295.31	PARANOID SCHIZO-SUBCHR
295.32	PARANOID SCHIZO-CHRONIC
295.33	PARAN SCHIZO-SUBCHR/EXAC
295.34	PARAN SCHIZO-CHR/EXACERB
295.35	PARANOID SCHIZO-REMISS
295.40	SCHIZOPHRENIFORM DISORDER, UNSPECIF
295.41	SCHIZOPHRENIFORM DISORDER, SUBCHRO
295.42	SCHIZ0PHRENIFORM DISORDER,CHRONIC
295.43	SCHIZOPHRENIFORM,SUBCHRONIC W/ACUT
295.44	SCHIZOPHRENIFORM,CHRONIC W/ACUTE EX
295.45	SCHIZOPHRENIFORM DISORDER, IN REMISS
295.50	LATENT SCHIZOPHREN-UNSP
295.51	LAT SCHIZOPHREN-SUBCHR
295.52	LATENT SCHIZOPHREN-CHR
295.53	LAT SCHIZO-SUBCHR/EXACER
295.54	LATENT SCHIZO-CHR/EXACER
295.55	LAT SCHIZOPHREN-REMISS
295.60	SCHIZOPHRENIC DISORD,RESIDUAL TYPE,U
295.61	SCHIZOPHRENIC DISORDER,RESID, SUBCHR
295.62	SCHIZOPHRENIC DISORDER,RESID TY, CHR
295.63	SCHIZOPHRENIC,RESID,SUBCHRONIC/ACUT
295.64	SCHIZOPHRENIC,RESID,CHRONIC W/ACUTE
295.65	SCHIZOPHRENIC DISORDER,RESID, REMISS
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIE
295.71	SCHIZOAFFECTIVE DISORDER, SUBCHRONI
295.72	SCHIZOAFFECTIVE DISORDER,CHRONIC
295.73	SCHIZOAFFECTIVE,SUBCHRONIC W/ACUTE
295.74	SCHIZOAFFECTIVE,CHRONIC W/ACUTE EXA

295.75	SCHIZOAFFECTIVE DISORDER, IN REMISSIO
295.80	SCHIZOPHRENIA NEC-UNSPEC
295.81	SCHIZOPHRENIA NEC-SUBCHR
295.82	SCHIZOPHRENIA NEC-CHR
Diagnosis Code	**Description**
295.83	SCHIZO NEC-SUBCHR/EXACER
295.84	SCHIZO NEC-CHR/EXACERB
295.85	SCHIZOPHRENIA NEC-REMISS
295.90	SCHIZOPHRENIA NOS-UNSPEC
295.91	SCHIZOPHRENIA NOS-SUBCHR
295.92	SCHIZOPHRENIA NOS-CHR
295.93	SCHIZO NOS-SUBCHR/EXACER
295.94	SCHIZO NOS-CHR/EXACERB
295.95	SCHIZOPHRENIA NOS-REMISS
296.00	BIPOLAR I, SINGLE MANIC EPISODE,UNSPE
296.01	BIPOLAR I, SINGLE MANIC EPISODE, MILD
296.02	BIPOLAR I, SINGLE MANIC EPISODE,MODER
296.03	BIPOLAR,MANIC EPI,SEVERE,NO MENTION/
296.04	BIPOLAR,MANIC EPI,SEVERE,W/PSYCHOTIC
296.05	BIPOLAR,MANIC EPI,PARTIAL/UNSP REMISS
296.06	BIPOLAR,SINGLE MANIC EPIS,FULL REMISS
296.10	RECUR MANIC DIS-UNSPEC
296.11	RECUR MANIC DIS-MILD
296.12	RECUR MANIC DIS-MOD
296.13	RECUR MANIC DIS-SEVERE
296.14	RECUR MANIC-SEV W PSYCHO
296.15	RECUR MANIC-PART REMISS
296.16	RECUR MANIC-FULL REMISS
296.20	DEPRESS PSYCHOSIS-UNSPEC
296.21	DEPRESS PSYCHOSIS-MILD
296.22	DEPRESSIVE PSYCHOSIS-MOD
296.23	DEPRESS PSYCHOSIS-SEVERE
296.24	DEPR PSYCHOS-SEV W PSYCH
296.25	DEPR PSYCHOS-PART REMISS
296.26	DEPR PSYCHOS-FULL REMISS
296.30	RECURR DEPR PSYCHOS-UNSP
296.31	RECURR DEPR PSYCHOS-MILD
296.32	RECURR DEPR PSYCHOS-MOD
296.33	RECUR DEPR PSYCH-SEVERE
296.34	REC DEPR PSYCH-PSYCHOTIC
296.35	RECUR DEPR PSYC-PART REM
296.36	RECUR DEPR PSYC-FULL REM
296.40	BIPOLAR,RECENT/CURRENT EPIS MANIC,UN

296.41	BIPOLAR I,RECENT/CURRENT EPIS MANIC,M
296.42	BIPOLAR I,RECENT/CURRENT EPIS MANIC,
296.43	BIPOL,RECNT/CURR MANIC,SEVR,NO MEN/P
296.44	BIPOL,RECNT/CURR MANIC,SEVR,SP W/PSY
296.45	BIPOL,RECNT/CURR MANIC,PART/UNSPEC R
Diagnosis Code	**Description**
296.46	BIPOL,RECENT/CURR MANIC, FULL REMISS
296.50	BIPOLAR,RECENT/CURR DEPRESSED,UNSPE
296.51	BIPOLAR,RECENT/CURR EPIS DEPRESSED, M
296.52	BIPOLAR,RECENT/CURR EPIS DEPRESSED, M
296.53	BIPOL,RECNT/CURR DEPRES,SEVR,W/O MEN
296.54	BIPOL,RECNT/CURR DEPRES,SEVR,SP W/PSY
296.55	BIPOL,RECNT/CURR DEPRES,PART/UNSP RE
296.56	BIPOL,RECNT/CURR DEPRESSED,FULL REMI
296.60	BIPOLAR,RECENT/CURRENT EPIS MIXED,UN
296.61	BIPOLAR,RECENT/CURRENT EPIS, MIXED, M
296.62	BIPOLAR I,RECENT/CURRENT EPIS MIXED,
296.63	BIPOL,RECNT/CURR MIXED,SEVR,W/O MEN
296.64	BIPOL,RECNT/CURR MIXED,SEVR,PSYCHOT
296.65	BIPOL,RECNT/CURR MIXED,PART/UNSP REM
296.66	BIPOLAR,RECENT/CURRENT MIXED,FULL R
296.7	BIPOLAR I,RECENT/CURRENT EPISODE UNS
296.80	BIPOLAR DISORDER, UNSPECIFIED
296.81	ATYPICAL MANIC DISORDER
296.82	ATYPICAL DEPRESSIVE DIS
296.89	OTHER&UNSPECIFIED BIPOLAR DISORDER,
296.90	UNSPECIFIED EPISODIC MOOD DISORDER
296.99	OTHER SPECIFIED EPISODIC MOOD DISORD
297.0	PARANOID STATE, SIMPLE
297.1	DELUSIONAL DISORDER
297.2	PARAPHRENIA
297.3	SHARED PSYCHOTIC DISORDER
297.8	PARANOID STATES NEC
297.9	PARANOID STATE NOS
298.0	REACT DEPRESS PSYCHOSIS
298.1	EXCITATIV TYPE PSYCHOSIS
298.2	REACTIVE CONFUSION
298.3	ACUTE PARANOID REACTION
298.4	PSYCHOGEN PARANOID PSYCH
298.8	REACT PSYCHOSIS NEC/NOS
298.9	PSYCHOSIS NOS
299.00	AUTISTIC DISORDR,CURRENT OR ACTIVE S
299.01	AUTISTIC DISORDER, RESIDUAL STATE

299.10	CHILDHD DISINTEGRATIVE DISORD,CURR/A
299.11	CHILDHD DISINTEGRATIVE DISORD,RESIDU
299.80	OTH SP PERVASIVE DEVELOP,CURR/ACTIVE
299.81	OTH SP PERVASIVE DEVELOP DISORD,RESI
299.90	UNSP PERVASIVE DEVELOP DISOR,CURR/AC
299.91	UNSPEC PERVASIVE DEVELOP DISORD,RESI
Diagnosis Code	**Description**
300.00	ANXIETY STATE NOS
300.01	PANIC DISORDER WITHOUT AGORAPHOBIA
300.02	GENERALIZED ANXIETY DIS
300.09	ANXIETY STATE NEC
300.10	HYSTERIA NOS
300.11	CONVERSION DISORDER
300.12	DISSOCIATIVE AMNESIA
300.13	DISSOCIATIVE FUGUE
300.14	DISSOCIATIVE IDENTITY DISORDER
300.15	DISSOCIATIVE REACT NOS
300.16	FACTITIOUS DISOR W/PSYCHOL SIGNS&SY
300.19	FACTITIOUS ILL NEC/NOS
300.20	PHOBIA NOS
300.21	AGORAPHOBIA WITH PANIC DISORDER
300.22	AGORAPHOBIA W/O PANIC
300.23	SOCIAL PHOBIA
300.29	OTHER ISOLATED OR SPECIFIC PHOBIAS
300.3	OBSESSIVE-COMPULSIVE DIS
300.4	DYSTHYMIC DISORDER
300.5	NEURASTHENIA
300.6	DEPERSONALIZATION DISORDER
300.7	HYPOCHONDRIASIS
300.81	SOMATIZATION DISORDER
300.82	UNDIFFERENTIATED SOMATOFORM DISOR
300.89	OTHER SOMATOFORM DISORDERS
300.9	UNSPECIFIED NONPSYCHOTIC MENTAL DIS
301.0	PARANOID PERSONALITY
301.10	AFFECTIV PERSONALITY NOS
301.11	CHRONIC HYPOMANIC PERSON
301.12	CHR DEPRESSIVE PERSON
301.13	CYCLOTHYMIC DISORDER
301.20	SCHIZOID PERSONALITY NOS
301.21	INTROVERTED PERSONALITY
301.22	SCHIZOTYPAL PERSONALITY DISORDER
301.3	EXPLOSIVE PERSONALITY
301.4	OBSESSIVE-COMPULSIVE PERSONALITY DIS

301.50	HISTRIONIC PERSON NOS
301.51	CHR FACTITIOUS ILLNESS
301.59	HISTRIONIC PERSON NEC
301.6	DEPENDENT PERSONALITY
301.7	ANTISOCIAL PERSONALITY
301.81	NARCISSISTIC PERSONALITY DISORDER
301.82	AVOIDANT PERSONALITY DISORDER
Diagnosis Code	**Description**
301.83	BORDERLINE PERSONALITY DISORDER
301.84	PASSIVE-AGGRESSIV PERSON
301.89	PERSONALITY DISORDER NEC
301.9	PERSONALITY DISORDER NOS
302.0	EGO-DYSTONIC SEXUAL ORIENTATION
302.1	ZOOPHILIA
302.2	PEDOPHILIA
302.3	TRANSVESTIC FETISHISM
302.4	EXHIBITIONISM
302.50	TRANS-SEXUALISM NOS
302.51	TRANS-SEXUALISM, ASEXUAL
302.52	TRANS-SEXUAL, HOMOSEXUAL
302.53	TRANS-SEX, HETEROSEXUAL
302.6	GENDER INDENTITY DISORDER IN CHILDR
302.70	PSYCHOSEXUAL DYSFUNC NOS
302.71	HYPOACTIVE SEXUAL DESIRE DISORDER
302.73	FEMALE ORGASMIC DISORDER
302.74	MALE ORGASMIC DISORDER
302.75	PREMATURE EJACULATION
302.76	DYSPAREUNIA,PSYCHOGENIC
302.79	PSYCHOSEXUAL DYSFUNC NEC
302.81	FETISHISM
302.82	VOYEURISM
302.83	SEXUAL MASOCHISM
302.84	SEXUAL SADISM
302.85	GENDER IDENTITY DISOR/ADOLESCENT OR
302.89	PSYCHOSEXUAL DIS NEC
302.9	PSYCHOSEXUAL DIS NOS
303.00	AC ALCOHOL INTOX-UNSPEC
303.01	AC ALCOHOL INTOX-CONTIN
303.02	AC ALCOHOL INTOX-EPISOD
303.03	AC ALCOHOL INTOX-REMISS
303.90	ALCOH DEP NEC/NOS-UNSPEC
303.91	ALCOH DEP NEC/NOS-CONTIN
303.92	ALCOH DEP NEC/NOS-EPISOD

303.93	ALCOH DEP NEC/NOS-REMISS
304.00	OPIOID DEPENDENCE-UNSPEC
304.01	OPIOID DEPENDENCE-CONTIN
304.02	OPIOID DEPENDENCE-EPISOD
304.03	OPIOID DEPENDENCE-REMISS
304.10	SEDATIVE,HYPNOTIC/ANXIOLYTIC DEPEND
304.11	SEDATIVE,HYPNOTIC/ANXIOLYTIC DEPEND
304.12	SEDATIVE,HYPNOTIC/ANXIOLYTIC DEPEND
Diagnosis Code	**Description**
304.13	SEDATIVE,HYPNOTIC/ANXIOLYTIC DEPEND
304.20	COCAINE DEPEND-UNSPEC
304.21	COCAINE DEPEND-CONTIN
304.22	COCAINE DEPEND-EPISODIC
304.23	COCAINE DEPEND-REMISS
304.30	CANNABIS DEPEND-UNSPEC
304.31	CANNABIS DEPEND-CONTIN
304.32	CANNABIS DEPEND-EPISODIC
304.33	CANNABIS DEPEND-REMISS
304.40	AMPHETAMIN DEPEND-UNSPEC
304.41	AMPHETAMIN DEPEND-CONTIN
304.42	AMPHETAMIN DEPEND-EPISOD
304.43	AMPHETAMIN DEPEND-REMISS
304.50	HALLUCINOGEN DEP-UNSPEC
304.51	HALLUCINOGEN DEP-CONTIN
304.52	HALLUCINOGEN DEP-EPISOD
304.53	HALLUCINOGEN DEP-REMISS
304.60	DRUG DEPEND NEC-UNSPEC
304.61	DRUG DEPEND NEC-CONTIN
304.62	DRUG DEPEND NEC-EPISODIC
304.63	DRUG DEPEND NEC-IN REM
304.70	OPIOID/OTHER DEP-UNSPEC
304.71	OPIOID/OTHER DEP-CONTIN
304.72	OPIOID/OTHER DEP-EPISOD
304.73	OPIOID/OTHER DEP-REMISS
304.80	COMB DRUG DEP NEC-UNSPEC
304.81	COMB DRUG DEP NEC-CONTIN
304.82	COMB DRUG DEP NEC-EPISOD
304.83	COMB DRUG DEP NEC-REMISS
304.90	DRUG DEPEND NOS-UNSPEC
304.91	DRUG DEPEND NOS-CONTIN
304.92	DRUG DEPEND NOS-EPISODIC
304.93	DRUG DEPEND NOS-REMISS
305.00	ALCOHOL ABUSE-UNSPEC

305.01	ALCOHOL ABUSE-CONTINUOUS
305.02	ALCOHOL ABUSE-EPISODIC
305.03	ALCOHOL ABUSE-IN REMISS
305.1	TOBACCO USE DISORDER
305.20	CANNABIS ABUSE-UNSPEC
305.21	CANNABIS ABUSE-CONTIN
305.22	CANNABIS ABUSE-EPISODIC
305.23	CANNABIS ABUSE-IN REMISS
305.30	HALLUCINOG ABUSE-UNSPEC
Diagnosis Code	**Description**
305.31	HALLUCINOG ABUSE-CONTIN
305.32	HALLUCINOG ABUSE-EPISOD
305.33	HALLUCINOG ABUSE-REMISS
305.40	SEDATIVE,HYPNOTIC/ANXIOLYTIC ABUSE,U
305.41	SEDATIVE,HYPNOTIC/ANXIOLYTIC ABUSE,C
305.42	SEDATIVE,HYPNOTIC/ANXIOLYTIC ABUSE,E
305.43	SEDATIVE,HYPNOTIC/ANXIOLYTIC ABUSE,R
305.50	OPIOID ABUSE-UNSPEC
305.51	OPIOID ABUSE-CONTINUOUS
305.52	OPIOID ABUSE-EPISODIC
305.53	OPIOID ABUSE-IN REMISS
305.60	COCAINE ABUSE-UNSPEC
305.61	COCAINE ABUSE-CONTINUOUS
305.62	COCAINE ABUSE-EPISODIC
305.63	COCAINE ABUSE-IN REMISS
305.70	AMPHETAMINE ABUSE-UNSPEC
305.71	AMPHETAMINE ABUSE-CONTIN
305.72	AMPHETAMINE ABUSE-EPISOD
305.73	AMPHETAMINE ABUSE-REMISS
305.80	ANTIDEPRESS ABUSE-UNSPEC
305.81	ANTIDEPRESS ABUSE-CONTIN
305.82	ANTIDEPRESS ABUSE-EPISOD
305.83	ANTIDEPRESS ABUSE-REMISS
305.90	DRUG ABUSE NEC-UNSPEC
305.91	DRUG ABUSE NEC-CONTIN
305.92	DRUG ABUSE NEC-EPISODIC
305.93	DRUG ABUSE NEC-IN REMISS
306.0	PSYCHOGEN MUSCULSKEL DIS
306.1	PSYCHOGENIC RESPIR DIS
306.2	PSYCHOGEN CARDIOVASC DIS
306.3	PSYCHOGENIC SKIN DISEASE
306.4	PSYCHOGENIC GI DISEASE
306.50	PSYCHOGENIC GU DIS NOS

306.51	PSYCHOGENIC VAGINISMUS
306.52	PSYCHOGENIC DYSMENORRHEA
306.53	PSYCHOGENIC DYSURIA
306.59	PSYCHOGENIC GU DIS NEC
306.6	PSYCHOGEN ENDOCRINE DIS
306.7	PSYCHOGENIC SENSORY DIS
306.8	PSYCHOGENIC DISORDER NEC
306.9	PSYCHOGENIC DISORDER NOS
307.0	STUTTERING
307.1	ANOREXIA NERVOSA
Diagnosis Code	**Description**
307.20	TIC DISORDER NOS
307.21	TRANSIENT TIC DISORDER
307.22	CHRONIC MOTOR OR VOCAL TIC DISORDER
307.23	TOURETTE'S DISORDER
307.3	STEREOTYPIC MOVEMENT DISORDER
307.40	NONORGANIC SLEEP DIS NOS
307.41	TRANSIENT INSOMNIA
307.42	PERSISTENT INSOMNIA
307.43	TRANSIENT HYPERSOMNIA
307.44	PERSISTENT HYPERSOMNIA
307.45	CIRCADIAN RHYTHM SLEEP DISORDER
307.46	SLEEP AROUSAL DISORDER
307.47	SLEEP STAGE DYSFUNC NEC
307.48	REPETIT SLEEP INTRUSION
307.49	NONORGANIC SLEEP DIS NEC
307.50	EATING DISORDER NOS
307.51	BULIMIA NERVOSA
307.52	PICA
307.53	RUMINATION DISORDER
307.54	PSYCHOGENIC VOMITING
307.59	EATING DISORDER NEC
307.6	ENURESIS
307.7	ENCOPRESIS
307.80	PSYCHOGENIC PAIN NOS
307.81	TENSION HEADACHE
307.89	OTHER,PAIN DISORDR/PSYCHOLOGICAL FA
307.9	SPECIAL SYMPTOM NEC/NOS
308.0	STRESS REACT, EMOTIONAL
308.1	STRESS REACTION, FUGUE
308.2	STRESS REACT, PSYCHOMOT
308.3	ACUTE STRESS REACT NEC
308.4	STRESS REACT, MIXED DIS

308.9	ACUTE STRESS REACT NOS
309.0	ADJUSTMENT DISORDER WITH DEPRESSED
309.1	PROLONG DEPRESSIVE REACT
309.21	SEPARATION ANXIETY
309.22	EMANCIPATION DISORDER
309.23	ACADEMIC/WORK INHIBITION
309.24	ADJUSTMENT DISORDER WITH ANXIETY
309.28	ADJUSTMNT DISOR/MIXED ANXIETY &DEP
309.29	ADJ REACT-EMOTION NEC
309.3	ADJUSTMNT DISOR W/DISTURBANCE OF CO
309.4	ADJUST DISOR W/MIX DISBURB EMOTIONS
Diagnosis Code	**Description**
309.81	POSTTRAUMATIC STRESS DISORDER
309.82	ADJUST REACT-PHYS SYMPT
309.83	ADJUST REACT-WITHDRAWAL
309.89	ADJUSTMENT REACTION NEC
309.9	ADJUSTMENT REACTION NOS
310.0	FRONTAL LOBE SYNDROME
310.1	PERSONALITY CHANGE/CONDITIONS CLAS
310.2	POSTCONCUSSION SYNDROME
310.8	NONPSYCHOT BRAIN SYN NEC
310.9	NONPSYCHOT BRAIN SYN NOS
311.	DEPRESSIVE DISORDER NEC
312.00	UNSOCIAL AGGRESS-UNSPEC
312.01	UNSOCIAL AGGRESSION-MILD
312.02	UNSOCIAL AGGRESSION-MOD
312.03	UNSOCIAL AGGRESS-SEVERE
312.10	UNSOCIAL UNAGGRESS-UNSP
312.11	UNSOCIAL UNAGGRESS-MILD
312.12	UNSOCIAL UNAGGRESS-MOD
312.13	UNSOCIAL UNAGGR-SEVERE
312.20	SOCIAL CONDUCT DIS-UNSP
312.21	SOCIAL CONDUCT DIS-MILD
312.22	SOCIAL CONDUCT DIS-MOD
312.23	SOCIAL CONDUCT DIS-SEV
312.30	IMPULSE CONTROL DIS NOS
312.31	PATHOLOGICAL GAMBLING
312.32	KLEPTOMANIA
312.33	PYROMANIA
312.34	INTERMITT EXPLOSIVE DIS
312.35	ISOLATED EXPLOSIVE DIS
312.39	IMPULSE CONTROL DIS NEC
312.4	MIX DIS CONDUCT/EMOTION

312.81	CONDUCT DISORDER, CHILDHOOD ONSET
312.82	CONDUCT DISORDER ADOLESCENT ONSET
312.89	OTHER SPEC COND DISORDER NOT ELSWH
312.9	CONDUCT DISTURBANCE NOS
313.0	OVERANXIOUS DISORDER
313.1	MISERY & UNHAPPINESS DIS
313.21	SHYNESS DISORDER-CHILD
313.22	INTROVERTED DIS-CHILD
313.23	SELECTIVE MUTISM
313.3	RELATIONSHIP PROBLEMS
313.81	OPPOSITONAL DEFIANT DISORDER
313.82	IDENTITY DISORDER
Diagnosis Code	**Description**
313.83	ACADEMIC UNDERACHIEVMENT
313.89	EMOTIONAL DIS CHILD NEC
313.9	UNSP EMOTIONAL DISTURB/CHILDHOOD O
314.00	ATTN DEFIC NONHYPERACT
314.01	ATTN DEFICIT W HYPERACT
314.1	HYPERKINET W DEVEL DELAY
314.2	HYPERKINETIC CONDUCT DIS
314.8	OTHER HYPERKINETIC SYND
314.9	HYPERKINETIC SYND NOS
315.00	READING DISORDER NOS
315.01	ALEXIA
315.02	DEVELOPMENTAL DYSLEXIA
315.09	READING DISORDER NEC
315.1	MATHEMATICS DISORDER
315.2	OTH LEARNING DIFFICULTY
315.31	EXPRESSIVE LANGUAGE DISORDER
315.32	MIXED RECEPTIVE-EXPRESSIVE LANGUAGE
315.39	SPEECH/LANGUAGE DIS NEC
315.4	DEVELOPMENTAL COORDINATION DISORD
315.5	MIXED DEVELOPMENT DIS
315.8	DEVELOPMENT DELAYS NEC
315.9	DEVELOPMENT DELAY NOS
316.	PSYCHIC FACTOR W OTH DIS
327.02	INSOMNIA DUE TO MENTAL DISORDERS
327.15	HYPERSOMNIA DUE TO MENTAL DISORDER
V61.10	COUNSELING MARITAL&PARTNER PROB, U
V61.11	COUNSELING/VICTIM OF SPOUSE&PARTNE
V61.12	COUNSELING/PERPETRATR-SPOUSE/PARTN
V61.20	COUNSELING PARENT-CHILD PROBLEM,UN
V61.8	OTHER SPECIFIED FAMILY CIRCUMSTANCE

V62.2	OTHER OCCUPATIONAL CIRCUM-MALADJUS
V62.81	INTERPERSONAL PROBLEMS, NOC
V62.82	BEREAVEMENT, UNCOMPLICATED
V62.83	COUNSELING/PERPETRATR PHYSICL/SEXUL
V62.84	SUICIDAL IDEATION
V62.89	OTHER LIFE PROBLEMS, PHASE PROBLEMS
V71.01	OBSV-ADULT ANTISOC BEHAV
V71.02	OBSV-ADOLESC ANTISOC BEH
V71.09	OBSERV-MENTAL COND NEC

CMS 1500 (Physician and Clinic)

If the following behavioral health codes are billed by a non-psychiatrist MD or para-professional, **FFS Medicaid (not MCO)** is responsible for payment:

Diagnosis Code	Description
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90853	Group psychotherapy (other than of a multiple-family group)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
99371	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals

If the following behavioral health codes are billed by a psychiatrist, **FFS Medicaid (not MCO)** is responsible for payment:

Diagnosis Code	Description
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	With medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90807	With medical evaluation and management services

90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90809	With medical evaluation and management services
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90811	With medical evaluation and management services

Diagnosis Code	Description
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90813	With medical evaluation and management services
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90815	With medical evaluation and management services
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
90817	With medical evaluation and management services
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
90819	With medical evaluation and management services
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
90822	With medical evaluation and management services
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
90824	With medical evaluation and management services
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient

90827	With medical evaluation and management services
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
90829	With medical evaluation and management services
90845	Psychoanalysis
Diagnosis Code	**Description**
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90857	Interactive group psychotherapy
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)
90870	Electroconvulsive (includes necessary monitoring)
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
90876	Approximately 45-50 minutes
90880	Hypnotherapy
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
90899	Unlisted psychiatric service or procedure

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-4 - Current Procedural Terminology, fourth 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.