

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov

February 18, 2009

Phys
MCO
Hosp

MEDICAID BULLETIN

TO: Physicians and Hospital Providers

SUBJECT: New Procedures for Organ Transplants

Effective March 1, 2009, the South Carolina Department of Health and Human Services (SCDHHS) will provide direct oversight of the Medicaid transplant program. SCDHHS staff, with the assistance of our Medical Directors, will review and authorize all requests for the evaluation of Group II organ transplant candidates.

The Agency will only support the referral of patients for an evaluation to Centers for Medicare and Medicaid Services (CMS) certified transplant centers. This will include certified facilities that are contracted with SCDHHS as well as certified facilities that are located outside of the South Carolina medical service area (> 25 miles of South Carolina borders).

All Group II organ transplants require prior authorization from SCDHHS. Referral requests for organ transplants to both in-state and out-of-state centers must be submitted to the Division of Physician Services before the services are rendered. The fax number for submitting the request is (803) 255-8255. The requests should include a letter from the attending physician that describes the type of transplant needed, the patient's current medical status, course of treatment, and the name of the center to which the patient is being referred. Upon approval, SCDHHS will issue an authorization number to the requesting physician for the transplant services with instructions for its use. The transplant authorization number must be included on all claims submitted for reimbursement. SCDHHS reserves the right to make recommendations to the provider for services at a certified center that has provided transplant services to Medicaid beneficiaries in the past. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

Attached are the list of Organ Transplants covered by South Carolina Medicaid and the Transplant Prior Authorization Form. For a complete list of CMS approved centers, visit the CMS website at <http://www.cms.hhs.gov/ApprovedTransplantCenters>.

Additional information regarding transplant services is available in the Physicians, Laboratories and Other Medical Professionals or Hospital Services Manual on our website at www.scdhhs.gov. Please be reminded that a patient's eligibility must be verified prior to starting the transplant process.

If you have any questions, please contact your program manager in Physician Services at (803) 898-2660 or Hospital Services at (803) 898-2665. Thank you for your continued support of South Carolina Medicaid.

/S/

Emma Forkner
Director

EF/mgvb

Attachments

Note: To sign up for Electronic Funds Transfer of your Medicaid payment, please go to <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select "Electronic Funds Transfer (EFT)" for instructions.

ATTACHMENT A

GROUP II COVERED TRANSPLANTS

Heart

Kidney/Pancreas

Liver

Liver/Small Bowel

Liver/Pancreas

Liver/Kidney

Lung

Pancreas

Small Bowel

Multivisceral

Bone and Marrow:

Allogenic Related

Allogenic Unrelated

Autologous - Inpatient

Autologous - Outpatient

Mismatched

Cord

ATTACHMENT B

INSTRUCTIONS FOR SUBMITTING REQUEST/PRIOR AUTHORIZATION FORM

In determining whether to provide Prior Authorization, the South Carolina Department of Health and Human Services (SCDHHS) may use guidelines that include clinical standards, protocols, or criteria regarding the treatment of specific conditions.

When submitting a completed Transplant Prior Authorization form:

1. The referring South Carolina (SC) Medicaid provider must complete the form.
2. All fields on the form must be completed.
3. Include supporting clinical documentation (e.g. clinical notes, diagnostic studies, lab results).
4. This is not an authorization for payment. Payments are made subject to the beneficiary's eligibility and benefits on the day of service.
5. Providers seeking reimbursement for services must be credentialed with SC Medicaid.
6. You must provide sufficient information to allow us to make a decision regarding your request.
7. If the transplant service is available in state and this case is being referred outside of the South Carolina Medical Service Area (SCMSA), you must indicate why.
8. Requests may be faxed to (803) 255-8255 or mailed to:

South Carolina Medicaid
Attn: Transplant Prior Authorization
Post Office Box 8206
Columbia, South Carolina 29202.8206

SCDHHS reserves the right to make recommendations to a certified center that has provided transplant services to Medicaid beneficiaries in the past. You must identify any services that are considered experimental and/or investigational, sponsored under a research program, as these services are non-covered by SC Medicaid. In addition, a copy of the beneficiary's medical records, relating to the transplant, for up to the past year must be included.

All transplant prior authorization requests require at least 10 days advance notice

Transplant Prior Authorization Request Form

Omissions, generalities, and illegibility will result in the form being returned for completion or clarification. Please note that the approval of a transplant evaluation does not guarantee the approval of the actual transplant.

NAME OF BENEFICIARY: _____ DATE OF BIRTH: _____

SC MEDICAID ID#: _____

NAME OF GUARDIAN (if applicable): _____ CONTACT NUMBER: _____

REFERRING PHYSICIAN: _____

NPI: _____ SC MEDICAID #: _____

TYPE OF TRANSPLANT: _____ Is the patient receiving a _____ living organ or a _____ cadaveric organ?

EXPECTED DATE OF SERVICE: _____ EXPECTED DATE OF RETURN: _____

WILL THE BENEFICARY REQUIRE TRANSPORTATION? YES _____ NO _____

RECOMMENDED MODE OF TRANSPORTATION: _____

Medicaid patients, as well as their escort, may be provided transportation when necessary. Prior approval is mandatory in order to make the necessary travel arrangements. Contact the Division of Preventative and Ancillary Services at (803) 898-2565 to make travel arrangements.

RENDERING PHYSICIANS/FACILITY

PATIENT REFERRED TO: _____

NAME OF FACILITY AND/OR PHYSICIAN (S)

ADDRESS: _____

TELEPHONE: _____ FAX: _____

NAME OF CONTACT PERSON/COORDINATOR: _____

REQUIRED DOCUMENTATION

- Letter of Medical Necessity for the transplant, including the following: summary of course of illness, current medications, smoking, alcohol, and drug abuse history
- Medical records, including physical exam, medical history, and family history
- Laboratory assessments including serologies
- Letter to support the need to have the transplant performed outside of the South Carolina Medical Service Area (SCMSA) – If applicable.

PLEASE ANSWER THE FOLLOWING QUESTIONS

	Yes	No
Does the patient have any unresolved psychosocial concerns or a history of non-compliance with medical management?		
Has the patient had active alcohol, tobacco, or substance abuse within the past 6 months?		
Does the patient have any serious health conditions that create an inability to tolerate transplant surgery or post transplant care?		
Does the patient have any uncontrolled/untreatable infections or diseases?		

If the answer is "Yes" to any of the above questions, please explain and provide medical documentation.

I certify that the above information is correct and that contact has been made with the Rendering Facility/Physician. I also certify that if the request is to a provider and/or facility outside of the SCMSA, that the service is not available and cannot be provided within the SCMSA.

SIGNATURE OF REFERRING PHYSICIAN

DATE