

**South Carolina Medicaid Managed Care Program**

**Policy and Procedure Guide  
For the  
SCHIP Managed Care Program**



*June 30, 2009*



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## **State Children's Health Insurance Program (SCHIP) Managed Care Program Healthy Connections Kids (HCK)**

### **SECTION 1 INTRODUCTION**

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency in South Carolina responsible for the administration of a program of medical assistance under Title XXI of the Social Security Act known as the SCHIP Program. Title XXI is jointly financed by the Federal and State governments and administered by States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides to States a capped amount of funds at a higher match rate to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children. States may provide coverage by expanding Medicaid, creating a separate program or a combination of the two.

South Carolina began SCHIP coverage through an expansion of children's Medicaid on August 1, 1997. Partners for Healthy Children (PHC) was created to cover children up to age 19 with income up to 150% of Federal Poverty Level (FPL). By Proviso, 2007 legislation established a separate, stand-alone SCHIP Program to expand eligibility for qualifying children under age 19 with income above 150% but less than 200% FPL. This program is known as Healthy Connections Kids (HCK).

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

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

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

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

## **SECTION 2 THE CONTRACT PROCESS**

This section of the guide is designed to provide the information necessary for preparing to initiate an HCK MCO contract with SCDHHS. SCDHHS will furnish potential MCOs with a copy of the model MCO contract upon request. This contract may also be found on the SCDHHS website at [www.scdhhs.gov](http://www.scdhhs.gov). The terms of the contract are established and are not negotiable.

The contracting process contained in this section applies to MCO's who do not have an existing Medicaid MCO Contract with SCDHHS. Many of the requirements listed below are fulfilled in the Medicaid MCO contracting process and do not need to be duplicated. Other requirements may be modified to avoid duplication. Existing Medicaid MCO's may contact SCDHHS for more information.

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

The potential MCO should enclose a copy of the Certificate of Authority with a letter requesting inclusion/participation/enrollment in the HCK program. The letter should be addressed to:

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

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

1. Two (2) copies of the contract
2. Enrollment Form (DHHS Form 219-HMO)
3. Minority Business Form
4. Disclosure of Ownership & Control Interest Statement Form SCDHHS 1513 (02/09)
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 HCK MCO Policy and Procedures Guide

The potential MCO should then sign and date both copies of the Contract and submit to SCDHHS, along with three (3) copies of the MCO's Required Submissions. The Department of Managed Care will review the Required Submissions internally. SCDHHS will notify the MCO of any changes or re-submissions that must be made prior to approval. Concurrent to this review process, the MCO will coordinate with the SCDHHS Division of MMIS to establish connectivity with SCDHHS information systems. Upon approval of all required submissions and the establishment of connectivity, SCDHHS will authorize its External Quality Review Organization (EQRO) to begin the Readiness Review of the MCO's South Carolina operation. If deficiencies are noted during the Readiness Review, the MCO must submit a Plan of Correction (PoC) to SCDHHS. The time frames given for correcting the deficiencies will be based on the severity and scope of the deficiencies. The SCDHHS staff will monitor the MCO's progress with its PoC. Once all Required Submissions have been approved, the MCO should only submit to SCDHHS, approved changes and modifications to the Required Submissions, not the entire package listed below. This is due no later than January 15<sup>th</sup> of each year.

Once the Readiness Review has been completed, the Managed Care staff will review county networks submitted by the MCO and determine network adequacy. Along with the county network submission, the MCO will provide an attestation that all provider contracts are in compliance with the following state requirements:

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

The "MCO Reports To SCDHHS" section of this Guide contains the Network Provider And Subcontractor Listing Spreadsheet Requirements as well as the Model MCO Attestation Form.

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

**Activities and Potential Time Frames**

- |   |  |
|---|--|
| 1. Review of Required Submissions                   | Up to 120 days                             |
| 2. Readiness Review (not including scheduling time) | 2 to 3 days                                |
| 3. Readiness Review Report Completed                | Within 30 days of site visit               |
| 4. Network Adequacy Desk Review                     | Submitted upon passing of Readiness Review |
| 5. Network Approval                                 | ASAP                                       |
| 6. Sign-up/assignment of members                    | Within 10 days following Network Approval  |
| 7. Enrollment of members                            | See Enrollment Process                     |

## **Required Submissions**

The following items/documents must be submitted by the MCO with the signed Signature Pages of the official contract. The contract sections indicated are intended as a guide only and may not be the only contract requirements related to the required submission listed. This information is being provided as a guide only and does not relieve the MCO 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 (02/09). (CONTRACT SECTION 10.11 -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 5.1.35, 3.7)
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 10.12)
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)**

1. A listing of network provider/subcontractors . (This should only include executed contracts). (CONTRACT SECTION 4.9.2) .
2. A copy of any Notice of Intent of Subcontractor Termination. (CONTRACT SECTION 5.1.31)

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

### **C. Service Delivery Requirements**

1. A description of expanded services, if any, offered for members. (CONTRACT SECTION 4.7)
2. A listing of the service area(s) as approved by SCDOI & HCK service area (if different). (CONTRACT SECTION 4.9.1)
3. A copy of the referral/monitoring process, policies and procedures, as well as forms, process for in/out of plan services. ( 4.1, 4.12)
4. 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 Management section of this document)
5. A copy of PCP selection procedures and forms. (CONTRACT SECTION 4.9.3.1)

### **D. Quality Assessment and Performance Improvement**

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

### **E. Marketing**

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

## **F. Reporting**

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

### **Readiness Review**

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

### **Provider Network Adequacy Determination Process**

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

The MCO and its network providers/subcontractors shall ensure access to health care services in accordance with the contract with SCDHHS. The MCO should also take into account prevailing medical community standards in the provision of services under the Contract. For example, the MCO or its Pharmacy Benefits Manager (PBM) is encouraged to contract with any Medicaid enrolled DME provider (using the appropriate NDC or UPC for billing purposes), for the provision of durable medical equipment and supplies, including diabetic testing strips and meters. MCOs are also encouraged to contract with DME providers that provide durable medical equipment and supplies via mail order.

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

Services must be accessible as described in the Proximity Guidelines. Generally, this is within a thirty (30) mile radius from a member's residence for PCPs and fifty (50) miles for specialty and hospital care. Exceptions may be made if the travel distance for medical care exceeds the mileage guidelines.

### **Changes to Approved Model Sub-Contracts**

Should an MCO modify a previously approved provider model sub-contract it must submitted an electronic redline version of the sub-contract to SCDHHS for approval prior to execution by either party. The submission must be electronic and in the document format required by SCDHHS. The electronic redline contract submission must contain the following information:

- An electronic redline version of the sub-contract showing all requested language changes and deviations from the approved model;
- Headers, completed reimbursement page, completed information of sub-contract facility(ies) including locations, complete provider information including location(s), attachments or amendments, and the projected execution date of the sub-contract;
- Covered programs i.e. Health Connection Choices, Health Connection Kids or both;
- Footer information containing the original model sub-contract approval number and date.

Once the redlined sub-contract has been given tentative approval by SCDHHS, the footer information will be changed to a tracking number provided by SCDHHS. The MCO must submit a black-line copy of the tentatively approved redlined sub-contract for final approval. Once the final approval has been given, the MCO and provider may execute the sub-contract. SCDHHS reserves the right to examine credentialing information prior to execution of the sub-contract.

### **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.

The MCO submits its network listing for a specific county to the Department of Managed Care, requesting approval to commence HCK member enrollment in that county. The MCO is to follow the NETWORK PROVIDER and SUBCONTRACTOR LISTING SPREADSHEET REQUIREMENTS found in the MCO Reports to SCDHHS section of this Guide, along with the Model Attestation Form found at the end of this section.

The MCO is responsible for ensuring that all enrolled providers are eligible to participate in the HCK Program. SCDHHS will transmit to the MCO, on a regular basis, information regarding individuals prohibited from receiving Federal funds who appear on

the OIG electronic database. However, the MCO should also check the LEIE and other applicable federal reporting sources to ensure compliance with the HCK contract.

The MCO are to only submit enrolled providers who have completed the MCO's credentialing process and are credentialed by the MCO.

1. Using the Provider Network Listing Spreadsheet and other appropriate provider listings the Department of Managed Care examines the listing for the inclusion & availability of provider types for the following categories of service: Ancillary, Hospital, Primary Care and Specialists.
2. The adequacy of each of these provider types is evaluated based on the MCO's projected maximum member enrollment for that county, proximity guidelines and the following network criteria: There are four categories of provider types noted on the Provider Network Listing Spreadsheet in the "status" column. Those listed as a status "1" are required and a contract with the provider must be completed. Status "2" services are optional. For status "3" services a contract is not required but the MCO must provide a signed statement attesting the service will be arranged and provided through any necessary means, including the use of out-of-network providers. Status "4" services are those that are not required but are optional services provided by the MCO. If they are offered and a contract does not exist, there must be a statement of attestation as described for status "3" services.
3. As appropriate, SCDHHS staff and physician consultants are utilized to determine access-to-care trends and provider type availability for each county. The goal is to ensure the approval of a network that will guarantee appropriate access to care for HCK MCO members.
4. 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
5. If SCDHHS finds that a network is not adequate, the MCO will be notified in writing that the network is not approved and the specific reasons for that decision.
6. If SCDHHS determines that the MCO has submitted an adequate network for that county, the Department of Managed Care will approve the network, set the effective date for enrollment and notify the MCO in writing. SCDHHS will also notify the MMIS system to modify the "counties served" indicator in the provider file to allow member enrollments to be processed. The enrollment broker is informed of the addition of approved counties.
7. SCDHHS reserves the right to perform a site review at the MCO to review provider subcontracts, including any applicable approved amendments, credentialing information and Hold Harmless Agreements or SCDHHS can require the MCO to

bring the contracts and credentialing material to the Managed Care Department. Should SCDHHS exercise its right to review, subcontracts, credentialing material and Hold Harmless Agreements are reviewed to determine whether the language in the subcontracts has been previously approved by SCDHHS and to ensure that all agreements are properly executed.

8. In the event that an MCO submits a county network that uses existing (approved) providers, SCDHHS may 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.
9. At least annually, on a date to be determined by SCDHHS, each MCO will submit their networks for all approved counties in the required format to SCDHHS. This is to validate the county networks and determine if there are areas that are not covered or in compliance with this section.

| <b>Provider Network Listing Spreadsheet</b> |               |   |
|---|---------------|---|
| <b>Service</b>                              | <b>Status</b> | <b>DHHS Comments</b>  |
| <b>ANCILLARY SERVICES:</b>                  |               |   |
| <i>Ambulance Services</i>                   | 3             |   |
| <i>Durable Medical Equipment</i>            | 1             |   |
| <i>Orthotics/Prosthetics</i>                | 1             |   |
| <i>Home Health</i>                          | 1             |   |
| <i>Infusion Therapy</i>                     | 1             | See Proximity Guidelines for Specialty Care Services            |
| <i>Laboratory/X-Ray</i>                     | 1             |   |
| <i>Pharmacies</i>                           | 1             | See Proximity Guidelines for Primary Care Provider Services     |
| <b>HOSPITALS</b>                            | 1             | See Proximity Guidelines for Specialty Care Services            |
| <b>PRIMARY CARE PROVIDERS:</b>              |               |   |
| <i>Family/Gen. Practice</i>                 | 1             |   |
| <i>Internal Medicine</i>                    | 1             |   |
| <i>RHC's/FQHC's</i>                         | 2             | Not required but may be utilized as PCP provider                |
| <i>Pediatrics</i>                           | 1             | May function as PCP (30 miles) or Specialty Provider (50 miles) |
| <i>OB/GYN</i>                               | 1             | May function as PCP (30 miles) or Specialty Provider (50 miles) |
| <b>SPECIALISTS</b>                          |               |   |
| <i>Allergy/Immunology</i>                   | 1             |   |
| <i>Anesthesiology</i>                       | 3             |   |
| <i>Audiology</i>                            | 3             |   |
| <i>Cardiology</i>                           | 1             |   |
| <i>Chiropractic</i>                         | 3             |   |
| <i>Dental</i>                               | 4             |   |
| <i>Dermatology</i>                          | 1             |   |
| <i>Emergency Medical</i>                    | 3             |   |
| <i>Endocrinology and Metab</i>              | 1             |   |
| <i>Gastroenterology</i>                     | 1             |   |
| <i>Hematology/Oncology</i>                  | 1             |   |
| <i>Hospice</i>                              | 3             |   |
| <i>Infectious Diseases</i>                  | 1             |   |
| <i>Neonatology</i>                          | 3             |   |
| <i>Nephrology</i>                           | 1             |   |
| <i>Neurology</i>                            | 1             |   |
| <i>Nuclear Medicine</i>                     | 3             |   |
| <i>Ophthalmology</i>                        | 1             |   |
| <i>Optician/Optomety</i>                    | 3             |   |
| <i>Orthopaedics</i>                         | 1             |   |

|  |   |   |
|--|---|---|
| <b>Otorhinolryngology</b>  | 1   |   |
| <b>Pathology</b>   | 3   |   |
| <b>Pediatrics, Allergy</b>   | 3   | South Carolina Medical Service Area (SCMSA)*  |
| <b>Pediatrics, Cardiology</b>  | 3   | SCMSA   |
| <b>Psychiatry</b>  | 3   |   |
| <b>Psychology</b>  | 3   |   |
| <b>Pulmonary Medicine</b>  | 1   |   |
| <b>Radiology, Diagnostic</b>   | 3   |   |
| <b>Radiology, Therapeutic</b>  | 3   |   |
| <b>Rheumatology</b>  | 1   |   |
| <b>Surgery - General</b>   | 1   |   |
| <b>Surgery - Thoracic</b>  | 3   |   |
| <b>Surgery - Cardiovascular</b>  | 3   |   |
| <b>Surgery - Colon and Rectal</b>  | 3   |   |
| <b>Surgery - Neurological</b>  | 3   |   |
| <b>Surgery - Pediatric</b>   | 3   |   |
| <b>Surgery - Plastic</b>   | 3   |   |
| <b>Urology</b>   | 1   |   |
| <b>Speech Therapy</b>  | 3   |   |
| <b>Physical Therapy</b>  | 3   |   |
| <b>Occupational Therapy</b>  | 3   |   |
| <b>Long Term Care</b>  | 3   | MCO has at least 60 days responsibility up to the earliest opportunity for disenrollment  |
|  |   |   |
|  | <b>1 = Required</b><br><b>2 = Optional</b><br><b>3 = Attestation</b><br><b>4 = Attest, if offered</b> | Attestation – The MCO attests that the service will be arranged and provided through any necessary means, including out-of-network providers. Use the <b>Attestation of Provider Network Submission</b> provided below. |
|  |   |   |
| <b>Proximity Guidelines</b>  |   |   |
| Primary Care Physicians should be within 30 miles  |   |   |
| Specialty Care Physicians should be within 50 miles  |   |   |
| In reviewing networks, SCDHHS considers both the above-listed "Proximity Guidelines", and utilization trends of the regular Medicaid Fee-For-Service system. SCDHHS may grant exceptions to these criteria on a case-by-case basis.                              |   |   |
| *The term South Carolina Medical Service Area (SCMSA) refers to the state of South Carolina and areas in North Carolina and Georgia within 25 miles of the South Carolina state border. Charlotte, Augusta, and Savannah are considered within the service area. |   |   |

(Company Letter Head)  
**Attestation of Provider Network Submission**  
For \_\_\_\_\_ Count(y)(ies)

Date \_\_\_\_\_

I, \_\_\_\_\_, as (Title) for (Name of Company), do hereby attest that the information provided on the Provider Network Listing Spreadsheet for \_\_\_\_\_ Count(y) (ies) is (are) accurate, true, and complete.

Based on the required submissions for review and approval of a Managed Care Organization's (MCO) network, I attest that each contracted provider has been properly credentialed as provided in the Contract between our organization and SCDHHS and the HCK Policy and Procedure Guide. I further attest that the necessary information for these providers has been loaded into our organization's system prior to providing services to South Carolina HCK members. Additionally, I attest that the following requirements have been met:

- All contracts and amendments utilize a model subcontract approved by SCDHHS, or any modifications to the model subcontract have been approved by SCDHHS prior to execution,
- All contracts have been properly signed, dated and executed by both parties, and
- All provider files contain information regarding hospital privileges (if appropriate), credentialing, and a list of group practice members.

In addition to the services provided through its contracted network, (health plan name) will provide access to medically necessary covered services through any necessary means, consistent with its contract with SCDHHS, including out-of-network providers; these alternative arrangements include, but are not limited to, single case agreements.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to sanctions and/or fines as outlined in Section 13.5 of the contract.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date

## **SECTION 3 BENEFICIARY ENROLLMENT**

### **Who is Eligible?**

A child who:

- Is under 19 years of age
- Has family income greater than 150% of the Federal Poverty Level and less than 200%
- Has family countable resources at or below \$30,000
- Does not have comprehensive health coverage (defined as coverage with at minimum, hospitalization, doctor visits, x ray and lab coverage.)
- Has been uninsured for 3 months if comprehensive health coverage was voluntarily dropped
- Meets non-financial requirements
  - State residency
  - Identity
  - Citizenship
  - Social Security Number
  - Assign rights to medical support

### **How Is Eligibility Determined?**

The South Carolina Department of Health and Human Services determines eligibility for HCK. Applications may be filed in person or by mail.

### **Infants**

Infants born to an HCK eligible pregnant female are not “deemed” to be eligible as in Medicaid. The mother must file an application for coverage. This process will determine if the newborn is eligible for Medicaid or HCK. Births must be reported to SCDHHS.

### **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 completed correctly, 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.

*For further information on eligibility or income and resource requirements, please see the DHHS website at [www.scdhhs.gov](http://www.scdhhs.gov)*

### **Enrollment Process**

The SCDHHS enrollment designee will **assign** new eligibles to a HCK plan using a sequential process. SCDHHS will provide the MCO notification of the eligibles who are enrolled, re-enrolled, or disenrolled from their plan. The MCO shall contact the members as required in §8 of the Contract.

The MCO shall not discriminate against members on the basis of their health history, health status or need for health care services or adverse change in health status. This applies to enrollment, re-enrollment or disenrollment from the MCO's plan. The MCO shall provide services to all eligible HCK members who enroll in the MCO's plan.

To change plans, a HCK Managed Care Plan Change Form must be completed.

### **Enrollment Period**

The HCK members shall be enrolled for a period of twelve (12) months. HCK eligibility is not connected to Medicaid eligibility; thus, Fee-for-Service Medicaid is not an option offered to HCK members unless their eligibility status changes.

The member may change plans without showing cause at any time during the first 90 days following the date of the member's initial enrollment. After 90 days, the member cannot change plans without just cause. . If a member's request to disenroll is not acted on within sixty (60) days, it shall be considered approved. The following are considered cause for disenrollment by the member as long as there is another HCK MCO plan in the member's county of residence:

- 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 ligations) to be performed at the same time, 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, South Carolina Healthy Connections Choices (SCHCC) will mail a re-enrollment offer to members to determine if they wish to continue to be enrolled with the MCO's plan. Unless the member becomes ineligible for HCK or provides written

notification that they no longer wish to be enrolled in the MCO's plan, the member will remain enrolled with the MCO.

A member who becomes disenrolled due to loss of eligibility and submits a new enrollment form and becomes enrolled in the MCO's plan within sixty (60) calendar days from the effective date of disenrollment may re-enroll with the MCO's plan without going through the education process again.

Prior to approving the member's disenrollment request, SCDHHS will refer the request to the MCO to explore the member's concerns and attempt to resolve them. The MCO will notify SCDHHS within 10 days of the result of their intervention. The final decision on whether to allow the member's disenrollment rests with SCDHHS, not the MCO. 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.

### **Effective Date of Enrollment**

There is a 90 day period during which members can choose to change their health plan. This choice period will be followed by a 9 month lock-in period with an Open Enrollment opportunity 60 days prior to the one year anniversary.

The MCO shall contact the member to assist the member in making a selection of a PCP. The MCO shall inform the member that each family member has the right to choose his/her own PCP. The MCO may explain the advantages of selecting the same primary care provider for all family members, as appropriate. The MCO shall confirm the PCP selection information in a written notice to the member.

Members can request a transfer form from the enrollment broker to select another plan during the initial 90 day period. The enrollment broker will enter all information and updates within three (3) working days of receipt of a completed transfer form.

### **Disenrollment**

Disenrollments may be initiated by (1) the member, (2) SCDHHS or (3) the MCO. The MCO may conduct an initial follow up for all voluntary disenrollees. The MCO 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 transfer form must be completed and submitted to SCDHHS for processing. The effective date of enrollment will be as specified in Section 6.3 of the contract.

Children currently enrolled in a HCK plan must use the HCK Transfer form to disenroll from the original plan prior to being enrolled in a new plan. A member must disenroll from one option and enroll in the MCO at the same time.

The SCDHHS will notify the MCO of the member's disenrollment due to the following reasons. The MCO may request to disenroll a member based upon the same reasons.

- ◆ Loss of HCK eligibility;
- ◆ Death of a Member;

- ◆ Member becomes an inmate of a Public Institution (see Appendix A -Definition of Terms);
- ◆ Member moves out of State;
- ◆ Member becomes institutionalized in a Skilled Nursing Facility for more than sixty (60) days;
- ◆ Loss of MCO's Participation;
- ◆ Member moves to a county the MCO does not serve;

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

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

The MCO's request for member disenrollment must be made in writing to South Carolina Healthy Connections Choices, the SCDHHS's Enrollment Broker using the SCDHHS Plan Initiated Disenrollment Form. The request must state the detailed reason for disenrollment. SCHCC will log this request and forward it to SCDHHS for review. SCDHHS will determine if the MCO has shown good cause to disenroll the member. The member shall have the right to appeal any adverse decision.

The MCO may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees which must be well documented and provided to SCDHHS.)

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 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 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 Sections).

| <b>Guidelines for Involuntary Member Disenrollment*</b>  |  |
|--|--|
| <b>Reason for Involuntary Disenrollment</b>  | <b>Disenrollment Effective Date</b>  |
| Loss of 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.   |
| 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 in SNF >60 days   | Member will be disenrolled at the earliest effective date allowed by system edits.   |
| Loss of MCO's participation  | Member will be disenrolled based on MCO's termination date   |
| Recipient on Inconsistent County Report  | Member will be disenrolled at the earliest effective date allowed by system edits following verification of new address.   |
| Member terminates with one MCO and joins another while in hospital (disenrollment/enrollment date occurs while in hospital)  | The insurance plan that covers a member on the day of admission to a hospital will be responsible for the entire 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. |
| 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.   |
| <p><i>All disenrollments are subject to the MMIS cutoff date.</i></p> <p><i>*SCDHHS policy allows special exceptions to the disenrollment provisions listed above when in the best interest of the member and/or the HCK program. These exceptions will be considered on a case by case basis.</i></p> <p><i>**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.</i></p> |  |

## SECTION 4 PAYMENTS/ADJUSTMENTS

The MCO will be paid through a capitated payment to provide services to HCK 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. SCDHHS uses Medicaid fee-for-service claims payment data in developing its managed care rates. SCDHHS encourages the MCO to reimburse out-of-network providers (non-participating providers) at the established Medicaid fee-for-service rate for payment of services provided to the MCO's enrollees.

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

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

### **Maternity Kicker Payment**

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

The MCO should request monthly payment for all deliveries in the preceding month. The MCO should complete the Monthly Maternity Notification Log (see "MCO Reports to SCDHHS" section). Target date for submission of these payment requests should be the 15th of each month. These reports should be submitted to the MCO's SCDHHS Program Manager using Excel software. This may be sent on a CD or via the SCDHHS Extranet. Based on the information in the payment request an adjustment will be prepared. Once prepared, a copy of documentation will be sent to the MCO indicating a 3 to 4 week turn-around time for payment. MCOs will be paid the MKP for stillborns.

The regular capitation payment is paid for subsequent months of coverage. The kicker payment represents all expenses (facility, professional, and pharmacy) associated with the birth of a child. **The expenses associated with high cost neonatal cases has been included in the overall rate and spread across rate cells.**

## **Rate Change Adjustments**

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

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

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

## **Interim Hospital Payments**

In the event that hospital claims for an individual have met the limitations as stated in the SCDHHS Hospital Services Provider Manual, an interim payment may be made. These limitations are charges have reached \$400,000 and discharge is not imminent.

## **SECTION 5 CORE BENEFITS AND NON-COVERED SERVICES**

- ✓ The “check” symbol is used to denote services that are in the MCO rate.
- ☒ The “X” symbol is used to denote services that are NOT in the MCO rate.

HCK plans are required, at a minimum, to provide uninsured children with “medically necessary” care at current limitations for the services listed in this section. HCK plans may offer expanded services to 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 limited. If the MCO elects not to provide, reimburse for, or provide coverage of a service because of an objection on moral or religious grounds, the MCO must furnish information about the services it does not cover as follows:

- To the State with its application for a HCK Provider 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.

SCDHHS, on a regular basis, may expand, limit, modify or eliminate specific services, procedures and diagnosis codes offered by the HCK program. These changes may also affect maximum reimbursement rates and service limitations (frequency and other). Generally, these changes are documented and distributed via bulletin. They are also reflected in the MCO Fee Schedule and Contract Rate Schedule, which are provided electronically to each MCO on a monthly basis. Please consult the latest Fee Schedule and Contract Rate Schedule for up to date coverage, pricing and limitations.

### **Prior Authorization and Decision Timeframes**

Prior Authorization is defined as the act of authorizing specific approved services by the MCO before they are rendered. In accordance with 42 CFR §438.210, Plan responses to requests for prior authorizations shall not exceed the following timeframes:

Standard authorization decisions -- For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.

Expedited authorization decisions -- For cases in which a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision and provide notice as expeditiously

as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

✓ **Autism Spectrum Disorder Benefit**

Applied Behavioral Analysis (ABA) for children diagnosed with an Autism Spectrum Disorder at age 8 or younger will be covered, subject to APS guidelines and preauthorization requirements, for up to a maximum of \$50,000 per plan year. A child must be younger than 16 years of age to receive benefits.

✓ **Behavioral Health Disorders**

A behavioral health disorder (including alcoholism and drug abuse) is a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind or other condition that is defined, described or classified as a psychiatric disorder or condition in the latest publication of the American Psychiatric Association entitled Diagnostic and Statistical Manual of Mental Disorders, or other similar authority generally recognized by Behavioral Health Providers, and which is not otherwise excluded by the terms and conditions of this contract. It may be treated by the inpatient or outpatient department of a hospital/treatment facility, licensed practitioner office setting and at facilities/programs operated by or under the auspices of the Department of Mental Health or Department of Alcohol and Other Drug Abuse Services.

✓ **Chiropractor Services**

The detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body, for the removal of nerve interference where such interference is the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition. Spinal axis aches, sprains, nerve pains, and functional disabilities of the spine are considered to provide therapeutic grounds for chiropractic treatment. Most other non-spinal diseases and pathological disorders do not provide therapeutic grounds for chiropractic treatment. Examples of these types of diseases and disorders are rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema.

✓ **Dental Care**

Dental services are covered outside the benefit package and reimbursed at the Medicaid fee for service rate. Routine dental services include any diagnostic, rehabilitative, or corrective procedure, supplies and preventive care furnished or administered under the supervision of a dentist.

✓ **Durable Medical Equipment**

Durable Medical Equipment is payable when required for therapeutic use for a specific condition when such equipment is used under the direction of a physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved. Non covered equipment includes, but is not limited to, home and vehicle modifications, an air conditioner, air filter or air filtration system, wig/hairpiece/other artificial device or procedure to replace scalp hair, dehumidifier, home whirlpool, exercise equipment, shoe supports, knee braces, bandages and gauze and similar equipment.

Medical supplies are limited to the following:

1. Syringes, and related supplies for conditions such as diabetes.
2. Dressings, for conditions such as cancer or burns.
3. Catheters.
4. Colostomy bags and related supplies.
5. Test tape.
6. Necessary supplies for renal dialysis equipment or machines.
7. Surgical trays.
8. Prosthetic Appliances are payable when necessary for the correction of conditions caused by trauma or disease and that restore a function to the body. The plan will replace existing prosthetic appliances that assist the body to function when the replacement is medically necessary or when the appliance is not functional due to wear or due to the growth of the covered person.
9. Oxygen and rental of equipment for its administration outside a hospital (rental payments shall not to exceed the equipment's purchase price).
10. Orthopaedic braces, crutches, lifts attached to braces, and orthopaedic shoes, which are medically necessary and required by a specific diagnosis. The service limitation is one pair of shoes each six months. Supplies or shoes that have non-therapeutic uses are not a covered medical expense.
11. C-Pap or Bi-Pap machines.

✓ **Emergency Transportation**

Emergency transportation is payable when 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 transportation 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. The plan 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.

✓ **Home Health Care Services**

The plan will provide benefits for the following medically necessary services and supplies provided at the members place of residence:

A. Covered Medical Expenses for the purpose of this section shall be limited to:

1. Part-time or intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis, not to exceed eight hours per day, for temporary and definitely fixed periods of time of up to 21 days, with allowances for extensions and exceptional circumstances where the need for care in excess of 21 days is finite and predictable) nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.) and home health aide services which consist primarily of caring for the individual, where appropriate.
2. Physical, occupational or speech therapy (speech therapy subject to restorative limitations) provided by the home health care agency;
3. Medical drugs, supplies and medicines prescribed by a physician and required for the care rendered by the nurse or therapist, but only to the extent that the medical drugs, supplies, durable medical equipment and medicines are otherwise covered.

B. The payment of benefits for Home Health Care is subject to the following additional requirements:

1. That the Home Health Care benefits, if provided, would permit the child to remain in a less intensive care facility, or at home, than would otherwise be required without these benefits;
2. The annual maximum benefit for professional services only is 100 visits. A visit shall consist of up to four hours, whether consecutive or non-consecutive, within any 24-hour period, incurred by a registered nurse or a licensed practical nurse to provide nursing care, by a therapist to provide therapeutic services or by a home health care aide to provide services within the scope of the license; and

3. Covered Medical Expenses under this section shall not include:
  - Any service or supply rendered by a person who ordinarily resides in the home of the covered person or is a member of the family, or
  - any transportation service.
4. The Plan will provide benefits for Medical Social Worker Services.

✓ **Hospice**

The plan will pay covered Hospice expenses subject to the following conditions:

- The covered person is diagnosed as having a terminal illness with a life expectancy of six months or less;
- The services are provided by a Hospice care agency or by others who are not its employees but who are supervised or coordinated by the Hospice care agency;
- The services are provided pursuant to a written treatment plan approved by a physician and reviewed by the physician at least once a month;
- The expenses incurred are covered Hospice expenses which are defined as services provided by a Hospice care agency, or provided under the supervision or coordination of the Hospice care agency by others who are not its employees for:
  - Part-time or intermittent (less than or up to four hours per day, if provided on a less-than-daily basis, or if provided on a daily basis not to exceed eight hours per day, for temporary and definitely fixed periods of time up to 21 days, with such extensions for additional fixed and definite periods of time that, in the discretion of the Plan Administrator, may be granted when there are exceptional circumstances and the period of such extension is predictable and fixed) nursing care provided by a registered nurse or licensed practical nurse and home health aide services which consist mainly of caring for the Covered Person;
- Medical social services provided under the direction of a physician including:
  - Assessment of the covered person's home and family situation and that person's social, emotional and medical needs,
  - Identification of community resources available to the covered person,
  - Assisting the covered person to obtain community resources to meet the covered person's needs,
  - Psychological and dietary counseling,
  - Consultation and case management services by a physician,
  - Physical or occupational therapy,

- Medical supplies, drugs, medicines prescribed by a physician.

Hospice benefits are not payable for:

- Funeral expenses
- Financial or legal counseling, including estate planning or the drafting of a will
- Pastoral counseling
- Homemaker or caretaker services
- Sitter or companion services for either the covered person or other members of the family
- Respite care, which is care furnished during a period when the family or usual caretaker cannot, or will not, attend to the covered person's needs.

✓ **Immunizations**

Immunization of children should be provided according to the immunization standards 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 (AAP), and South Carolina State Law.

The MCO's network providers shall report the required immunization data to the State Immunization Information System (SIIS) administered by the SCDHEC. If a provider does not routinely administer immunizations as part of his/her practice, he/she should refer the child to the county health department and maintain a record of the child's immunization status.

✓ **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. 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. Inpatient hospital services include room and board, miscellaneous hospital services, medical supplies, and equipment.

✓ **Laboratory and X-Ray Services**

The plan will pay for the following outpatient diagnostic services when such service is performed or ordered by a physician:

- Diagnostic X-ray, laboratory and pathological services for the diagnosis of an illness or injury;

- Clinical laboratory and tissue diagnostic examinations and medical diagnostic procedures for the diagnosis of an illness or injury, provided however, that the physician charges for any machine generated tests are not a covered medical expense.

✓ **Occupational, Speech and Physical Therapy**

Occupational and Physical Therapy Services are payable when provided by a therapist licensed in the appropriate professional discipline. Only one Speech Therapy assessment is covered per year. Speech Therapy services are only covered as a part of Rehabilitative Care (see this section). Speech Therapy services are not covered if the condition is a result of developmental delay or disability.

✓ **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 Clinic (OPAC). Included in these services are assessments for mental health and substance abuse and treatment of renal disease. Also included in the MCO rate are anesthesia services related to dental surgical procedures.

Outpatient services 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 members 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 and occupational therapy rendered in an outpatient hospital setting. Services performed in an outpatient hospital setting with a primary diagnosis of Family Planning are not payable.

✓ **Pap Smear**

The plan will cover one Pap Smear per female 18 years of age, when determined medically necessary by a physician.

✓ **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, patient's 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 separate service.

✓ **Podiatry Services**

The benefits for services of a podiatrist, acting within the scope of his license, are payable only to the extent that benefits under this plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition, except that no payment is provided when the services consist of, either in whole or in part, the removal of corns, callosities, hypertrophy or hyperplasia of the skin or any subcutaneous tissues; or the cutting, trimming, or other partial removal of toenails.

✓ **Prescription Drugs**

Rebated drugs and medicines are payable when required to bear the legend "Caution: Federal law prohibits dispensing without prescription," insulin, or drugs and medicines licensed or accepted for a specific diagnosis. A maximum 31 day supply per prescription is allowed. The basic objective is to provide needed pharmaceuticals for the purpose of saving lives in an emergency or a short-term illness, for sustaining life in chronic or long-term illness, or for limiting the need for hospitalization.

Pharmacy services include the dispensing of most *generic* legend (i.e., products that require a prescription in order to be dispensed) and most *generic* non-legend pharmaceuticals to eligible children. For each pharmaceutical dispensed, a valid prescription authorized by a licensed practitioner (physician, dentist, optometrist, podiatrist, or other health care provider authorized by law to diagnose and prescribe drugs and devices) must be on file.

✓ **Rehabilitative Care**

The plan will provide benefits for physical rehabilitation designed to restore bodily function that has been lost because of trauma or disease process. The rehabilitation care may consist of physical therapy, speech therapy, occupational therapy, and therapy to teach ambulation, transfer technique, bed mobility, dressing, feeding technique, bowel and bladder training and other activities of daily living.

Acute Rehabilitation Phase shall refer to therapy beginning soon after the onset of illness or injury. In many cases, acute phase rehabilitation is appropriately done in an

outpatient setting. In complex cases, the appropriate setting may be an acute care facility and then a sub-acute rehabilitation facility or a full service rehabilitation unit. Acute rehabilitation may last days, weeks or several months depending on the severity of illness or injury beginning soon after onset of illness or injury.

Long Term Rehabilitation shall refer to the point where further functional improvement is theoretically possible but the gains are slow and the cause/effect relationship with formal treatment is unclear.

**The following terms and conditions must be established:**

- Pre-certification is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs subsequent to an inpatient admission for rehabilitation therapy;
- The rehabilitation therapy must be performed in the most cost-effective setting as required by the condition;
- The Provider must submit a treatment plan with the proposed treatment, the expected result and the length of the treatment required to reach that result;
- There must be reasonable expectation that sufficient function can be restored for the patient to live outside the institutional setting;
- Continued rehabilitation therapy is dependent upon documentation that progress is continuing to be made, and only so long as there is a significant improvement in the capabilities of the patient;
- An inpatient admission must be to a rehabilitation facility under the same licensure as a short term general hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH), or if to a freestanding rehabilitation facility, one accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF);
- Rehabilitation benefits are not payable for vocational rehabilitation intended to teach a patient how to be gainfully employed; or pulmonary rehabilitation, except in conjunction with a covered and approved lung transplant; or behavior therapy; or long term rehabilitation after the acute phase, including cognitive retraining and community re-entry programs.

✓ **Skilled Nursing Care**

The Plan will pay the covered medical expense for room and board and a skilled nursing level of treatment in such facility for 60 days. The plan is responsible for reimbursing the long-term care facility/nursing home/hospital who provides swing beds or administrative days for the first sixty (60) days of services in any given episode of

long-term care/nursing home placement. The plan is responsible for notifying SCDHHS of any members requiring institutionalization in a long term care facility/nursing home and providing accompanying documentation. The member's eligibility will be reevaluated for Medicaid program membership by SCDHHS.

✓ **Transplants**

The plan will provide human organ transplants benefits to a covered person when hospitalized for a human organ or tissue transplant from a living donor or a donor under a living will to a transplant recipient which requires the surgical removal of the donated part under the following conditions:

- When both the transplant recipient and the donor are covered, benefits will be provided for both;
- When the transplant recipient is covered and the donor is not, benefits will be provided for both recipient and donor, to the extent that benefits to the donor are not provided by any other source. This includes, but is not limited to, other insurance coverage, any government program, or any employee welfare benefit plan. Benefits provided to the donor will be charged against the recipient's coverage and are limited only to charges arising out of the surgical removal of the donated part;
- When the transplant recipient is not covered and the donor is, the donor will receive benefits to the extent that such benefits are not provided by any coverage available to the recipient of the organ or tissue transplant procedure. This includes, but is not limited to, other insurance coverage, any government program, or any employee welfare benefit plan. Benefits will not be provided to a non-eligible transplant recipient.

Human organ transplant procedures are payable as specified below:

1. Transplant procedures are covered when such procedures conform to the following circumstances:
  - a. Covered procedures are liver, lung (single or double), heart, heart/lung, kidney and pancreas transplants.
  - b. In order for benefits to be available for the above major organ transplant procedures, pre-approval in writing must be obtained.
  - c. The organ transplant is the only treatment for the illness or injury that has an equivalent of better prognosis than an alternative form or treatment.

2. Allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high dose chemotherapy and/or radiation) are available for benefits under the following conditions:
  - a. There are no other recognized treatments that provide the patient with an equivalent or better prognosis;
  - b. Bone marrow transplantation is the patient's only reasonable opportunity to survive, and
  - c. The patient is an acceptable candidate for the treatment.
3. Autologous bone marrow transplants or other forms of autologous stem cell rescue (in which the patient is the donor) with high dose chemotherapy or radiation, is covered provided the patient meets the following criteria:
  - a. There are no other recognized treatments that provide the patient with an equivalent or better prognosis;
  - b. The autologous bone marrow transplantation or peripheral stem cell rescue with high dose chemotherapy is the patient's only reasonable opportunity to survive; and,
  - c. The patient is an acceptable candidate for the treatment.
4. The following transplants of tissue (rather than whole major organs) are eligible for benefits under this Plan when medically necessary. Such procedures are subject to all the provisions of this Plan, and prior approval in writing must be obtained.
  - a. Blood transfusions;
  - b. Autologous parathyroid transplants;
  - c. Corneal transplants;
  - d. Bone and cartilage grafting; and
  - e. Skin grafting.

No other transplant procedures are covered unless it can be determined that: (1) there are no other recognized treatments that provide the patient with a better prognosis for the illness or injury; and, (2) the tissue transplant is the only treatment for the illness or injury that has an equivalent or better prognosis than an alternative form of treatment; and, (3) the patient is an acceptable candidate for treatment.

5. All medical costs incurred in the identification of a donor, including surgical, storage and transportation expenses incurred and directly related to the donation of an organ used in a covered organ transplant procedure for liver, lung (single or

double) heart, heart/lung, kidney, pancreas, kidney/pancreas, and bone marrow transplants are subject to an established maximum payment.

6. Transportation expenses to and from the site of a covered organ transplant procedure for liver, heart, heart/lung, kidney, bone marrow or pancreas are covered for the recipient and one other individual. If the recipient is a minor, transportations costs are covered for two other individuals accompanying the recipient. All reasonable and necessary lodging and meal expenses are covered up to a daily established maximum per individual accompanying the recipient. The aggregate sum of transportation, lodging and meal expenses under this provision shall not exceed an established maximum for expenses incurred within five days immediately prior to, and one year immediately following, a covered organ transplant procedure. These transportation expenses are specifically for transportation of the patient and/or a family member to the site of the transplantation. This benefit is not available for transportation expenses related to evaluation of a patient for an organ transplant procedure.

✓ **Vision Care**

One comprehensive eye examination every 365 days is payable. Eye glasses 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. Procedures that are routinely covered are found in Appendix 3.

✓ **Well Care**

The intent of well care services for members, ages birth through the month of their 19<sup>th</sup> birthday is to direct attention to the importance of preventive health services and early detection and treatment of problems identified during a well child visit. The MCO shall have written procedures for notification, tracking, and follow-up to ensure these services will be available to all eligible children. The MCO shall assure that all medically necessary, covered diagnosis, treatment services and screenings are provided, either directly, through subcontracting, or by referral. The utilization of these services shall be reported as referenced in the **Policy and Procedure Guide**. The Plan will provide the following benefits for routine Well Child Care visits.

- Younger than 1 year old—five annual visits
- 1 year old—three annual visits
- 2 through 18 years old—one annual visit

#### **4. Non Covered Services**

- Family Planning
- Treatment of Mental Retardation and Developmental Disorders
- Diet Treatments and Weight Loss Surgery
- Audiology and Hearing Aids
- Dental services are covered outside the MCO benefit package and are reimbursed at the Medicaid fee-for-service rate.

**SECTION 6**  
**STANDARDS OF CARE**

The MCO must adopt practice guidelines consistent with current standards of care, complying with recommendations of professional specialty groups or national and state governmental agency guidelines e.g., the US Task Force on Preventive Care, Centers for Disease Control, etc. MCO should identify for SCDHHS those other evidence-based tools (i.e., hard copy or electronic) that are used to encourage and support best practice standards of care in their provider network.

**SECTION 7**  
**THIRD PARTY LIABILITY**

A child who has comprehensive health coverage is not eligible for the HCK program. Comprehensive health coverage is defined as coverage with at minimum, hospitalization, doctor visits, x-ray and lab coverage. If the child's coverage does not have this basic coverage, they can qualify. The MCO must report to SCDHHS if they learn that the HCK member has comprehensive health coverage.

## **SECTION 8 PROVIDER CERTIFICATION AND LICENSING**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mobile Ultrasound - No license or certification required.

Physiology Labs - Providers must be enrolled with Medicare.

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

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

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

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

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

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

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

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

Chiropractic – Chiropractors are licensed by the Board of Chiropractic Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Occupational Therapy – Occupational Therapists are licensed by the Board of Occupational Therapy, under the South Carolina Department of Labor, Licensing and Regulations.

Physical Therapy – Physical Therapists are licensed by the Board of Physical Therapy, under the South Carolina Department of Labor, Licensing and Regulations.

Speech Therapy and Audiology – Speech Therapists and Audiologists are licensed by the Board of Examiners in Speech-Language Pathology and Audiology, under the South Carolina Department of Labor, Licensing and Regulations.

### **Credentialing and Re-Credentialing**

The MCO may delegate the credentialing / re-credentialing process, with SCDHHS approval. The MCO is responsible for contracting delegated credentialing responsibilities and ensuring the delegated entity follows the requirements as set forth by SCDHHS and the National Commission for Quality Assurance (NCQA). Re-credentialing will be no less often every three (3) years. All delegated agreements must be approved by SCDHHS prior to execution.

The MCO will develop and maintain policies and procedures regarding the credentialing /re-credentialing processes, submit the policies for SCDHHS' approval and submit with the January 15th submissions the summary of all changes that have occurred throughout the year. This however does not release the MCO from its obligation to submit changes to its policy as they occur and receive SCDHHS approval prior to execution when changes occur. The re-credentialing process will be no less than every three (3) years, with query of the National Practitioner Databank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners ( for the specific discipline) and other performance data.

An onsite review will be required of providers and subcontractors , prior to the completion of the initial credentialing process . An on-site after initial review will be completed when a complaint has been lodged against the specific provider. The MCO must document that the location has adequate facilities and the practitioner's record

keeping practices are consistent with the appropriate Federal and State laws and regulations.

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

The process will include, but not be limited to:

- Current Valid License / Actions
- Current DEA and / or CDS certificate / Actions
- Education / Training / Board Certification(s)
- Work History (5 years) / Justifications for Gaps
- Professional Liability / Claims History (5 years)
- Hospital Privileges / Coverage Plan
- Sanctions by Medicare / Medicaid (5 years)
- Ownership Disclosure
- National Practitioner Databank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners (for the specific discipline)
- Disclosure by Practitioner:

Physical / mental stability

History of chemical / substance abuse

History of loss of license / felony convictions

History of loss or limitations of privileges

Attestation: Correctness / completeness of application

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

## SECTION 9

### QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

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

1. Comply with 42 Code of Federal Regulations (CFR) 434.34 which states that the MCO must have a quality assessment system that :
  - a) Is consistent with the utilization control requirement of 42 CFR 456;
  - b) Provides for review by appropriate health professionals of the process followed in providing health services;
  - c) Provides for systematic data collection of performance and patient results;
  - d) Provides for interpretation of this data to the practitioners; and
  - e) Provides for making needed changes.
2. Maintain and operate a Quality Assessment (QA) program which includes at least the following elements :
  - a) A quality assessment plan which shall include a statement that the objective of the QA plan is to "monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems." QA efforts should be health outcome oriented and rely upon data generated by the MCO as well as that developed by outside sources. The plan must be organized and written so that staff members and practitioners can understand the program's goals, objectives and structure and should incorporate information from customer service, appeals and grievances, medical management, credentialing, and provider relations.
  - b) QA Staff - The QA plan developed by the MCO shall name a quality director, manager or coordinator responsible for the operation and success of the QA program. Such person shall be a registered nurse, have adequate and appropriate experience to conduct a successful QA program, and shall be accountable for QA in all of the MCOs own providers, as well as the MCOs subcontractors . The person shall spend at least 80% of his/her time dedicated to QA activities to ensure the success of the QA program. . 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 has the substantial involvement of the medical director and 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.). with emphasis on primary care including 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 committee shall meet at least quarterly and produce dated and signed written documentation of all meetings and committee activities. This documentation as well documented QA activities and outcomes shall be submitted on a quarterly basis to the MCO Board of Directors and the SCDHHS authorized agents.
- f) 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/subcontractors QA efforts.
- g) 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, and copies provided to both the MCO Board of Directors and the SCDHHS.
- h) The MCO shall make use of the SCDHHS utilization data or their own utilization data, if equally or more useful than the SCDHHS utilization data, as part of the QA program.
- i) Quality Assessment and Performance Improvement Program (QAPI): The MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to members. At a minimum, the MCO 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.

j) Performance Measurements: Annually the MCO shall:

1. Measure and report to SCDHHS its performance using ALL NCQA defined HEDIS measures applicable to Medicaid/HCK by June 15<sup>th</sup> of the following calendar year. Reporting must use the NCQA definitions for that respective measurement year (i.e. 2009 data must use 2009 definitions.)
2. Perform a combination of the activities described in the two items k(1) and k(2) listed above.

k) Performance Improvement Projects (PIP): Annually, the MCO shall have an ongoing program of performance improvement projects (a minimum of one project and a maximum of three projects) that focus on clinical and non-clinical areas, and involve the following:

- Quantitative and Qualitative measurements of performance using standard 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.

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.

l) In future contracts, pay-for-performance will be used to access the quality improvement measured in HEDIS and CAHPS survey.

3. Assist the SCDHHS in its quality assurance activities.

4. 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.

5. 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.

6. 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.

7. 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.

When deficiencies are found, the MCO will submit a Plan of Correction which includes the following:

- Identifies each deficiency
  - Specifies the corrective action to be taken
  - Provides a timeline by which corrective action will be completed.
8. Assure that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the provider, are properly licensed and/or certified under applicable state law and/or regulations and are eligible to participate in the Medicaid/Medicare program.

The MCO must have written policies and procedures for credentialing and re-credentialing. The MCO may use its own Credentialing Form or the South Carolina Uniform Managed Care Provider Credentialing Application developed by the South Carolina Medical Association. The MCO may use its own Re-Credentialing Form or the South Carolina Uniform Managed Care Provider Credentials Update Form also developed by the South Carolina Medical Association. Copies of these may be downloaded at the following site: <http://www.scmca.org/download/UCA2004.pdf>.

The MCO shall maintain a copy of all plan providers current valid license to practice.

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

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

9. The MCO must have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum:
- (a) Written policies and procedures for assigning every member a primary care provider.
  - (b) Management and integration of health care through primary care providers. The MCO agrees to provide available, accessible and adequate numbers of institutional facilities, service location, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis.

- (c) Systems to assure referrals for medically necessary, specialty, secondary and tertiary care.
  - (d) Systems to assure provision of care in emergency situations, including an education process to help assure that members know where and how to obtain medically necessary care in emergency situations.
  - (e) Specific referral requirements for in and out of plan services. MCO shall clearly specify referral requirements to providers and subcontractors and keep copies of referrals (approved and denied) in a central file or the member's medical record.
  - (f) The MCO must assign an MCO qualified representative to interface with the case manager for those members receiving out of plan continuity of care and case management services. The MCO representative shall work with the case manager to identify what HCK covered services, in conjunction with the other identified social services, are to be provided to the member.
10. The MCO shall have a system for maintaining medical records for all HCK members in the plan, to ensure the medical record:
- (a) Is accurate, legible and safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all individuals evaluated or treated, and is accessible for review and audit. Also, the MCO shall maintain, or require its network providers and subcontractors to maintain, individual medical records for each HCK member which make readily available to the SCDHHS and/or its designee and to appropriate health professionals all pertinent and sufficient information relating to the medical management of each enrolled member. Procedures shall also exist to provide for the prompt transfer of patient care records to other in - or out-of-plan providers for the medical management of the member.
  - (b) Is readily available for MCO-wide QA and UM activities and provides adequate medical and other clinical data required for QA/UM.
  - (c) Has adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.
  - (d) Contains at least the following items:
    - ✓ Patient's name, identification number, age, sex, and places of residence and employment. Next of kin, sponsor or responsible party.
    - ✓ Services provided through the MCO, date of service, service site, and name of service provider.
    - ✓ Medical history, diagnoses, treatment prescribed, therapy prescribed and drug administered or dispensed, commencing at least with the first patient examination made through or by the MCO.
    - ✓ Referrals and results of specialist referrals.

- ✓ Documentation of emergency and/or after-hours encounters and follow-up.
- ✓ Signed and dated consent forms.
- ✓ For pediatric records (**ages 6 and under**) there must be a notation that immunizations are up-to-date.
- ✓ Documentation of advance directives, as appropriate.
- ✓ Documentation for each visit must include:
  - Date
  - Grievance or purpose of visit
  - Diagnosis or medical impression
  - Objective finding
  - Assessment of patient's findings
  - Plan of treatment, diagnostic tests, therapies and other prescribed regimens.
  - Medications prescribed
  - Health education provided
  - Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

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

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

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

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

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

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

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

- a) Have written policies and procedures which detail what the grievance system is and how it operates. The grievance procedures must comply with the guidelines outlined in the Contract.
- b) Inform members about the existence of the grievance processes.
- c) Attempt to resolve grievances through internal mechanisms whenever possible.
- d) Maintain a record keeping system for oral and written grievances and appeals and records of disposition.
- e) Provide to SCDHHS on a quarterly basis written summaries of the grievances and appeals which occurred during the reporting period to include:
  - Nature of grievances and/or appeals
  - Date of their filing
  - Current status
  - Resolutions and resulting corrective action

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

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

- a) SCDHHS will review and approve the MCOs written Quality Assurance Plan. The MCO must submit any subsequent changes and/or revisions to its Quality Assurance Plan to SCDHHS for approval on or before April 30<sup>th</sup> annually.
- b) The SCDHHS will review and approve the MCOs written grievance and appeal policies and procedures. The MCO must submit any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval prior to implementation.
- c) The SCDHHS shall review monthly individual encounter/claim data. Encounter claim data shall be reported in a standardized format as specified by SCDHHS and transmitted through approved electronic media to SCDHHS.
- d) The SCDHHS shall review quarterly quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.
- e) SCDHHS staff will review the MCOs reports of grievances, appeals, and resolution.
- f) SCDHHS staff will approve the MCOs Plan of Correction (PoC) and monitor the MCOs progress with the corrective actions developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective actions.

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

- Readiness Review Survey. The EQRO will conduct a readiness review of the MCO as designated by DHHS. The Medicaid Managed Care External Review Services Manual will serve as a guide for the readiness review survey. DHHS will receive a written report within 30 days of the survey. DHHS will convey the final report findings to the MCO with a request for a PoC.
- Effective January 1, 2013, verify the most recent NCQA Accreditation survey and corresponding status. This survey is conducted every three years by NCQA and is required for plans to serve as MCOs to SCDHHS. Prior to this date, verification of the most recent NCQA or URAC Accreditation survey and status with those organizations.
- With SCDHHS staff, conduct workshop and training for MCO staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.

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

### **NCQA HEDIS Reporting Measures**

Use guidelines for HEDIS measures defined by NCQA for that respective measurement year (i.e. measures reported in 2010 are for the 2009 measurement year and must follow the specifications published for that measurement year). Measures must be submitted to SCDHHS by June 15<sup>th</sup> of the following calendar year ( the reporting year). Data must be submitted to SCDHHS in XML format. A timeline for submitting HEDIS and CAHPS survey measures is published by the NCQA, and should be followed to ensure timely submission.

#### **2011 Timeline:**

- Use the services of a contracted NCQA accredited compliance auditor or schedule a certified HEDIS Compliance auditor for the calendar year.
- Collect measures January 1, 2010 – December 31, 2010.
- Audit collection process by NCQA certified auditor.
- Do chart review for hybrid measures. In the event that a MCO does not have a contract with an NCQA accredited vendor for auditing, this will be arranged by SCDHHS , and fees for auditing will be paid to SCDHHS to pay for auditing services.
  - NCQA data software is available to help with data processing.
- Submit measures to NCAQA.

#### **June 15<sup>th</sup> 2011:**

- 1) Submit finalized measures to SCDHHS in XML format used for submission to NCQA.

While not necessary for 2009 measurement year data, it is highly recommended that HEDIS and CAHPS reports are generated and reported in 2010 for data and quality improvement purposes.

## **SECTION 10**

### **MARKETING/ADVERTISING AND MEMBER EDUCATION**

The MCO shall be responsible for developing and implementing a written marketing/advertising plan designed to provide the HCK member with information about the MCO's managed care plan. All marketing/advertising and member education materials must contain the 1-877-552-4642 telephone number of the statewide Healthy Connections Kids Help Line and the plan's toll free number. The marketing/advertising plan and all related accompanying materials are governed by 42CFR § 438.104 and the following definitions and policies. Should an MCO require additional guidance or interpretation, it should consult with the SCDHHS.

#### **Definitions**

Beneficiary – A person who is determined to be eligible for HCK services.

Member - A HCK beneficiary who is enrolled with a HCK managed care plan.

Marketing/advertising means any communication, from an MCO to a HCK beneficiary who is not enrolled in that entity, which can reasonably be interpreted as intended to influence the HCK beneficiary to enroll in that particular MCO's HCK product or either to not enroll in, or to disenroll from, another MCO's HCK product.

Marketing materials/media means materials that (1) Are produced in any medium, by or on behalf of an MCO; and (2) Can reasonably be interpreted as intended to market to beneficiaries. Marketing/advertising and education materials/media include, but are not limited to the following:

- Brochures
- Fact sheets
- Posters
- Videos
- Billboards
- Banners
- Signs
- Commercials (radio and television ads/scripts)
- Print ads (newspapers, magazines)
- Event signage
- Vehicle coverings (buses, vans, etc)
- Internet sites (corporate and advertising)
- Other advertising media as determined by SCDHHS

Member education is educational activities and materials directed at MCO members that increases the awareness and favorably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis. Member

education also includes information and materials that inform the member on the MCO's policies, procedures, requirements and practices.

Marketing activities include, but are not limited to, distribution of marketing and advertising materials; health plan promotion, including attendance of community, business and other events; and, any other means of calling public attention to the HCK managed care plan or company.

Value Added Items and Services (VAIS) are defined as items and services provided to a member that are not included in the core benefits and are not funded by HCK dollars. SCDHHS only allows "health care related" VAIS. Health care related VAIS are items or services that are intended to maintain or improve the health status of members.

### **General Marketing/Advertising and Member Education Policies**

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

Violation of any of the listed policies shall subject the MCO to sanctions, including suspension, fine and termination, as described in Section 13 of the MCO HCK contract and as determined by the SCDHHS. The MCO may appeal these actions in writing to SCDHHS.

The MCO's marketing/advertising plan shall guide and control the actions of its marketing staff. In developing and implementing its plan and materials, the MCO shall abide by the following policies:

#### **Permitted Activities**

- The MCO is allowed to offer nominal gifts, with a fair market value of no more than \$10.00; with such gifts being offered regardless of the beneficiary's intent to enroll in a plan. Cash gifts of any amount, including contributions made on behalf of people attending a marketing event, gift certificates or gift cards **are not permitted** to be given to beneficiaries or general public. Cash gifts, including gift cards, **are permitted** to be given to MCO members as incentives or rewards for healthy behaviors. These are known as health care related "value added items and services (VAIS)."
- The marketing representative is responsible for providing the beneficiary with information on participating PCPs and assisting in determining if his/her current physician is a member of the MCO's network.
- Any claims stating that the MCO is recommended or endorsed by any public or private agency or organization, or by any individual must be prior approved by

SCDHHS and must be certified in writing by the person or entity that is recommending or endorsing the MCO.

- The MCO is allowed to directly and/or indirectly conduct marketing/advertising activities in a doctor's office, clinic, pharmacy, hospital or any other place where health care is delivered, with the written consent of the provider. This also includes government facilities, such as local offices of the South Carolina Department of Health and Human Services, the Department of Social Services, the Department of Health and Environmental Control, HeadStart and public schools. The use of government facilities is only allowed with the written permission of the government entity involved. Any stipulations made by the provider or government entity must be followed (allowable dates, times, locations, etc).
- All marketing/advertising activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.
- The MCO may provide approved marketing/advertising and educational materials for display and distribution by providers. This includes printed material and audio/video presentations.
- Upon request by a HCK beneficiary, marketing representatives may provide him/her with information (excluding an enrollment form) about the MCO to give to other interested HCK beneficiaries (i.e. business card, marketing brochure).

### **Activities Which Are Not Permitted**

- The MCO is prohibited from distributing enrollment forms or aiding a HCK beneficiary in filling out or transmitting an enrollment form in any way.
- When conducting marketing/advertising activities, the MCO shall not use their personal or provider-owned communication devices (i.e. telephone or cell phone, fax machine, computer) to assist a person in enrolling in a health plan.
- The MCO shall not make any claims or imply in any way that a HCK beneficiary will lose his/her benefits under any governmental health or welfare program or, benefits to which he/she is legally entitled, if he/she does not enroll with the MCO.
- The MCO cannot make offers of material or financial gain (such as gifts, gift certificates, insurance policies) to HCK beneficiaries to induce plan enrollment.
- The MCO (and any subcontractors or representatives of the MCO) shall not engage in marketing/advertising practices or distribute any marketing/advertising materials that misrepresent, confuse or defraud HCK beneficiaries, providers or

the public. The MCO shall not misrepresent or provide fraudulent misleading information about the HCK program, SCDHHS and/or its policies.

- The MCO cannot discriminate on the basis of a beneficiary's or member's health status, prior health service use or need for present or future health care services. Discrimination includes, but is not limited to, expulsion or refusal to re-enroll a member except as permitted by Title XXI.
- The MCO's marketing representatives may not solicit or accept names of HCK beneficiaries from HCK beneficiaries or MCO members for the purpose of offering information regarding its plan.
- The MCO may only market in the beneficiary's residence if they obtain a signed statement from the HCK beneficiary; giving permission for the MCO's representative to conduct a home visit for the sole purpose of marketing activities.
- The MCO is prohibited from comparing their organization/plan to another organization/plan by name.
- HCK Beneficiary and MCO Member Contact
- The MCO is not allowed to directly or indirectly, conduct door-to-door, telephonic, or other "cold call" marketing/advertising activities. This includes initiating contact with a member of the public or beneficiary at a marketing event.
- The MCO is not allowed to initiate direct contact (defined as a face to face interaction where communication takes place) with HCK beneficiaries for purposes of soliciting enrollment in their plan.
- The MCO may not market directly to HCK beneficiaries in person or through direct mail advertising or telemarketing.
- The MCO may contact members who are listed on their monthly member listing to assist with HCK re-certification/eligibility
- The MCO may conduct an initial follow up with all disenrollees listed on their monthly member listing. However, these activities must be in accordance with marketing requirements, including no direct or indirect "cold call" marketing. The MCO cannot make repeated follow up calls unless specifically requested by the HCK beneficiary.

## **Beneficiary Marketing and Member Education Materials/Media**

Marketing may include providing informational materials to enhance the ability of an HCK beneficiary to make an informed choice of HCK managed care options. Such 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/advertising material developed by the MCO for inclusion in the SCDHHS enrollment package to be distributed to HCK beneficiaries. The SCDHHS at its sole discretion will determine which materials will be included.

The MCO shall be responsible for developing and distributing its own beneficiary marketing/advertising and member education materials. The MCO shall ensure that all HCK managed care marketing/advertising and education materials, brochures and presentations clearly present the core benefits and approved expanded benefits, as well as any limitations. The MCO shall also include a written statement to inform beneficiaries and members that enrollment is voluntary.

SCDHHS has established the following requirements for the MCO's HCK managed care marketing/advertising and education materials:

- MCOs can, **with SCDHHS written prior approval**, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by MCO), advertising in newspapers, magazines, church bulletins, billboards and buses.
- All marketing/advertising materials/media must include the 1-877-552-4642 telephone number of the statewide Healthy Connections Kids Help Line and the plan's toll free number. Promotional materials (items designed as "give-aways") are excluded from this requirement. Education materials for members and third party education publications, such as CDC guidelines, dietary information, disease education, etc., are also exempt.
- All marketing/advertising materials/media, including flyers, brochures, commercials, billboards, websites must include a statement that enrollment is voluntary.
- MCOs can **passively** distribute approved marketing/advertising and educational materials, with written authorization from the entity responsible for the distribution site, to HCK beneficiaries and members. Passive distribution is defined as the display of materials with no MCO marketing or education staff present.
- MCOs may mail SCDHHS approved marketing/advertising and educational materials within its approved service areas. Mass mailings directed to only

HCK beneficiaries are prohibited.

- MCOs' network providers can correspond with beneficiaries concerning their participation status in the HCK Program and the MCO. These letters may not contain MCOs' marketing/advertising/education materials or SCDHHS enrollment forms. Letters must be developed, produced, mailed and/or distributed directly by the network provider's office at their expense. This function cannot be delegated by the provider, to the MCO or an agent of the MCO. In addition, the use of these letters must be in accordance with SC Department of Insurance policies and regulations.
- The MCO shall ensure that all materials are accurate, are not misleading or confusing, and do not make material misrepresentations.
- All materials shall be submitted to be reviewed and approved for readability, content, reading level and clarity by SCDHHS or its designee, prior to use or distribution.
- The MCO 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 SCDHHS.
- The MCO shall ensure that appropriate foreign language versions of all marketing/advertising and education materials are developed and available to HCK beneficiaries and MCO members. 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 MCO.) These materials must be approved, in writing, by SCDHHS. Affidavits of accuracy and reading level compliance by a professional translation service must accompany all foreign language translations and be submitted with the approval request.
- The MCO shall issue a certificate/evidence of coverage and/or member handbook which describes/contains at a minimum, the following:

|   |   |
|---|---|
| Specific information on core benefits                           | Instructions on how to choose a primary care provider                                 |
| Approved expanded benefits                                      | Instructions on the plan's Prior Authorization process                                |
| Out-of-plan services or benefits                                | Information on the plan's pharmacy formulary and authorization policies               |
| Non-covered services  | Instructions/procedures for making appointments for medical care                      |
| A glossary/definition of generic MCO terms                      | Instructions on accessing the MCO's member services departments                       |
| A description of how the plan operates                          | Information on the responsibilities and rights of an MCO member                       |
| An explanation of how the plan's identification (ID) card works | An explanation of its confidentiality of medical records                              |
| An explanation of the plan's referral process                   | An explanation of member's grievance(s), appeals rights, and advance directive rights |
| A description of the WIC program                                | Information on member disenrollment and termination                                   |
| A description of the plan's well-care program                   | An explanation of the MCO member(s) effective date of enrollment and coverage         |
| Comprehensive instructions on how to obtain medical care        | The plan's toll-free telephone numbers  |

- When the MCO identifies HCK beneficiaries or MCO members who have visual and/or hearing impairments, an interpreter must be made available.
- The MCO's written material shall include its current network provider list, which includes names, area of specialty, address, and telephone number(s) of all participating providers, groups and facilities including primary care, specialty

care, hospitals and clinics, pharmacies, ancillary providers (such as labs and x-ray), DME providers and all other required services providers. It shall also include a map or description of the MCO's service area.

- The MCO's written material must include a definition of the terms "emergency medical care" and "urgent medical care" and the procedures on how to obtain such care within and outside of the MCO's service area.
- The MCO must provide a description of its services for communicable diseases such as TB, STD, and HIV/AIDS. Also included must be a statement of the member's right to obtain TB, STD, HIV/AIDS services from any state public health agency.
- Summary documents and brochures must include a statement that the document 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 Activities**

MCOs can conduct, sponsor and participate in marketing/advertising activities only with prior written notice to SCDHHS in a format defined by SCDHHS. Written approval by SCDHHS is NOT necessary. Notice of the date, time and location of each activity/event must be received by SCDHHS three (3) business days prior to the event. A business day is the time period between 8:30am and 5:00pm Eastern time. South Carolina state holidays are excluded from being counted as a business day. (For example, if a marketing event is on Friday the 15<sup>th</sup> of the month, the notification to SCDHHS must be received by 5:00pm on Monday, the 11<sup>th</sup>. Using this same example, if Wednesday the 13<sup>th</sup> is a holiday, the notification must be received by Friday the 8<sup>th</sup>). Any exceptions to this policy will be considered on a case-by-case basis.

When conducting marketing activities, the MCO may not initiate contact with members of the public or beneficiaries. They may respond to contact initiated by the member of the public or beneficiary. For example, if a marketing representative is operating a booth at a health fair – the representative may give out information or materials, if requested. The representative may not approach a person and give out information or material (including promotional items).

SCDHHS reserves the right to attend all marketing activities/events. The MCO must also secure the written permission of the business or event sponsor to conduct marketing/advertising activities (this satisfies the "written prior approval" requirement of the MCO Contract) and make this document available to SCDHHS, if requested (Fax copies are acceptable).

MCOs may conduct marketing/advertising activities at events and locations including, but not limited to health fairs, health screenings, schools, churches,

housing authority meetings, private businesses (excluding providers referenced in this Section) and other community events. The MCO may also be a participating or primary sponsor of a community event. The MCO may not present at employee benefit meetings.

### **Focus Groups**

MCOs may conduct focus group research with their members in order to determine what their member's expectations of the MCO for improving services and benefits to its members, with prior approval from SCDHHS. The request must be received by SCDHHS by noon (12 PM EST) at least twenty (20) business days prior to the first date the focus group will meet. In its request for approval, the MCO must include the following information:

- Identity of the entity conducting the focus group event(s) – MCO staff or contractor (including name of contractor)
- Date, time, contact information and location of each event
- Selection criteria for participation
- Agenda/list of questions being asked to participants
- Participant compensation, separated into monetary amount and other expenses (transportation, refreshments). For instance, If the participant total compensation is \$80, the separate monetary amount might be \$50 and the other expenses might be \$20 transportation voucher and \$10 for a meal.

The MCO may not offer gift cards, drawing, prizes or any other type of rewards for the MCO members or sponsor attending these meetings. SCDHHS reserves the right to obtain additional information during the review and approval process and to attend focus group meetings.

### **Member Services**

The MCO shall maintain an organized, integrated member services function to assist MCO members in understanding the MCO's policies and procedures. The function of the member services unit is to provide additional information about the MCO's providers, facilitate referrals to providers and assist in the resolution of service and/or medical delivery concerns or problems. The MCO shall identify and educate its members who access the system inappropriately and provide additional education, as needed. The MCO shall provide a written description of its member services functions to its members no later than fourteen (14) business days from receipt of enrollment data from SCDHHS. This written description may be included in the certificate/evidence of coverage document or member handbook and must include the following information:

- Definitions of appropriate and inappropriate utilization of services
- Instructions on how to access services

- Instructions on how to select a primary care physician
- Information on how to access out-of-network (non-par) providers
- Information on how to access emergency care (in or out-of-area)
- Explanation of the process for prior authorization of services
- Toll free telephone numbers for member services
- Explanation of how to authorize the provider to release medical information to the federal and state governments or their duly appointed agents

### **HCK Program Identification (ID) Card**

The MCO shall issue an identification card for its members to use when obtaining core benefits and any approved expanded services. To ensure immediate access to services, the MCO shall establish appropriate mechanisms, procedures and policies to identify its members to providers until the member receives its HCK ID card from the MCO. A permanent MCO ID card must be issued by the MCO within fourteen (14) calendar days of selection of a PCP by the HCK MCO program member or date of receipt of enrollment data from SCDHHS, whichever is later.

The MCO is responsible for issuing an ID card that identifies the holder as a HCK MCO 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:

- MCO name
- A twenty-four (24) hour telephone number for HCK MCO Program members use in urgent or emergency situations or to obtain any other information
- Primary care physician name
- Member name and identification number
- Expiration date (optional)
- Toll free telephone numbers

### **Enrollment**

- All enrollment activities are to be exclusively conducted by the enrollment broker. This includes distribution of forms, assistance to HCK beneficiaries

and transmittal of enrollment information to the enrollment broker and SCDHHS.

- No distribution of enrollment forms is allowed by a MCO or employee/agent of a MCO. Distribution is defined as making the enrollment form available directly or indirectly through the MCO or representative of the MCO.

### **Enrollment Incentives**

- No offers of material or financial gain, other than core benefits expressed in the MCO contract, may be made to any HCK beneficiary as incentive to enroll or remain enrolled with the MCO. This includes, but is not limited to, cash, vouchers, gift certificates, insurance policies or other incentive. The MCO 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 MCO members for the full contract period which has been approved by SCDHHS. Optional expanded benefits that have been approved by SCDHHS may be used in marketing materials and activities. These benefits include, but are not limited to: medications, additional services and visits, increases over HCK limitations or membership in clubs and activities.

## **SECTION 11**

### **COUNTY NETWORK TERMINATION and/or TRANSITION PROCESS**

In the event an approved HCK MCO provider network loses essential provider (s), the network must be reviewed for either termination or the possibility of transferring of the MCO's HCK member to another MCO. SCDHHS has developed a Termination and/or Transition Process, which will go into effect upon the receipt of written notification from the MCO or essential provider that the essential provider will no longer be apart of the MCO network. Because termination can only occur at the end of a month, it is possible for a termination process to exceed 90 days, depending on when the notice was given.

#### **County Network Termination and/or Transition Procedures**

There are three ways in which the County(s) Network Termination and/or Transition Process can be initiated.

- 1) SCDHHS Care Management Staff receives verbal and written notification from the MCO, along with a copy of the termination letter to the essential provider(s). The verbal or written notification, with a copy of the termination letter, must be provided to SCDHHS within 24 hours of receipt of essential provider(s)'s intent to terminate its contract(s) with the MCO. The MCO must provide, at a minimum, ninety (90) days prior written notice to SCDHHS. MCO may take no actions to remove or change any provider assignment formula in the affected counties until SCDHHS has given the MCO approval to do so. Termination dates can only occur at the end of a month, thus it is possible for a termination process to exceed 90 days, depending on when the notice was given.
- 2) SCDHHS Care Management Staff receives verbal or written notice notification directly from essential provider(s) of its intent to terminate its contract with MCO. SCDHHS will notify the MCO (either verbally or by email) within 24 hours of receipt of the essential provider's intent to terminate. The provider must provide, at a minimum, ninety (90) days prior written notice to SCDHHS. The provider may not deny services to affected MCO members during the Termination and/or Transition process.
- 3) SCDHHS Care Management Staff determines that MCO County Network providers no longer meets network adequacy standards. Once SCDHHS determines MCO county network is not adequate, it will notify the MCO either verbally or by email. SCDHHS will begin the termination and/or Transition process and establish the key days during the initial meeting with the MCO.

Upon initiation of the County Network Termination and/or the Transition Process, SCDHHS will schedule the initial County Network Termination and/or the Transition Plan Meeting between SCDHHS Care Management Staff and the MCO. At this meeting, the SCDHHS Care Management Staff will determine the specific and critical dates. The MCO will be given the required dates to submit county network reports, member correspondence (in both English and other applicable languages), call center scripts,

frequently asked question and answer scripts and other requirements. The MCO will be responsible for , maintaining and updating the County Termination and /or the Transition Form on a weekly basis. The MCO will also arrange a weekly call- in and provide a conference call telephone number for use by participants.

SCDHHS may, at its discretion, halt the assignment of MCO members to the affected county(s) at anytime during this process, SCDHHS also reserves the right to allow MCO members to leave the affected plan in order to maintain their continuity of care. Any additional charges incurred by the enrollment broker or SCDHHS during of this process will be reimbursed by the MCO. The MCO will not take any action to remove providers or limit their members' access or right to choose the affected providers in the affected county (ies) without the prior consent of SCDHHS. If the MCO does take any actions to change the way it assigns it members, delete the providers from weekly submissions to the enrollment broker or any other type of action, without prior approval from SCDHHS, it will be subject to sanctions and fines as outline in Section 13 of the HCK MCO contract.

## County Network Termination/Transition Plan Form

### Project Plan

|                            |   |
|----------------------------|---|
| <b>Project Name</b>        | County (ies) Network Termination/Transition Plan Form |
| <b>Project Description</b> | South Carolina Provider Task Force                    |
| <b>Team</b>                | MCO & SCDHHS dated mm/dd/yy                           |

### Key: Overall Status

|          |   |
|----------|---|
| Green    | Not Yet Started or On-Track                     |
| Yellow   | Cautionary concern; requires close management   |
| Red      | Off-Track; immediate course correction required |
| Complete | Milestone Complete                              |

### Overall Project Timeline

| CAP # | Task # | Task                                 | Target End Date | Revised Date | Status      | Accountability | Comments |
|-------|--------|--------------------------------------|-----------------|--------------|-------------|----------------|----------|
| 1     |        | Provider Notification of Termination |                 |              |             |                |          |
|       |        |                                      |                 |              | Not Started |                |          |
| 2     |        | Member Communications                |                 |              |             |                |          |
|       |        |                                      |                 |              |             |                |          |
| 3     |        | Contingency Plan Milestones          |                 |              |             |                |          |
|       |        |                                      |                 |              |             |                |          |
| 4     |        | Provider Notification Plan           |                 |              |             |                |          |
|       |        |                                      |                 |              | Not Started |                |          |
| 5     |        | Website                              |                 |              |             |                |          |
|       |        |                                      |                 |              | Not Started |                |          |

## **SECTION 12 COORDINATION OF MANAGED CARE FRAUD AND ABUSE COMPLAINTS AND REFERRALS**

The following set of Policies and Procedures has been developed to govern the disposition of fraud and abuse complaints along with the coordination of activities between SCDHHS and MCOs.

### **Purpose**

To establish policy for coordination and referral of complaints made against healthcare providers providing services under a managed care plan and beneficiaries enrolled in a managed care plan, in accordance with 42 CFR 455.

The Division of Program Integrity and the Division of Care Management will work jointly with the managed care plans and medical home networks providing services to the South Carolina Medicaid and SCHIP populations in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate.

### **Coordination Involving DHHS Fraud Hotline Complaints**

- If the SCDHHS Fraud Hotline receives a complaint about an MCO beneficiary/member's eligibility for HCK, the complaint is referred within three business days to the Division of Program Integrity.
- If the SCDHHS Fraud Hotline receives a complaint about an MCO beneficiary / member's utilization of benefits, the complaint is referred within three business days to the appropriate Plan, using the DHHS secure portal to share information.
- If the SCDHHS Fraud Hotline receives a complaint about a provider with indications they are in a managed care network, the complaint is referred to Program Integrity and Division of Care Management for preliminary screening for fraud and abuse and/or referral to the appropriate Plan for action.
- The Division of Program Integrity will capture data on complaints made against beneficiaries receiving services under a managed care plan.

### **Coordination for Fraud and Abuse Complaints Received by Managed Care Organizations**

- If the MCO receives a complaint about a member's eligibility for HCK, the complaint is referred to Program Integrity. The referral is made within three business days using the SCDHHS secure portal to share information.
- If the MCO receives a complaint about a member's utilization of benefits, the complaint is handled internally in accordance with the Plan's fraud and abuse / program integrity plan.

- If the MCO receives a complaint against a health care provider or subcontractor in its network, the MCO will investigate in accordance with its fraud and abuse/ program integrity plan.

### **Fraud and Abuse Referrals**

- If a complaint or the findings of a preliminary investigation give the MCO reason to believe that fraud or abuse of the HCK program has occurred, the MCO must immediately (within one working day) report this information to the Division of Program Integrity. Any suspicion or knowledge of fraud and abuse would include, but not be limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or subcontractors . The MCO should submit all relevant information about the case, including its findings and the details of its investigation.
- Upon suspicion of HCK fraud on the part of a beneficiary/member enrolled in an MCO, the MCO will refer the complaint to the Division of Program Integrity with all supporting evidence so the complaint can be referred to the Medicaid Recipient Fraud Unit in the SC Attorney General's Office. DHHS will refer the case to the Medicaid Recipient Fraud Unit either during its monthly meeting or as soon as possible in urgent cases.
- Upon suspicion of HCK fraud on the part of a health care provider paid to provide services to SC HCK beneficiaries, either as a participating or non-participating provider in the MCO, the Division of Program Integrity will refer the case to the Medicaid Fraud Control Unit in the SC Attorney General's Office, either during its monthly meeting or as soon as possible in urgent cases.
- Division of Care Management will send a copy to Program Integrity of any fraud and abuse reports received from the MCOs.
- For fraud cases against providers and members either initiated or referred by DHHS, DHHS will inform the MCO and the Division of Care Management when the case results in a criminal conviction, loss of benefits, and/or exclusion from the HCK program.

### **Excluded Providers**

- Division of Program Integrity will send copies of exclusion letters to the Division of Care Management to share with all Plans, and would likewise notify the Division of Care Management if an excluded provider is reinstated by DHHS.
- These letters will include exclusions based on fraud convictions as well as loss of license, patient abuse, and other reasons

## **Information Sharing**

The Secure Portal (extranet) established by Program Integrity should be used for sharing all beneficiary/member and provider information in the context of fraud and abuse reviews and referrals. Each MCO has an assigned contact person and password. The portal address is:

<https://extranet.scdhhs.gov/dhhs/Default.aspx?alias=extranet.scdhhs.gov/dhhs/pi>

## **SECTION 13 INCENTIVE PLANS**

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

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

1. Whether services not furnished by the physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.
2. The type of incentive arrangement; for example, withhold, bonus, capitation.
3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.
4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.
5. The panel size and, if patients are pooled, the approved method used.
6. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent calendar year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example, nursing home and home health agency) services.
7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results (which must be provided in a timely manner to members 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 MCO must disclose this information to the SCDHHS when requested. The MCO must provide the capitation data required no later than three (3) months after the end of the calendar year. The MCO 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 MCO 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 members. 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 MCO 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 members 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 SCHIP enrollees in the MCO'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. MCOs, 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 MCOs 42 CFR 434.70(a)(2002, as amended) sets the conditions for FFP. Federal funds will be available for payments to MCOs only for the periods that the MCOs 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 MCO 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 MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to members enrolled in the MCO.

**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 be 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 MCO 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.

**SECTION 14**  
**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.

**SECTION 15  
REQUIRED FILES, REPORTS AND FORMS**

- This chart is a summary listing of 1) all files to be submitted by MCOs to SCDHHS, 2) all reports to be submitted by MCOs to SCHHHS, 3) all files to be submitted by SCDHHS to MCOs and 4) all applicable SCDHHS forms to be used by MCOs in the conduct of business. A file is defined as a set of related records compiled in a specified format. A report is defined as a written document containing pre-defined data elements or record of information and a form is defined as a document used to collect or report information. The medium of all files and reports shall be electronic and follow the specifications noted in Section 13.43 Software Reporting Requirement of the MCO Contract or MMIS guidelines and requirements(as applicable). Existing MCOs can combine the HCK claims with existing encounter claims submission. When submitted, the SCDHHS MMIS system will obtain the payment category number from the member file in order to correctly distinguish between the two programs.
- **All files/reports with a frequency of “monthly” are due no later than the 15<sup>th</sup> (fifteenth) day after the end of the reporting month.** The exceptions to this requirement are 1) Third Party Liability File, which is due by the 8<sup>th</sup> (eighth) day of the month and 2) encounter files, which can be submitted no later than the 25<sup>th</sup> (twenty-fifth) of the following month. **All files/reports with a quarterly frequency are due no later than the 30<sup>th</sup> (thirtieth) day after the end of the reporting quarter. All annual reports are due no later than the 90<sup>th</sup> (ninetieth) day after the end of the reporting year period.**
- For the purposes of this section all references to Medicaid number are to be construed as Healthy Connections Kids number. This number is a 10-digit number to be used in all fields labeled Medicaid number.
- Healthy Connections Kids Payment Category is 99. Any reference in this document to EPSDT should be construed as Well Care.

|   |  |         |  |
|---|--|---------|--|
| General Instructions                      |  |         |  |
| Data Transmission Requirements            |  | Page 77 |  |
| Security Requirements For Users of SCDHHS |  | Page 78 |  |

|   |                  |                              |                  |
|---|------------------|------------------------------|------------------|
| Computer Systems  |                  |                              |                  |
| Use of Control Files for EDI Transfers                                  |                  | Page 79                      |                  |
| Void Instructions for HIC, HOSP or DRUG Encounters                      |                  | Page 84                      |                  |
| <b>MCO Files to SCDHHS</b>  | <b>Frequency</b> | <b>Format Specifications</b> | <b>Recipient</b> |
| Encounter Data Submission Process                                       | NA               | Page 86                      | NA               |
| Protocol for File Exchange Between SCDHHS and MCOs                      | NA               | Page 87                      | NA               |
| MCO HCFA 1500 Encounter Rec (ambulatory encounters) File                | Monthly*         | Page 90                      | SCDHHS MMIS      |
| MCO Hospital Encounter Rec (hospital encounters) File                   | Monthly*         | Page 108                     | SCDHHS MMIS      |
| MCO Drug Encounter Rec INP – 3 (drug encounters) File                   | Monthly*         | Page 119                     | SCDHHS MMIS      |
| Third Party Liability File  | Monthly          | Page 122                     | SCDHHS MMIS      |
| MCO Provider Identification Record File Layout (Non-Medicaid Providers) | Monthly          | Page 124                     | SCDHHS MMIS      |

| MCO Reports to SCDHHS  | Frequency   | Format Specifications         | Recipient                                    |
|--|---|-------------------------------|--|
| Model Attestation  | To be attached to all reports                           | Page 127                      | Recipient of Report                          |
| Network Providers and Subcontractors Listing Spreadsheet Requirements  | Monthly   | Page 128                      | Department of Managed Care, Quality Programs |
| Grievance Log with Summary Information   | Collected Monthly and Reported Quarterly                | Page 129                      | Department of Managed Care, Quality Programs |
| Appeals Log with Summary Information   | Collected Monthly and Reported Quarterly                | Page 130                      | Department of Managed Care, Quality Programs |
| HCK Monthly Maternity Notification Log   | Monthly   | Page 131                      | Department of Managed Care, Quality Programs |
| Claims Payment Report  | Monthly   | Page 133                      | Department of Managed Care, Quality Programs |
| Quality Assurance (QA)<br>A. QA Plan<br>B. QA Plan of Correction<br>C. Quality Measures<br>D. HEDIS Reporting Measures | As required<br>As required<br><br>Quarterly<br>Annually | See Contract                  | Department of Managed Care, Quality Programs |
| Member Satisfaction Survey   | Annually  | Instrument and Survey Results | Department of Managed Care, Quality Programs |

| SCDHHS FILES TO MCOS  | Frequency                         | Format Specifications | Recipient   |
|---|-----------------------------------|-----------------------|-------------|
| Managed Care MLE Record Description - MCO Member Listing Record           | Monthly                           | Page 137              | MCO         |
| Output Record for Provider Identification File                            | Monthly                           | Page 140              | MCO         |
| Output Encounter Data Layout for Pharmacy Services                        | One business day after processing | Page 141              | MCO         |
| Output Encounter Data Layout for Ambulatory Services                      | One business day after processing | Page 147              | MCO         |
| Output Encounter Data Layout for Hospital Services                        | One business day after processing | Page 154              | MCO         |
| Well Care File for Visits and Immunizations (File report refers to EPSDT) | Monthly                           | Page 161              | MCO         |
| Claims Record Description   | Monthly                           | Page 163              | MCO         |
| MCO/MHN Recipient Review Recertification File                             | Monthly                           | Page 169              | SCDHHS MMIS |
| Other Files to be received (no examples in this Guide):                   | Monthly                           | NA                    | MCO         |

|  |                  |                                  |                  |
|--|------------------|----------------------------------|------------------|
| - Carrier Codes File<br>- Contract Rates File<br>- Fee Schedule File<br>- Recertification File<br>- 820 File |                  |                                  |                  |
| <b>Files Exchanged<br/>between MCOs and<br/>SCDHHS</b>   | <b>Frequency</b> | <b>Format<br/>Specifications</b> | <b>Recipient</b> |
| MCO/MHN/MAXIMUS<br>Sync File Layout  |                  | Page 173                         | MCO/SCDHHS       |
| <b>Form Listing</b>  |                  |                                  |                  |
| - Sample WIC Referral<br>Form  |                  | Page 177                         |                  |
| - Abortion Statement   |                  | Page 178                         |                  |
| - Instructions for<br>Completion of Abortion<br>Statement  |                  | Page 179                         |                  |
| - SC Managed Care<br>General Drug Request<br>Form  |                  | Page 181                         |                  |

\*Encounter files may be submitted more frequently than monthly. See following page for instructions

## **GENERAL INSTRUCTIONS**

## **Data Transmission Requirements**

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 COMPUTER SYSTEMS

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

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

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

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

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

Organization Contact Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HHS Approver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## USE OF CONTROL FILES FOR EDI TRANSFERS

### **Purpose:**

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

### **Definition:**

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

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

Sender: If control file is present, last copy of data file was not used.

Sender: If control file is not present, it is ok to overwrite existing data file.

Receiver: If control file is not present, there is no file to transfer.

Consider: if the Sender is wanting to create a new file he will check to see if a control file exists. If it does, the run is aborted. Reasoning is; the file from the last run was not picked up. This should cause the Sender to call the Receiver and clarify if the last file was picked up.

If YES then the Receiver will delete the control file and the file will be created.

If NO then the Receiver will download the last file, delete the control file and then the Sender will produce the new file.

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

### **Control file details:**

- Each file will contain a minimum of 5 records. Even if a record is not used it will still be present in the control file.
- Each control file is application specific. Use of the comment record can be used to tailor to the specific need.
- Each record has its own purpose.
- Each record is a fixed 80 byte record.
- A hash total is not required. Some files transferred may not have a common offset that will always be numeric. Recommended to always include comment record stating no hash total present. Optionally, the decision may be made to

include additional bytes at the end of the record for the purpose of hash totalling. A suggestion is to use MMSS (minutes and seconds) as the value of the additional bytes.

**Refer to control file description of records below.**

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

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

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

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

EXAMPLE of file contents:

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

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

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

**RECORD ONE 80 bytes:**

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

**RECORD TWO 80 bytes:**

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | Description   |
|--------------|------------------------|-----------------|-------------------|-----------------|---|
| 1            | Description:           | 25              | 1                 | 25              | Contains constant value FILE CREATION DATE&TIME:    |
| 2            | Creation Date And Time | 14              | 26                | 39              | Contains file creation date and time CCYYMMDD HH:MM |
|              | Filler                 | 41              | 40                | 80              |   |

**RECORD THREE 80 bytes:**

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

**RECORD FOUR 80 bytes:**

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

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

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

## VOID INSTRUCTIONS FOR A HIC, HOSP OR DRUG ENCOUNTER

Submit the **EXACT** original encounter AND:

1. Place a 'V' in the ADJUSTMENT-INDICATOR.
2. Place the 16 bytes of the HMO-OWN-REF-NUMBER from the original encounter (the one you wish to void) including any ending spaces followed by an 'E' in the RE-SUBMIT-ENCOUNTER-NUMBER field. The 'E' will always be in the 17 byte of this field.
3. Place a new encounter ID in the HMO-OWN-REF-NUMBER.

Example:

- 1) The **original** encounter had HMO-OWN-REF-NUMBER = '12345612345ac ' and the RE-SUBMIT-ENCOUNTER field = spaces (this would be spaces because it is the original submitted encounter).
- 2) The MCO decides to void the encounter.

The MCO should submit the exact same encounter as the original but **also** place a 'V' in the ADJUSTMENT-INDICATOR field **and** place '12345612345ac E' in the RE-SUBMIT-ENCOUNTER-NUMBER. In this void record, a new HMO-OWN-REF-NUMBER would be assigned (the MCO would assign a new/different encounter ID).

**MCO FILES TO SCDHHS**

## ENCOUNTER DATA SUBMISSION PROCESS

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

Steps in processing Encounter data:

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

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

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

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

## **PROTOCOL FOR FILE EXCHANGE BETWEEN SCDHHS AND MCOs**

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

### **NAMING CONVENTIONS**

These files are proprietary files.

Files follow these naming conventions.

XXXXXX.YYYYYYYY

where XXXXXX is the provider number assigned by DHHS (ex: HM0500)

where YYYYYYYY is a descriptive extension of up to 8 characters (does not have to be 8, but at most, 8 characters). May not always contain this node.

EXAMPLE: HM0500.ENCOUN.TEST

Each node name (between the '.') has a max of eight characters.

### **ACTUAL FILES SENT TO SCDHHS FROM MCO**

XXXXXX.PROV

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

XXXXXX.TPL

This full/completed file of all TPL information for each recipient for that given month is required to be submitted to DHHS by the 8<sup>th</sup> of the month. This file must be submitted even if you have no input. In the case of no input, a blank file must be submitted to SCDHHS.

XXXXXX.ENCOUN

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

### **FILES UPLOADED**

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

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

## **ACTUAL FILES AND FILE NAMES SENT TO MCO FROM SCDHHS**

### **ENXXXXXX**

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

### **XXXXXX.CLAIMS.HISTORY**

Historical Fee for Service (FFS) claims not encounter data. This file contains the prior 12 months of FFS claims data for each member in your cutoff MLE file. History for those assigned to the plan between cutoff and the 1<sup>st</sup> of the month will be included in the following months FFS claims history extract. This file is sent within 3 business days after cutoff.

### **MCXXXXXX**

This is a complete provider file created at MGC cutoff.

### **RSXXXXXX**

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

#### **Example:**

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

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

### **XXXXXX. Well Care**

There are two files created with visit codes. One set for office visits and one set for immunizations. These files are created after the last payment run of the month. There is only 1 file that is sent on the last day of the month.

### **XXXXXX.REVIEW.RECIP**

Monthly file for re-certification is prepared by the 5<sup>th</sup> of each month.

**Monthly files for pricing information and procedure codes. These files are prepared by the 5<sup>th</sup> of each month.**

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

## **NOTIFICATION**

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

## **HIPAA FILE NAMING CONVENTION**

RUNNUMBER.EDI where 'RUNNUMBER' = an eight digit number assigned by the translator when the file is put in the mailbox. This number has no intelligence associated with it.

A submitter ID is required to exchange HIPAA EDI files.

An 834 transaction file is utilized.

An 820 transaction file is used.

Refer to the SCDHHS companion guides at;

<http://www.dhhs.state.sc.us/dhhsnew/hipaa/Companion%20Guides.asp>

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

| Field Number | Field Name                   | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------------|-----------------|-------------------|-----------------|-------|---|
| 1.           | JULIAN-SUBMISSION-DATE       | 7               | 1                 | 7               | N     | This is the last date of the period for which you are reporting<br>Mask: CCYYDDDD   |
| 2.           | CLAIM-TYPE                   | 1               | 8                 | 8               | C     | HCFA-7500-DATA VALUE 'A'  |
| 3.           | FILLER                       | 1               | 9                 | 9               | C     |   |
| 4.           | FILLER                       | 1               | 10                | 10              | C     |   |
| 5.           | HMO-PAYMENT-DENIED-INDICATOR | 1               | 11                | 11              | C     | <b>FOR FUTURE USE</b><br>THIS FIELD IS NOT CURRENTLY BEING USED, PLEASE LEAVE THIS FIELD BLANK.   |
| 6.           | ADJUSTMENT-INDICATOR         | 1               | 12                | 12              | C     | THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED ENCOUNTER.<br>This field should be blank unless the encounter is a void. If it is a void put a 'V' in this field. |
| 7.           | MISC-IND-1                   | 1               | 13                | 13              | C     | Future use  |
| 8.           | CLAIM-PAID-DATE              | 4               | 14                | 17              | C     | Date claim paid<br>Mask: YYMM   |
| 9.           | RECIPIENT-MEDICAID-NUM       | 10              | 18                | 27              | N     | Client Medicaid number  |
| 10.          | INSURED-POLICY-NUMBER        | 15              | 28                | 42              | C     | HMO Client ID number  |
| 11.          | HMO-NUMBER                   | 6               | 43                | 48              | C     | Managed Care plan number  |
| 12.          | TPL-INFO-1                   | 71              |                   |                 |       | THIRD PARTY INSURANCE INFORMATION   |
| 13.          | CARRIER-CODE-1               | 5               | 49                | 53              | C     |   |
| 14.          | CARRIER-POLICY-<br>NUM-1     | 25              | 54                | 78              | C     |   |
| 15.          | INSURED-NAME-1.              | 32              |                   |                 | C     |   |
| 16.          | INSURED-                     | 17              | 79                | 95              | C     |   |

| Field Number | Field Name               | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                   |
|--------------|--------------------------|-----------------|-------------------|-----------------|-------|------------------------------------|
|              | LAST-NAME-1              |                 |                   |                 |       |                                    |
| 17.          | INSURED-FIRST-NAME-1     | 14              | 96                | 109             | C     |                                    |
| 18.          | INSURED-MIDDLE-INIT-1    | 1               | 110               | 110             | C     |                                    |
| 19.          | TPL-AMOUNT-PAID-1        | 9               | 111               | 119             | N     | 999999999 Assumed 2 decimal places |
| 20.          | TPL-INFO-2               | 71              |                   |                 |       | THIRD PARTY INSURANCE INFORMATION  |
| 21.          | CARRIER-CODE-2           | 5               | 120               | 124             | C     |                                    |
| 22.          | CARRIER-POLICY-<br>NUM-2 | 25              | 125               | 149             | C     |                                    |
| 23.          | INSURED-NAME-2           | 32              |                   |                 | C     |                                    |
| 24.          | INSURED-<br>LAST-NAME-2  | 17              | 150               | 166             | C     |                                    |
| 25.          | INSURED-FIRST-NAME-2     | 14              | 197               | 180             | C     |                                    |
| 26.          | INSURED-MIDDLE-INIT-2    | 1               | 181               | 181             | C     |                                    |
| 27.          | TPL-AMOUNT-PAID-2        | 9               | 182               | 190             | N     | Mask: 9999999V99                   |
| 28.          | TPL-INFO-3               | 71              |                   |                 |       | THIRD PARTY INSURANCE INFORMATION  |
| 29.          | CARRIER-CODE-3           | 5               | 191               | 195             | C     |                                    |
| 30.          | CARRIER-POLICY-<br>NUM-3 | 25              | 196               | 220             | C     |                                    |
| 31.          | INSURED-NAME-3           | 32              |                   |                 | C     |                                    |
| 32.          | INSURED-<br>LAST-NAME-3  | 17              | 221               | 237             | C     |                                    |
| 33.          | INSURED-FIRST-NAME-3     | 14              | 238               | 251             | C     |                                    |
| 34.          | INSURED-MIDDLE-INIT-3    | 1               | 252               | 252             | C     |                                    |
| 35.          | TPL-AMOUNT-PAID-3        | 9               | 253               | 261             | N     | Mask: 99999999V99                  |

| Field Number | Field Name            | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask   |
|--------------|-----------------------|-----------------|-------------------|-----------------|-------|--|
| 36.          | REFERRING-PROVIDER    | 6               | 262               | 267             | C     | Provider who referred patient for service  |
| 37.          | PRINCIPAL-DIAGNOSIS   | 6               | 268               | 273             | C     | Diagnosis code for principal condition   |
| 38.          | OTHER-DIAGNOSIS-1     | 6               | 274               | 279             | C     | Diagnosis other than principal   |
| 39.          | OTHER-DIAGNOSIS-2     | 6               | 280               | 285             | C     | Diagnosis other than principal   |
| 40.          | OTHER-DIAGNOSIS-3     | 6               | 286               | 291             | C     | Diagnosis other than principal   |
| 41.          | LINE-ENCOUNTER-DATA-1 |                 | 292               | 348             |       | Data line for up to eight procedures   |
| 42.          | PROCEDURE-CODE-1      | 5               | 292               | 296             | C     |  |
|              | MODIFIER-1            | 3               | 297               | 299             | C     | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero). |
| 43.          |                       |                 |                   |                 |       |  |
| 44.          | UNITS-MILES-1         | 3               | 300               | 302             | N     |  |
| 45.          | FIRST-DATE-OF-SERV-1  |                 | 303               | 310             |       |  |
| 46.          | FIRST-DATE-CENTURY-1  | 2               | 303               | 304             | N     |  |
| 47.          | FIRST-DATE-YEAR-1     | 2               | 305               | 306             | N     |  |
| 48.          | FIRST-DATE-MONTH-1    | 2               | 307               | 308             | N     |  |
| 49.          | FIRST-DATE-DAY-1      | 2               | 309               | 310             | N     |  |
| 50.          | LAST-DATE-OF-SERV-1   |                 | 311               | 318             |       |  |
| 51.          | LAST-DATE-CENTURY-1   | 2               | 311               | 312             | N     |  |
| 52.          | LAST-DATE-YEAR-1      | 2               | 313               | 314             | N     |  |
| 53.          | LAST-DATE-MONTH-1     | 2               | 315               | 316             | N     |  |
| 54.          | LAST-DATE-DAY-1       | 2               | 317               | 318             | N     |  |

| Field Number | Field Name                     | Number of Bytes | Starting Location | Ending Location | N / C  | Description/Mask  |
|--------------|--------------------------------|-----------------|-------------------|-----------------|--------|---|
| 55.          | PLACE-OF-SERVICE-1             | 2               | 319               | 320             | C      | See PLACE OF SERVICE table for values   |
| 56.          | SERV-PROVIDER-NUM-1            | 6               | 321               | 326             | C      | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid  |
| 57.          | PAID-TO-PROVIDER-NUM-1         | 6               | 327               | 332             | C      | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 58.          | EPSDT-INDICATOR-1              | 1               | 333               | 333             | C      | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
| 59.          | REIMBURSE-IND-1                | 1               | 334               | 334             | C      | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge   |
| 60.          | AMOUNT-BILLED-1                | 7               | 335               | 341             | N      | Amount billed by provider of service<br>Mask: 99999V99  |
| 61.          | AMOUNT-PAID-1                  | 7               | 342               | 348             | N      | Amount paid by HMO plan for service<br>Mask: 99999V99   |
| 62.          | LINE-ENCOUNTER-DATA-2          |                 | 349               | 405             |        |   |
| 63.          | PROCEDURE-CODE-2<br>MODIFIER-2 | 5<br>3          | 349<br>354        | 353<br>356      | C<br>C | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero).  |
| 64.          | UNITS-MILES-2                  | 3               | 357               | 359             | N      |   |
| 66.          | FIRST-DATE-OF-SERV-2           |                 | 360               | 367             |        |   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-------|---|
| 67.          | FIRST-DATE-CENTURY-2   | 2               | 360               | 361             | N     |   |
| 68.          | FIRST-DATE-YEAR-2      | 2               | 362               | 363             | N     |   |
| 69.          | FIRST-DATE-MONTH-2     | 2               | 364               | 365             | N     |   |
| 70.          | FIRST-DATE-DAY-2       | 2               | 366               | 367             | N     |   |
| 71.          | LAST-DATE-OF-SERV-2    |                 | 368               | 375             |       |   |
| 72.          | LAST-DATE-CENTURY-2    | 2               | 368               | 369             | N     |   |
| 73.          | LAST-DATE-YEAR-2       | 2               | 370               | 371             | N     |   |
| 74.          | LAST-DATE-MONTH-2      | 2               | 372               | 373             | N     |   |
| 75.          | LAST-DATE-DAY-2        | 2               | 374               | 375             | N     |   |
| 76.          | PLACE-OF-SERVICE-2     | 2               | 376               | 377             | C     | See PLACE OF SERVICE table for values   |
| 77.          | SERV-PROVIDER-NUM-2    | 6               | 378               | 383             | C     | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid  |
| 78.          | PAID-TO-PROVIDER-NUM-2 | 6               | 384               | 389             | C     | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 79.          | EPSDT-INDICATOR-2      | 1               | 390               | 390             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |

| Field Number | Field Name           | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|----------------------|-----------------|-------------------|-----------------|-------|---|
|              | REIMBURSE-IND-2      | 1               | 391               | 391             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge |
| 80.          | AMOUNT-BILLED-2      | 7               | 392               | 398             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 81.          | AMOUNT-PAID-2        | 7               | 399               | 405             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |
| 82.          | LINE-COUNTER-DATA-3  |                 | 406               | 462             |       |   |
| 83.          | PROCEDURE-CODE-3     | 5               | 406               | 410             | C     |   |
| 84.          | MODIFIER-3           | 3               | 411               | 413             | C     | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero).                              |
| 85.          |                      |                 |                   |                 |       |   |
| 86.          | UNITS-MILES-3        | 3               | 414               | 416             | N     |   |
| 87.          | FIRST-DATE-OF-SERV-3 |                 | 417               | 424             |       |   |
| 88.          | FIRST-DATE-CENTURY-3 | 2               | 417               | 418             | N     |   |
| 89.          | FIRST-DATE-YEAR-3    | 2               | 419               | 420             | N     |   |
| 90.          | FIRST-DATE-MONTH-3   | 2               | 421               | 422             | N     |   |
| 91.          | FIRST-DATE-DAY-3     | 2               | 423               | 424             | N     |   |
| 92.          | LAST-DATE-OF-SERV-3  |                 | 425               | 432             |       |   |
| 93.          | LAST-DATE-CENTURY-3  | 2               | 425               | 426             | N     |   |
| 94.          | LAST-DATE-YEAR-3     | 2               | 427               | 428             | N     |   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-------|---|
| 95.          | LAST-DATE-MONTH-3      | 2               | 429               | 439             | N     |   |
| 96.          | LAST-DATE-DAY-3        | 2               | 431               | 432             | N     |   |
| 97.          | PLACE-OF-SERVICE-3     | 2               | 433               | 434             | C     | See PLACE OF SERVICE table for values   |
| 98.          | SERV-PROVIDER-NUM-3    | 6               | 435               | 440             | C     | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid  |
| 99.          | PAID-TO-PROVIDER-NUM-3 | 6               | 441               | 446             | C     | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 100.         | EPSDT-INDICATOR-3      | 1               | 447               | 447             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
| 101.         | REIMBURSE-IND-3        | 1               | 448               | 448             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge   |
| 102.         | AMOUNT-BILLED-3        | 7               | 449               | 455             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 103.         | AMOUNT-PAID-3          | 7               | 456               | 462             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |
| 104.         | LINE-ENCOUNTER-DATA-4  |                 | 463               | 467             |       |   |
| 105.         | PROCEDURE-CODE-4       | 5               | 463               | 467             | C     |   |
| 106.         | MODIFIER-4             | 3               | 468               | 470             | C     | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-------|---|
|              |                        |                 |                   |                 |       | put in this field (make sure to include the leading zero).  |
| 107.         | UNITS-MILES-4          | 3               | 471               | 473             | N     |   |
| 108.         | FIRST-DATE-OF-SERV-4   |                 | 474               | 481             |       |   |
| 109.         | FIRST-DATE-CENTURY-4   | 2               | 474               | 475             | N     |   |
| 110.         | FIRST-DATE-YEAR-4      | 2               | 476               | 477             | N     |   |
| 111.         | FIRST-DATE-MONTH-4     | 2               | 478               | 479             | N     |   |
| 112.         | FIRST-DATE-DAY-4       | 2               | 480               | 481             | N     |   |
| 113.         | LAST-DATE-OF-SERV-4    |                 | 482               | 489             |       |   |
| 114.         | LAST-DATE-CENTURY-4    | 2               | 482               | 483             | N     |   |
| 115.         | LAST-DATE-YEAR-4       | 2               | 484               | 485             | N     |   |
| 116.         | LAST-DATE-MONTH-4      | 2               | 486               | 487             | N     |   |
| 117.         | LAST-DATE-DAY-4        | 2               | 488               | 489             | N     |   |
| 118.         | PLACE-OF-SERVICE-4     | 2               | 490               | 491             | C     | See PLACE OF SERVICE table for values   |
|              | SERV-PROVIDER-NUM-4    | 6               | 492               | 497             | C     | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid  |
| 119.         |                        |                 |                   |                 |       |   |
|              | PAID-TO-PROVIDER-NUM-4 | 6               | 498               | 503             | C     | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number |
| 120.         |                        |                 |                   |                 |       |   |

| Field Number | Field Name            | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|-----------------------|-----------------|-------------------|-----------------|-------|---|
|              |                       |                 |                   |                 |       | assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made.   |
| 121.         | EPSDT-INDICATOR-4     | 1               | 504               | 504             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
| 122.         | REIMBURSE-IND-4       | 1               | 505               | 505             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge |
| 123.         | AMOUNT-BILLED-4       | 7               | 506               | 512             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 124.         | AMOUNT-PAID-4         | 7               | 513               | 519             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |
| 125.         | LINE-ENCOUNTER-DATA-5 |                 | 520               | 576             |       |   |
| 126.         | PROCEDURE-CODE-5      | 5               | 520               | 524             | C     |   |
| 127.         | MODIFIER-5            | 3               | 525               | 527             | C     | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero).                              |
| 128.         | UNITS-MILES-5         | 3               | 528               | 530             | N     |   |
| 129.         | FIRST-DATE-OF-SERV-5  |                 | 531               | 538             |       |   |
| 130.         | FIRST-DATE-CENTURY-5  | 2               | 531               | 532             | N     |   |
| 131.         | FIRST-DATE-YEAR-5     | 2               | 533               | 534             | N     |   |
| 132.         | FIRST-DATE-MONTH-5    | 2               | 535               | 536             | N     |   |
| 133.         | FIRST-DATE-DAY-5      | 2               | 537               | 538             | N     |   |
| 134.         | LAST-DATE-OF-SERV-5   |                 | 539               | 546             |       |   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-------|---|
| 135.         | LAST-DATE-CENTURY-5    | 2               | 539               | 540             | N     |   |
| 136.         | LAST-DATE-YEAR-5       | 2               | 541               | 542             | N     |   |
| 137.         | LAST-DATE-MONTH-5      | 2               | 543               | 544             | N     |   |
| 138.         | LAST-DATE-DAY-5        | 2               | 545               | 546             | N     |   |
| 139.         | PLACE-OF-SERVICE-5     | 2               | 547               | 548             | C     | See PLACE OF SERVICE table for values   |
|              | SERV-PROVIDER-NUM-5    | 6               | 549               | 554             | C     | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid  |
| 140.         |                        |                 |                   |                 |       |   |
|              | PAID-TO-PROVIDER-NUM-5 | 6               | 555               | 560             | C     | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 141.         |                        |                 |                   |                 |       |   |
| 142.         | EPSDT-INDICATOR-5      | 1               | 561               | 561             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
|              | REIMBURSE-IND-5        | 1               | 562               | 562             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge   |
| 143.         |                        |                 |                   |                 |       |   |
| 144.         | AMOUNT-BILLED-5        | 7               | 563               | 569             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 145.         | AMOUNT-PAID-5          | 7               | 570               | 576             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |

| Field Number | Field Name                                | Number of Bytes | Starting Location | Ending Location | N / C  | Description/Mask  |
|--------------|---|-----------------|-------------------|-----------------|--------|---|
| 146.         | LINE-ENCOUNTER-DATA-6                     |                 | 577               | 563             |        |   |
| 147.         | PROCEDURE-CODE-6<br>MODIFIER-6            | 5<br>3          | 577<br>582        | 581<br>584      | C<br>C | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero).                        |
| 148.         |   |                 |                   |                 |        |   |
| 149.         | UNITS-MILES-6                             | 3               | 585               | 587             | N      |   |
| 150.         | FIRST-DATE-OF-SERV-6                      |                 | 588               | 595             |        |   |
| 151.         | FIRST-DATE-CENTURY-6                      | 2               | 588               | 589             | N      |   |
| 152.         | FIRST-DATE-YEAR-6                         | 2               | 590               | 591             | N      |   |
| 153.         | FIRST-DATE-MONTH-6                        | 2               | 592               | 593             | N      |   |
| 154.         | FIRST-DATE-DAY-6                          | 2               | 594               | 595             | N      |   |
| 155.         | LAST-DATE-OF-SERV-6                       |                 | 596               | 603             |        |   |
| 156.         | LAST-DATE-CENTURY-6                       | 2               | 596               | 597             | N      |   |
| 157.         | LAST-DATE-YEAR-6                          | 2               | 598               | 599             | N      |   |
| 158.         | LAST-DATE-MONTH-6                         | 2               | 600               | 601             | N      |   |
| 159.         | LAST-DATE-DAY-6                           | 2               | 602               | 603             | N      |   |
| 160.         | PLACE-OF-SERVICE-6<br>SERV-PROVIDER-NUM-6 | 2<br>6          | 604<br>606        | 605<br>611      | C<br>C | See PLACE OF SERVICE table for values<br>Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid |
| 161.         |   |                 |                   |                 |        |   |
| 162.         | PAID-TO-PROVIDER-NUM-6                    | 6               | 612               | 617             | C      | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number |

| Field Number | Field Name            | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|-----------------------|-----------------|-------------------|-----------------|-------|---|
| 163.         | EPSDT-INDICATOR-6     | 1               | 618               | 618             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
| 164.         | REIMBURSE-IND-6       | 1               | 619               | 619             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge |
| 165.         | AMOUNT-BILLED-6       | 7               | 620               | 626             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 166.         | AMOUNT-PAID-6         | 7               | 627               | 633             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |
| 167.         | LINE-ENCOUNTER-DATA-7 |                 | 634               | 690             |       |   |
| 168.         | PROCEDURE-CODE-7      | 5               | 634               | 638             | C     |   |
| 169.         | MODIFIER-7            | 3               | 639               | 641             | C     | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero).                              |
| 170.         | UNITS-MILES-7         | 3               | 642               | 644             | N     |   |
| 171.         | FIRST-DATE-OF-SERV-7  |                 | 645               | 652             |       |   |
| 172.         | FIRST-DATE-CENTURY-7  | 2               | 645               | 646             | N     |   |
| 173.         | FIRST-DATE-YEAR-7     | 2               | 647               | 648             | N     |   |
| 174.         | FIRST-DATE-MONTH-7    | 2               | 649               | 650             | N     |   |
| 175.         | FIRST-DATE-DAY-7      | 2               | 651               | 652             | N     |   |
| 176.         | LAST-DATE-OF-SERV-7   |                 | 653               | 660             |       |   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-------|---|
| 177.         | LAST-DATE-CENTURY-7    | 2               | 653               | 654             | N     |   |
| 178.         | LAST-DATE-YEAR-7       | 2               | 655               | 656             | N     |   |
| 179.         | LAST-DATE-MONTH-7      | 2               | 657               | 658             | N     |   |
| 180.         | LAST-DATE-DAY-7        | 2               | 659               | 660             | N     |   |
| 181.         | PLACE-OF-SERVICE-7     | 2               | 661               | 662             | C     | See PLACE OF SERVICE table for values   |
|              | SERV-PROVIDER-NUM-7    | 6               | 663               | 668             | C     | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid  |
| 182.         |                        |                 |                   |                 |       |   |
|              | PAID-TO-PROVIDER-NUM-7 | 6               | 669               | 674             | C     | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 183.         |                        |                 |                   |                 |       |   |
| 184.         | EPSDT-INDICATOR-7      | 1               | 675               | 675             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
|              | REIMBURSE-IND-7        | 1               | 676               | 676             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge   |
| 185.         |                        |                 |                   |                 |       |   |
| 186.         | AMOUNT-BILLED-7        | 7               | 677               | 683             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 187.         | AMOUNT-PAID-7          | 7               | 684               | 690             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |

| Field Number | Field Name            | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask   |
|--------------|-----------------------|-----------------|-------------------|-----------------|-------|--|
| 188.         | LINE-ENCOUNTER-DATA-8 |                 | 691               | 747             |       |  |
| 189.         | PROCEDURE-CODE-8      | 5               | 691               | 695             | C     |  |
| 190.         | MODIFIER-8            | 3               | 696               | 698             | C     | If a procedure code modifier is used, a value from the Proc Code Modifier table (table 7) needs to be put in this field (make sure to include the leading zero). |
| 191.         | UNITS-MILES-8         | 3               | 699               | 701             | N     |  |
| 192.         | FIRST-DATE-OF-SERV-8  |                 | 702               | 709             |       |  |
| 193.         | FIRST-DATE-CENTURY-8  | 2               | 702               | 703             | N     |  |
| 194.         | FIRST-DATE-YEAR-8     | 2               | 704               | 705             | N     |  |
| 195.         | FIRST-DATE-MONTH-8    | 2               | 706               | 707             | N     |  |
| 196.         | FIRST-DATE-DAY-8      | 2               | 708               | 709             | N     |  |
| 197.         | LAST-DATE-OF-SERV-8   |                 | 710               | 717             |       |  |
| 198.         | LAST-DATE-CENTURY-8   | 2               | 710               | 711             | N     |  |
| 199.         | LAST-DATE-YEAR-8      | 2               | 712               | 713             | N     |  |
| 200.         | LAST-DATE-MONTH-8     | 2               | 714               | 715             | N     |  |
| 201.         | LAST-DATE-DAY-8       | 2               | 716               | 717             | N     |  |
| 202.         | PLACE-OF-SERVICE-8    | 2               | 718               | 719             | C     | See PLACE OF SERVICE table for values  |
| 203.         | SERV-PROVIDER-NUM-8   | 6               | 720               | 725             | C     | Number assigned to provider of service<br>Medicaid number if enrolled in Medicaid<br>Unique number assigned by HMO if not enrolled in Medicaid                   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-------|---|
| 204.         | PAID-TO-PROVIDER-NUM-8 | 6               | 726               | 731             | C     | If this is a FQHC or RHC encounter, you must put the provider number of the FQHC or RHC in this field. Otherwise put the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 205.         | EPSDT-INDICATOR-8      | 1               | 732               | 732             | C     | Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'  |
| 206.         | REIMBURSE-IND-8        | 1               | 733               | 733             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge   |
| 207.         | AMOUNT-BILLED-8        | 7               | 734               | 740             | N     | Amount billed by provider of service<br>Mask: 99999V99  |
| 208.         | AMOUNT-PAID-8          | 7               | 741               | 747             | N     | Amount paid by HMO plan for service<br>Mask: 99999V99   |
| 209.         | FILLER                 | 10              | 748               | 757             | C     |   |
| 210.         | LINE-NPI-GROUP-1       |                 |                   |                 |       |   |
| 211.         | RENDERING-NPI-1        | 10              | 758               | 767             | C     |   |
| 212.         | PAID-TO-NPI-1          | 10              | 768               | 777             | C     |   |
| 213.         | LINE-NPI-GROUP-2       |                 |                   |                 |       |   |
| 214.         | RENDERING-NPI-2        | 10              | 778               | 787             | C     |   |
| 215.         | PAID-TO-NPI-2          | 10              | 788               | 797             | C     |   |
| 216.         | LINE-NPI-GROUP-3       |                 |                   |                 |       |   |
| 217.         | RENDERING-NPI-3        | 10              | 798               | 807             | C     |   |
| 218.         | PAID-TO-NPI-3          | 10              | 808               | 817             | C     |   |
| 219.         | LINE-NPI-GROUP-4       |                 |                   |                 |       |   |
| 220.         | RENDERING-NPI-4        | 10              | 818               | 827             | C     |   |
| 221.         | PAID-TO-NPI-4          | 10              | 828               | 837             | C     |   |

| Field Number | Field Name                | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|---------------------------|-----------------|-------------------|-----------------|-------|---|
| 222.         | LINE-NPI-GROUP-5          |                 |                   |                 |       |   |
| 223.         | RENDERING-NPI-5           | 10              | 838               | 847             | C     |   |
| 224.         | PAID-TO-NPI-5             | 10              | 848               | 857             | C     |   |
| 225.         | LINE-NPI-GROUP-6          |                 |                   |                 |       |   |
| 226.         | RENDERING-NPI-6           | 10              | 858               | 867             | C     |   |
| 227.         | PAID-TO-NPI-6             | 10              | 868               | 877             | C     |   |
| 228.         | LINE-NPI-GROUP-7          |                 |                   |                 |       |   |
| 229.         | RENDERING-NPI-7           | 10              | 878               | 887             | C     |   |
| 230.         | PAID-TO-NPI-7             | 10              | 888               | 897             | C     |   |
| 231.         | LINE-NPI-GROUP-8          |                 |                   |                 |       |   |
| 232.         | RENDERING-NPI-8           | 10              | 898               | 907             | C     |   |
| 233.         | PAID-TO-NPI-8             | 10              | 908               | 917             | C     |   |
| 234.         | REFERRING-NPI             | 10              | 918               | 927             | C     | Claim Level Referring Provider NPI  |
| 235.         | LINE-PROC-CODE-EDIT-IND-1 | 1               | 928               | 928             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y' |
| 236.         | LINE-PROC-CODE-EDIT-IND-2 | 1               | 929               | 929             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y' |
| 237.         | LINE-PROC-CODE-EDIT-IND-3 | 1               | 930               | 930             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y' |
| 238.         | LINE-PROC-CODE-EDIT-IND-4 | 1               | 931               | 931             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y' |
| 239.         | LINE-PROC-CODE-EDIT-      | 1               | 932               | 932             | C     | Indicates the procedure code is not recognized by   |

| Field Number | Field Name                 | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|----------------------------|-----------------|-------------------|-----------------|-------|---|
|              | IND-5                      |                 |                   |                 |       | SCDHHS but the MCO covered the service/procedure. Value 'Y'   |
| 240.         | LINE-PROC-CODE-EDIT-IND-6  | 1               | 933               | 933             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y'   |
| 241.         | LINE-PROC-CODE-EDIT-IND-7  | 1               | 934               | 934             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y'   |
| 242.         | LINE-PROC-CODE-EDIT-IND-8  | 1               | 935               | 935             | C     | Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y'   |
| 243.         | FILLER                     | 332             | 936               | 1267            |       |   |
| 244.         | HMO-OWN-REF-NUMBER         | 16              | 1268              | 1283            | C     | HMO own reference number  |
| 245.         | RE-SUBMIT-ENCOUNTER-NUMBER | 17              | 1284              | 1300            | C     | THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED ENCOUNTER. It is the system assigned number for the encounter (Made up of the provider's own reference number (of the original encounter) followed by an 'E'. The 'E' should be in byte 1300. |

**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

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AMBULATORY ENCOUNTER DATA RECORD LAYOUT FOR: \*

- PHYSICIANS \*

- OTHER PRACTITIONERS \*

NURSE PRACTITIONER, CERTIFIED NURSE MIDWIFE, \*  
CERTIFIED REGISTERED NURSE ANESTHETIST, PODIATRIST, \*  
AND PHYSICIAN ASSISTANT \*

- CLINICS \*

FQHC, RHC, ASC ESRD, MENTAL HEALTH, INFUSION CENTERS, \*  
AND ALCOHOL AND SUBSTANCE ABUSE \*

- OTHER CAPITATED SERVICES \*

INDEPENDENT LAB, RADIOLOGY, DME, HOME HEALTH, AMBULANCE \*

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

| Field Number | Field Name                   | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------------|-----------------|-------------------|-----------------|-------|---|
| 1.           | JULIAN-SUBMISSION-DATE       | 7               | 1                 | 7               | N     | This is the last date of the period for which you are reporting.<br>Mask: CCYYDDDD  |
| 2.           | CLAIM-TYPE                   | 1               | 8                 | 8               | C     | HCFA-7500-DATA VALUE 'Z'  |
| 3.           | FILLER                       | 1               | 9                 | 9               | C     |   |
| 4.           | FILLER                       | 1               | 10                | 10              | C     |   |
| 5.           | HMO-PAYMENT-DENIED-INDICATOR | 1               | 11                | 11              | C     | <b>FOR FUTURE USE</b><br>THIS FIELD IS NOT CURRENTLY BEING USED, PLEASE LEAVE THIS FIELD BLANK.   |
| 6.           | ADJUSTMENT-INDICATOR         | 1               | 12                | 12              | C     | THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED ENCOUNTER.<br>This field should be blank unless the encounter is a void. If it is a void put a 'V' in this field. |
| 7.           | MISC-IND-1                   | 1               | 13                | 13              | C     | Future use  |
| 8.           | CLAIM-PAID-DATE              | 4               | 14                | 17              | C     | Date claim paid<br>Mask: YYMM   |
| 9.           | RECIPIENT-MEDICAID-NUM       | 10              | 18                | 27              | N     | Client Medicaid number  |
| 10.          | INSURED-POLICY-NUMBER        | 15              | 28                | 42              | C     | HMO Client ID number  |
| 11.          | HMO-NUMBER                   | 6               | 43                | 48              | C     | Managed Care plan number  |
| 12.          | TPL-INFO-1                   | 71              |                   |                 |       | THIRD PARTY INSURANCE INFORMATION   |
| 13.          | CARRIER-CODE-1               | 5               | 49                | 53              | C     |   |
| 14.          | CARRIER-POLICY-NUM-1         | 25              | 54                | 78              | C     |   |
| 15.          | INSURED-NAME-1.              | 32              |                   |                 | C     |   |

| Field Number | Field Name               | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                  |
|--------------|--------------------------|-----------------|-------------------|-----------------|-------|-----------------------------------|
| 16.          | INSURED-LAST-NAME-1      | 17              | 79                | 95              | C     |                                   |
| 17.          | INSURED-FIRST-NAME-1     | 14              | 96                | 109             | C     |                                   |
| 18.          | INSURED-MIDDLE-INIT-1    | 1               | 110               | 110             | C     |                                   |
| 19.          | TPL-AMOUNT-PAID-1        | 9               | 111               | 119             | N     | 99999999 Assumed 2 decimal places |
| 20.          | TPL-INFO-2               | 71              |                   |                 |       | THIRD PARTY INSURANCE INFORMATION |
| 21.          | CARRIER-CODE-2           | 5               | 120               | 124             | C     |                                   |
| 22.          | CARRIER-POLICY-<br>NUM-2 | 25              | 125               | 149             | C     |                                   |
| 23.          | INSURED-NAME-2           | 32              |                   |                 | C     |                                   |
| 24.          | INSURED-LAST-NAME-2      | 17              | 150               | 166             | C     |                                   |
| 25.          | INSURED-FIRST-NAME-2     | 14              | 197               | 180             | C     |                                   |
| 26.          | INSURED-MIDDLE-INIT-2    | 1               | 181               | 181             | C     |                                   |
| 27.          | TPL-AMOUNT-PAID-2        | 9               | 182               | 190             | N     | Mask: 99999999V99                 |
| 28.          | TPL-INFO-3               | 71              |                   |                 |       | THIRD PARTY INSURANCE INFORMATION |
| 29.          | CARRIER-CODE-3           | 5               | 191               | 195             | C     |                                   |
| 30.          | CARRIER-POLICY-<br>NUM-3 | 25              | 196               | 220             | C     |                                   |
| 31.          | INSURED-NAME-3           | 32              |                   |                 | C     |                                   |
| 32.          | INSURED-LAST-NAME-3      | 17              | 221               | 237             | C     |                                   |
| 33.          | INSURED-FIRST-NAME-3     | 14              | 238               | 251             | C     |                                   |
| 34.          | INSURED-MIDDLE-INIT-3    | 1               | 252               | 252             | C     |                                   |

| Field Number | Field Name           | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|----------------------|-----------------|-------------------|-----------------|-------|---|
| 35.          | TPL-AMOUNT-PAID-3    | 9               | 253               | 261             | N     | Mask: 9999999V99  |
| 36.          | ATTENDING-PHYSICIAN  | 6               | 262               | 267             | C     | Attending physician   |
| 37.          | PAID-TO-PROVIDER-NUM | 6               | 268               | 273             | C     | This is to whom the payment was made. This is usually the SERVICE PROVIDER NUMBER (Hospital's Medicaid ID).   |
| 38.          | AMOUNT-BILLED        | 9               | 274               | 282             | N     | Amount billed by the service provider   |
| 39.          | AMOUNT-PAID BY HMO   | 9               | 283               | 291             | N     | Amount paid by HMO plan for service   |
| 40.          | REIMBURSE-IND        | 1               | 292               | 292             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge |
| 41.          | FIRST-DATE-OF-SERV-1 | 8               | 293               | 300             |       |   |
| 42.          | FIRST-DATE-CENTURY-1 | 2               | 293               | 294             | N     |   |
| 43.          | FIRST-DATE-YEAR-1    | 2               | 295               | 296             | N     |   |
| 44.          | FIRST-DATE-MONTH-1   | 2               | 297               | 298             | N     |   |
| 45.          | FIRST-DATE-DAY-1     | 2               | 299               | 300             | N     |   |
| 46.          | LAST-DATE-OF-SERV-1  |                 | 301               | 308             |       |   |
| 47.          | LAST-DATE-CENTURY-1  | 2               | 301               | 302             | N     |   |
| 48.          | LAST-DATE-YEAR-1     | 2               | 303               | 304             | N     |   |
| 49.          | LAST-DATE-MONTH-1    | 2               | 305               | 306             | N     |   |
| 50.          | LAST-DATE-DAY-1      | 2               | 307               | 308             | N     |   |
| 51.          | ADMISSION-DATE       | 8               | 309               | 316             |       | Admission date  |

| Field Number | Field Name           | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                     |
|--------------|----------------------|-----------------|-------------------|-----------------|-------|--------------------------------------|
| 52.          | ADMIT-DATE-CENTURY-1 | 2               | 309               | 310             | N     |                                      |
| 53.          | ADMIT-DATE-YEAR-1    | 2               | 311               | 312             | N     |                                      |
| 54.          | ADMIT-DATE-MONTH-1   | 2               | 313               | 314             | N     |                                      |
| 55.          | ADMIT-DATE-DAY-1     | 2               | 315               | 316             | N     |                                      |
| 56.          | DISCHARGE-DATE       | 8               | 317               | 324             |       | Discharge date                       |
| 57.          | DISCH-DATE-CENTURY-1 | 2               | 317               | 318             | N     |                                      |
| 58.          | DISCH-DATE-YEAR-1    | 2               | 319               | 320             | N     |                                      |
| 59.          | DISCH-DATE-MONTH-1   | 2               | 321               | 322             | N     |                                      |
| 60.          | DISCH-DATE-DAY-1     | 2               | 323               | 324             | N     |                                      |
| 61.          | PATIENT-STATUS       | 2               | 325               | 326             | C     | See PATIENT STATUS table for values  |
| 62.          | ADMISSION-DIAGNOSIS  | 6               | 327               | 332             | C     |                                      |
| 63.          | PRINCIPAL-DIAGNOSIS  | 6               | 333               | 338             | C     | ICD-9 code for principal condition   |
| 64.          | OTHER-DIAGNOSIS-1    | 6               | 339               | 344             | C     | ICD-9 diagnoses other than principal |
| 65.          | OTHER-DIAGNOSIS-2    | 6               | 345               | 350             | C     | ICD-9 diagnoses other than principal |
| 66.          | OTHER-DIAGNOSIS-3    | 6               | 351               | 356             | C     | ICD-9 diagnoses other than principal |
| 67.          | OTHER-DIAGNOSIS-4    | 6               | 357               | 362             | C     | ICD-9 diagnoses other than principal |
| 68.          | OTHER-DIAGNOSIS-5    | 6               | 363               | 368             | C     | ICD-9 diagnoses other than principal |
| 69.          | OTHER-DIAGNOSIS-6    | 6               | 369               | 374             | C     | ICD-9 diagnoses other than principal |
| 70.          | OTHER-DIAGNOSIS-7    | 6               | 375               | 380             | C     | ICD-9 diagnoses other than principal |
| 71.          | OTHER-DIAGNOSIS-8    | 6               | 381               | 386             | C     | ICD-9 diagnoses other than principal |
| 72.          | PRINCIPAL-SURGERY    | 14              | 387               | 400             |       |                                      |
| 73.          | PRIM-SURG-PROC       | 6               | 387               | 392             | C     | ICD-9 Performed                      |

| Field Number | Field Name        | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                      |
|--------------|-------------------|-----------------|-------------------|-----------------|-------|---------------------------------------|
| 74.          | PRIM-SURG-DATE    | 8               | 393               | 400             | N     | CCYYMMDD                              |
| 75.          | OTHER-SURGERY-1   | 14              | 401               | 414             |       |                                       |
| 76.          | OTHER-SURG-PROC-1 | 6               | 401               | 406             | C     | ICD-9 Performed                       |
| 77.          | OTHER-SURG-DATE-1 | 8               | 407               | 414             | N     | CCYYMMDD                              |
| 78.          | OTHER-SURGERY-2   | 14              | 415               | 428             |       |                                       |
| 79.          | OTHER-SURG-PROC-2 | 6               | 415               | 420             | C     | ICD-9 Performed                       |
| 80.          | OTHER-SURG-DATE-2 | 8               | 421               | 428             | N     | CCYYMMDD                              |
| 81.          | OTHER-SURGERY-3   | 14              | 429               | 442             |       |                                       |
| 82.          | OTHER-SURG-PROC-3 | 6               | 429               | 434             | C     | ICD-9 Performed                       |
| 83.          | OTHER-SURG-DATE-3 | 8               | 435               | 442             | N     | CCYYMMDD                              |
| 84.          | OTHER-SURGERY-4   | 14              | 443               | 456             |       |                                       |
| 85.          | OTHER-SURG-PROC-4 | 6               | 443               | 448             | C     | ICD-9 Performed                       |
| 86.          | OTHER-SURG-DATE-4 | 8               | 449               | 456             | N     | CCYYMMDD                              |
| 87.          | OTHER-SURGERY-5   | 14              | 457               | 470             |       |                                       |
| 88.          | OTHER-SURG-PROC-5 | 6               | 457               | 462             | C     | ICD-9 Performed                       |
| 89.          | OTHER-SURG-DATE-5 | 8               | 463               | 470             | N     | CCYYMMDD                              |
| 90.          | DRG               | 3               | 471               | 473             | C     |                                       |
| 91.          | REVENUE-CODE-1    | 4               | 474               | 477             | N     | Code for specific hospital service    |
| 92.          | PROCEDURE-CODE-1  | 5               | 478               | 482             | C     | HCPCS Code applicable to revenue code |
| 93.          | UNITS-1           | 4               | 483               | 486             | N     |                                       |
| 94.          | REVENUE-CODE-2    | 4               | 487               | 490             | N     | Code for specific hospital service    |
| 95.          | PROCEDURE-CODE-2  | 5               | 491               | 495             | C     | HCPCS Code applicable to revenue code |
| 96.          | UNITS-2           | 4               | 496               | 499             | N     |                                       |
| 97.          | REVENUE-CODE-3    | 4               | 500               | 503             | N     | Code for specific hospital service    |
| 98.          | PROCEDURE-CODE-3  | 5               | 504               | 508             | C     | HCPCS Code applicable to revenue code |
| 99.          | UNITS-3           | 4               | 509               | 512             | N     |                                       |
| 100.         | REVENUE-CODE-4    | 4               | 513               | 516             | N     | Code for specific hospital service    |
| 101.         | PROCEDURE-CODE-4  | 5               | 517               | 521             | C     | HCPCS Code applicable to revenue code |
| 102.         | UNITS-4           | 4               | 522               | 525             | N     |                                       |
| 103.         | REVENUE-CODE-5    | 4               | 526               | 529             | N     | Code for specific hospital service    |

| Field Number | Field Name        | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                      |
|--------------|-------------------|-----------------|-------------------|-----------------|-------|---------------------------------------|
| 104.         | PROCEDURE-CODE-5  | 5               | 530               | 534             | C     | HCPCS Code applicable to revenue code |
| 105.         | UNITS-5           | 4               | 535               | 538             | N     |                                       |
| 106.         | REVENUE-CODE-6    | 4               | 539               | 542             | N     | Code for specific hospital service    |
| 107.         | PROCEDURE-CODE-6  | 5               | 543               | 547             | C     | HCPCS Code applicable to revenue code |
| 108.         | UNITS-6           | 4               | 548               | 551             | N     |                                       |
| 109.         | REVENUE-CODE-7    | 4               | 552               | 555             | N     | Code for specific hospital service    |
| 110.         | PROCEDURE-CODE-7  | 5               | 556               | 560             | C     | HCPCS Code applicable to revenue code |
| 111.         | UNITS-7           | 4               | 561               | 564             | N     |                                       |
| 112.         | REVENUE-CODE-8    | 4               | 565               | 568             | N     | Code for specific hospital service    |
| 113.         | PROCEDURE-CODE-8  | 5               | 569               | 573             | C     | HCPCS Code applicable to revenue code |
| 114.         | UNITS-8           | 4               | 574               | 577             | N     |                                       |
| 115.         | REVENUE-CODE-9    | 4               | 578               | 581             | N     | Code for specific hospital service    |
| 116.         | PROCEDURE-CODE-9  | 5               | 582               | 586             | C     | HCPCS Code applicable to revenue code |
| 117.         | UNITS-9           | 4               | 587               | 590             | N     |                                       |
| 118.         | REVENUE-CODE-10   | 4               | 591               | 594             | N     | Code for specific hospital service    |
| 119.         | PROCEDURE-CODE-10 | 5               | 595               | 599             | C     | HCPCS Code applicable to revenue code |
| 120.         | UNITS-10          | 4               | 600               | 603             | N     |                                       |
| 121.         | REVENUE-CODE-11   | 4               | 604               | 607             | N     | Code for specific hospital service    |
| 122.         | PROCEDURE-CODE-11 | 5               | 608               | 612             | C     | HCPCS Code applicable to revenue code |
| 123.         | UNITS-11          | 4               | 613               | 616             | N     |                                       |
| 124.         | REVENUE-CODE-12   | 4               | 617               | 620             | N     | Code for specific hospital service    |
| 125.         | PROCEDURE-CODE-12 | 5               | 621               | 625             | C     | HCPCS Code applicable to revenue code |
| 126.         | UNITS-12          | 4               | 626               | 629             | N     |                                       |
| 127.         | REVENUE-CODE-13   | 4               | 630               | 633             | N     | Code for specific hospital service    |
| 128.         | PROCEDURE-CODE-13 | 5               | 634               | 638             | C     | HCPCS Code applicable to revenue code |
| 129.         | UNITS-13          | 4               | 639               | 642             | N     |                                       |
| 130.         | REVENUE-CODE-14   | 4               | 643               | 646             | N     | Code for specific hospital service    |
| 131.         | PROCEDURE-CODE-14 | 5               | 647               | 651             | C     | HCPCS Code applicable to revenue code |
| 132.         | UNITS-14          | 4               | 652               | 655             | N     |                                       |
| 133.         | REVENUE-CODE-15   | 4               | 656               | 659             | N     | Code for specific hospital service    |

| Field Number | Field Name        | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                      |
|--------------|-------------------|-----------------|-------------------|-----------------|-------|---------------------------------------|
| 134.         | PROCEDURE-CODE-15 | 5               | 660               | 664             | C     | HCPCS Code applicable to revenue code |
| 135.         | UNITS-15          | 4               | 665               | 668             | N     |                                       |
| 136.         | REVENUE-CODE-16   | 4               | 669               | 672             | N     | Code for specific hospital service    |
| 137.         | PROCEDURE-CODE-16 | 5               | 673               | 677             | C     | HCPCS Code applicable to revenue code |
| 138.         | UNITS-16          | 4               | 678               | 681             | N     |                                       |
| 139.         | REVENUE-CODE-17   | 4               | 682               | 685             | N     | Code for specific hospital service    |
| 140.         | PROCEDURE-CODE-17 | 5               | 686               | 690             | C     | HCPCS Code applicable to revenue code |
| 141.         | UNITS-17          | 4               | 691               | 694             | N     |                                       |
| 142.         | REVENUE-CODE-18   | 4               | 695               | 698             | N     | Code for specific hospital service    |
| 143.         | PROCEDURE-CODE-18 | 5               | 699               | 703             | C     | HCPCS Code applicable to revenue code |
| 144.         | UNITS-18          | 4               | 704               | 707             | N     |                                       |
| 145.         | REVENUE-CODE-19   | 4               | 708               | 711             | N     | Code for specific hospital service    |
| 146.         | PROCEDURE-CODE-19 | 5               | 712               | 716             | C     | HCPCS Code applicable to revenue code |
| 147.         | UNITS-19          | 4               | 717               | 720             | N     |                                       |
| 148.         | REVENUE-CODE-20   | 4               | 721               | 724             | N     | Code for specific hospital service    |
| 149.         | PROCEDURE-CODE-20 | 5               | 725               | 729             | C     | HCPCS Code applicable to revenue code |
| 150.         | UNITS-20          | 4               | 730               | 733             | N     |                                       |
| 151.         | REVENUE-CODE-21   | 4               | 734               | 737             | N     | Code for specific hospital service    |
| 152.         | PROCEDURE-CODE-21 | 5               | 738               | 742             | C     | HCPCS Code applicable to revenue code |
| 153.         | UNITS-21          | 4               | 743               | 746             | N     |                                       |
| 154.         | REVENUE-CODE-22   | 4               | 747               | 750             | N     | Code for specific hospital service    |
| 155.         | PROCEDURE-CODE-22 | 5               | 751               | 755             | C     | HCPCS Code applicable to revenue code |
| 156.         | UNITS-22          | 4               | 756               | 759             | N     |                                       |
| 157.         | REVENUE-CODE-23   | 4               | 760               | 763             | N     | Code for specific hospital service    |
| 158.         | PROCEDURE-CODE-23 | 5               | 764               | 768             | C     | HCPCS Code applicable to revenue code |
| 159.         | UNITS-23          | 4               | 769               | 772             | N     |                                       |
| 160.         | REVENUE-CODE-24   | 4               | 773               | 776             | N     | Code for specific hospital service    |
| 161.         | PROCEDURE-CODE-24 | 5               | 777               | 781             | C     | HCPCS Code applicable to revenue code |
| 162.         | UNITS-24          | 4               | 782               | 785             | N     |                                       |
| 163.         | REVENUE-CODE-25   | 4               | 786               | 789             | N     | Code for specific hospital service    |

| Field Number | Field Name        | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                      |
|--------------|-------------------|-----------------|-------------------|-----------------|-------|---------------------------------------|
| 164.         | PROCEDURE-CODE-25 | 5               | 790               | 794             | C     | HCPCS Code applicable to revenue code |
| 165.         | UNITS-25          | 4               | 795               | 798             | N     |                                       |
| 166.         | REVENUE-CODE-26   | 4               | 799               | 802             | N     | Code for specific hospital service    |
| 167.         | PROCEDURE-CODE-26 | 5               | 803               | 807             | C     | HCPCS Code applicable to revenue code |
| 168.         | UNITS-26          | 4               | 808               | 811             | N     |                                       |
| 169.         | REVENUE-CODE-27   | 4               | 812               | 815             | N     | Code for specific hospital service    |
| 170.         | PROCEDURE-CODE-27 | 5               | 816               | 820             | C     | HCPCS Code applicable to revenue code |
| 171.         | UNITS-27          | 4               | 821               | 824             | N     |                                       |
| 172.         | REVENUE-CODE-28   | 4               | 825               | 828             | N     | Code for specific hospital service    |
| 173.         | PROCEDURE-CODE-28 | 5               | 829               | 833             | C     | HCPCS Code applicable to revenue code |
| 174.         | UNITS-28          | 4               | 834               | 837             | N     |                                       |
| 175.         | REVENUE-CODE-29   | 4               | 838               | 841             | N     | Code for specific hospital service    |
| 176.         | PROCEDURE-CODE-29 | 5               | 842               | 846             | C     | HCPCS Code applicable to revenue code |
| 177.         | UNITS-29          | 4               | 847               | 850             | N     |                                       |
| 178.         | REVENUE-CODE-30   | 4               | 851               | 854             | N     | Code for specific hospital service    |
| 179.         | PROCEDURE-CODE-30 | 5               | 855               | 859             | C     | HCPCS Code applicable to revenue code |
| 180.         | UNITS-30          | 4               | 860               | 863             | N     |                                       |
| 181.         | REVENUE-CODE-31   | 4               | 864               | 867             | N     | Code for specific hospital service    |
| 182.         | PROCEDURE-CODE-31 | 5               | 868               | 872             | C     | HCPCS Code applicable to revenue code |
| 183.         | UNITS-31          | 4               | 873               | 876             | N     |                                       |
| 184.         | REVENUE-CODE-32   | 4               | 877               | 880             | N     | Code for specific hospital service    |
| 185.         | PROCEDURE-CODE-32 | 5               | 881               | 885             | C     | HCPCS Code applicable to revenue code |
| 186.         | UNITS-32          | 4               | 886               | 889             | N     |                                       |
| 187.         | REVENUE-CODE-33   | 4               | 890               | 893             | N     | Code for specific hospital service    |
| 188.         | PROCEDURE-CODE-33 | 5               | 894               | 898             | C     | HCPCS Code applicable to revenue code |
| 189.         | UNITS-33          | 4               | 899               | 902             | N     |                                       |
| 190.         | REVENUE-CODE-34   | 4               | 903               | 906             | N     | Code for specific hospital service    |
| 191.         | PROCEDURE-CODE-34 | 5               | 907               | 911             | C     | HCPCS Code applicable to revenue code |
| 192.         | UNITS-34          | 4               | 912               | 915             | N     |                                       |
| 193.         | REVENUE-CODE-35   | 4               | 916               | 919             | N     | Code for specific hospital service    |

| Field Number | Field Name        | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask                      |
|--------------|-------------------|-----------------|-------------------|-----------------|-------|---------------------------------------|
| 194.         | PROCEDURE-CODE-35 | 5               | 920               | 924             | C     | HCPCS Code applicable to revenue code |
| 195.         | UNITS-35          | 4               | 925               | 928             | N     |                                       |
| 196.         | REVENUE-CODE-36   | 4               | 929               | 932             | N     | Code for specific hospital service    |
| 197.         | PROCEDURE-CODE-36 | 5               | 933               | 937             | C     | HCPCS Code applicable to revenue code |
| 198.         | UNITS-36          | 4               | 938               | 941             | N     |                                       |
| 199.         | REVENUE-CODE-37   | 4               | 942               | 945             | N     | Code for specific hospital service    |
| 200.         | PROCEDURE-CODE-37 | 5               | 946               | 950             | C     | HCPCS Code applicable to revenue code |
| 201.         | UNITS-37          | 4               | 951               | 954             | N     |                                       |
| 202.         | REVENUE-CODE-38   | 4               | 955               | 958             | N     | Code for specific hospital service    |
| 203.         | PROCEDURE-CODE-38 | 5               | 959               | 963             | C     | HCPCS Code applicable to revenue code |
| 204.         | UNITS-38          | 4               | 964               | 967             | N     |                                       |
| 205.         | REVENUE-CODE-39   | 4               | 968               | 971             | N     | Code for specific hospital service    |
| 206.         | PROCEDURE-CODE-39 | 5               | 972               | 976             | C     | HCPCS Code applicable to revenue code |
| 207.         | UNITS-39          | 4               | 977               | 980             | N     |                                       |
| 208.         | REVENUE-CODE-40   | 4               | 981               | 984             | N     | Code for specific hospital service    |
| 209.         | PROCEDURE-CODE-40 | 5               | 985               | 989             | C     | HCPCS Code applicable to revenue code |
| 210.         | UNITS-40          | 4               | 990               | 993             | N     |                                       |
| 211.         | REVENUE-CODE-41   | 4               | 994               | 997             | N     | Code for specific hospital service    |
| 212.         | PROCEDURE-CODE-41 | 5               | 998               | 1002            | C     | HCPCS Code applicable to revenue code |
| 213.         | UNITS-41          | 4               | 1003              | 1006            | N     |                                       |
| 214.         | REVENUE-CODE-42   | 4               | 1007              | 1010            | N     | Code for specific hospital service    |
| 215.         | PROCEDURE-CODE-42 | 5               | 1011              | 1015            | C     | HCPCS Code applicable to revenue code |
| 216.         | UNITS-42          | 4               | 1016              | 1019            | N     |                                       |
| 217.         | REVENUE-CODE-43   | 4               | 1020              | 1023            | N     | Code for specific hospital service    |
| 218.         | PROCEDURE-CODE-43 | 5               | 1024              | 1028            | C     | HCPCS Code applicable to revenue code |
| 219.         | UNITS-43          | 4               | 1029              | 1032            | N     |                                       |
| 220.         | REVENUE-CODE-44   | 4               | 1033              | 1036            | N     | Code for specific hospital service    |
| 221.         | PROCEDURE-CODE-44 | 5               | 1037              | 1041            | C     | HCPCS Code applicable to revenue code |
| 222.         | UNITS-44          | 4               | 1042              | 1045            | N     |                                       |
| 223.         | REVENUE-CODE-45   | 4               | 1046              | 1049            | N     | Code for specific hospital service    |

| Field Number | Field Name                 | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|----------------------------|-----------------|-------------------|-----------------|-------|---|
| 224.         | PROCEDURE-CODE-45          | 5               | 1050              | 1054            | C     | HCPCS Code applicable to revenue code   |
| 225.         | UNITS-45                   | 4               | 1055              | 1058            | N     |   |
| 226.         | REVENUE-CODE-46            | 4               | 1059              | 1062            | N     | Code for specific hospital service  |
| 227.         | PROCEDURE-CODE-46          | 5               | 1063              | 1067            | C     | HCPCS Code applicable to revenue code   |
| 228.         | UNITS-46                   | 4               | 1068              | 1071            | N     |   |
| 229.         | REVENUE-CODE-47            | 4               | 1072              | 1075            | N     | Code for specific hospital service  |
| 230.         | PROCEDURE-CODE-47          | 5               | 1076              | 1080            | C     | HCPCS Code applicable to revenue code   |
| 231.         | UNITS-47                   | 4               | 1081              | 1084            | N     |   |
| 232.         | REVENUE-CODE-48            | 4               | 1085              | 1088            | N     | Code for specific hospital service  |
| 233.         | PROCEDURE-CODE-48          | 5               | 1089              | 1093            | C     | HCPCS Code applicable to revenue code   |
| 234.         | UNITS-48                   | 4               | 1094              | 1097            | N     |   |
| 235.         | REVENUE-CODE-49            | 4               | 1098              | 1101            | N     | Code for specific hospital service  |
| 236.         | PROCEDURE-CODE-49          | 5               | 1102              | 1106            | C     | HCPCS Code applicable to revenue code   |
| 237.         | UNITS-49                   | 4               | 1107              | 1110            | N     |   |
| 238.         | REVENUE-CODE-50            | 4               | 1111              | 1114            | N     | Code for specific hospital service  |
| 239.         | PROCEDURE-CODE-50          | 5               | 1115              | 1119            | C     | HCPCS Code applicable to revenue code   |
| 240.         | UNITS-50                   | 4               | 1120              | 1123            | N     |   |
| 241.         | FILLER                     | 10              | 1124              | 1133            | C     |   |
| 242.         | ATTENDING-PHYSICIAN-NPI    | 10              | 1134              | 1143            | C     | Physician NPI   |
| 243.         | PAID-TO-PROVIDER-NPI       | 10              | 1144              | 1153            | C     | This is to whom the payment was made. This is usually the SERVICE PROVIDER NPI (Hospital's NPI).  |
| 244.         | FILLER                     | 114             | 1154              | 1267            | C     |   |
| 245.         | HMO-OWN-REF-NUMBER         | 16              | 1268              | 1283            | C     | HMO own reference number  |
| 246.         | RE-SUBMIT-ENCOUNTER-NUMBER | 17              | 1284              | 1300            | C     | THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED ENCOUNTER. It is the system assigned number for the encounter (Made up of the provider's own reference number (of the original encounter) followed by an 'E'. The 'E' should be in byte 1300. |

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 4223 will appear as 004223

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

Unless otherwise specified there will be no signed fields

\*\*\*\*\*

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

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

| Field Number | Field Name                   | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------------------------|-----------------|-------------------|-----------------|-------|---|
| 1.           | DEI-CC                       | 2               | 1                 | 2               | C     | ENCOUNTER SUBMIT DATE CENTURY   |
| 2.           |                              | 2               | 3                 | 4               | N     | ENCOUNTER SUBMIT DATE YEAR  |
| 3.           | DEI-DDD                      | 3               | 5                 | 7               | N     | ENCOUNTER SUBMIT DATE DAYS (JULIAN)   |
| 4.           | DEI-ENC-DOC-TYPE             | 1               | 8                 | 8               | C     | RECORD TYPE, DRUG='D'   |
| 5.           | FILLER                       | 3               | 9                 | 11              | C     | FILLER  |
| 6.           | DEI-ADJUSTMENT-IND           | 1               | 12                | 12              |       | THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED ENCOUNTER.<br>This field should be blank unless the encounter is a void. If it is a void put a 'V' in this field. |
| 7.           | FILLER                       | 1               | 13                | 13              | C     |   |
| 8.           | DEI-CLAIM-PAID-DATE          | 4               | 14                | 17              | C     | DATE CLAIM PAID<br>Mask: YYYYMM   |
| 9.           | DEI-INDIV-NO                 | 10              | 18                | 27              | N     | RECIPIENT MEDICAID NUMBER   |
| 10.          | DEI-HMO-RECIP-ID             | 15              | 28                | 42              | C     | HMO RECIPIENT NUMBER  |
| 11.          | DEI-PROV-NUMBER              | 6               | 43                | 48              |       | SC ASSIGNED PROVIDER NUMBER (MCO ID)  |
| 12.          | FILLER                       | 225             | 49                | 273             | C     |   |
| 13.          | DEI-PAID-TO-PROVIDER-NO      | 6               | 274               | 279             | C     | This is to whom the payment was made. This is usually the SERVICE PROVIDER NUMBER (sc assigned to pharmacy).  |
| 14.          | DEI-TOT-AMT-HMO-BILLED-INPUT | 9               | 280               | 288             |       | AMOUNT BILLED BY HMO (AMT BEING BILLED BY PDP)<br>MASK 9999999V99 ZERO FILLED, NO SIGN  |
| 15.          | DEI-TOT-AMT-HMO-PAID         | 9               | 289               | 297             | N     | AMOUNT PAID<br>MASK 9999999V99 ZERO FILLED, NO SIGN   |

| Field Number | Field Name                     | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|--------------------------------|-----------------|-------------------|-----------------|-------|---|
| 16.          | DEI-REIMBURSE-METHOD           | 1               | 298               | 298             | C     | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge                   |
| 17.          | DEI-DD-CCYY                    | 4               | 299               | 302             |       | DISPENSE DATE CENTURY AND YEAR  |
| 18.          | DEI-DD-MO                      | 2               | 303               | 304             | N     | DISPENSE DATE MONTH   |
| 19.          | DEI-DD-DA                      | 2               | 305               | 306             | N     | DISPENSE DATE DAY OF MONTH  |
| 20.          | DEI-DRUG-CODE                  | 11              | 307               | 317             | C     | NDC DRUG CODE   |
| 21.          | DEI-UNIT-TYPE                  | 3               | 318               | 320             | C     | AHF - ANTI-HEMOPHILIC FACTOR INJECTABLES<br>CAP - CAPSULES<br>EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE<br>GM - GRAMS<br>ML - MILLILITERS<br>SUP - SUPPOSITORIES<br>TAB - TABLETS<br>TDP - TRANSDERMAL PATCHES |
| 22.          | DEI-QUANTITY-DISPENSED-INPUT   | 6               | 321               | 326             |       | QUANTITY DISPENSED  |
| 23.          | DEI-DAYS-SUPPLY-INPUT          | 3               | 327               | 329             | N     | DAYS SUPPLY DISPENSED   |
| 24.          | DEI-ENC-PRESCRIPTION-NO        | 15              | 330               | 344             | C     | PRESCRIPTION NUMBER   |
| 25.          | DEI-PHYSICIAN-NO               | 6               | 345               | 350             | C     | PHYSICIAN PROVIDER NUMBER   |
| 26.          | FILLER                         | 2               | 351               | 352             | C     |   |
| 27.          | DEI-REFILL-INP                 | 2               | 353               | 354             | C     |   |
| 28.          | FILLER                         | 10              | 355               | 364             |       |   |
| 29.          | DEI-PAID-TO-PROVIDER-NPI       | 10              | 365               | 374             |       | This is to whom the payment was made. This is usually the SERVICE PROVIDER (PHARMACY) NPI.  |
| 30.          | DEI-PHYSICIAN-NPI              | 10              | 375               | 384             |       | PHYSICIAN NPI   |
| 31.          | FILLER                         | 883             | 385               | 1267            |       |   |
| 32.          | DEI-HMO-OWN-REF-NUMBER         | 16              | 1268              | 1283            |       | PROVIDER'S OWN REFERENCE NUMBER   |
| 33.          | DEI-RE-SUBMIT-ENCOUNTER-NUMBER | 17              | 1284              | 1300            | C     | THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED   |

| Field Number | Field Name | Number of Bytes | Starting Location | Ending Location | N / C | Description/Mask  |
|--------------|------------|-----------------|-------------------|-----------------|-------|---|
|              |            |                 |                   |                 |       | ENCOUNTER. It is the system assigned number for the encounter (Made up of the provider's own reference number (of the original encounter) followed by an 'E'. The 'E' should be in byte 1300. |

**Special instruction:**

All records must be fixed length:

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

C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields

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

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

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

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

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

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

Mask is 9999999v99 zero filled to the left.

Field number 30: DEI-PHYSICIAN-NO is the SCDHHS physician assigned number.

Field number 32: 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.

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
THIRD PARTY LIABILITY FILE**

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

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.  
EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

C = Character – All character fields are left justified and space filled to the right  
Unless otherwise specified there will be no signed fields

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**MCO PROVIDER IDENTIFICATION RECORD LAYOUT (NON-MEDICAID PROVIDERS)**

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

| Field Number | Field Name              | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask |
|--------------|-------------------------|-----------------|-------------------|-----------------|-----|------------------|
| 16.          | PROVIDER-LICENSE-NUMBER | 10              | 169               | 178             | C   |                  |
| 17.          | FILLER                  | 22              | 179               | 200             | C   |                  |
| 18.          |                         |                 |                   |                 |     |                  |
| 19.          |                         |                 |                   |                 |     |                  |
| 20.          |                         |                 |                   |                 |     |                  |
| 21.          |                         |                 |                   |                 |     |                  |
| 22.          |                         |                 |                   |                 |     |                  |
| 23.          |                         |                 |                   |                 |     |                  |
| 24.          |                         |                 |                   |                 |     |                  |
| 25.          |                         |                 |                   |                 |     |                  |

**Special instruction:**

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields

**MCO Reports to SCDHHS**

**Model Attestation Letter**

(Company Letter Head)  
Attestation for Reports

Date \_\_\_\_\_

I, \_\_\_\_\_, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the \_\_\_\_\_ Report(s) is accurate, true, and complete.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to liquidated damages as outlined in Section 13.3 of the contract or sanctions and/or fines as outlined in Section 13.5 of the contract.

\_\_\_\_\_

\_\_\_\_\_  
Signature/Title

Date

## NETWORK PROVIDER and SUBMCO LISTING SPREADSHEET REQUIREMENTS

Please provide the following information regarding network providers and sub MCOs:

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, County, 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, if they are a Medicaid provider.
6. Specialty Code - Indicate the practitioner's specialty using the attached Medicaid Specialty Codes .
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. Do so by listing all 46 counties in alphabetical order (one column per county) and placing an "X" in each appropriate column, indicating that the provider **serves that county**. For example, if the provider has offices in 3 counties, but is used by the MCO to provide services in 6 counties, place an "X" in the columns of each of the 6 counties served.

**On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month. For these tabs, please provide the information requested in items 1-12 above.**

## 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 MCO.

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 MCO 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., Include enough information to provide SCDHHS with an understanding of how the grievance was resolved. If the grievance is pharmaceutical in nature, please provide the name of the medication and the date the prescription was filled by the member.

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

Date of Resolution: The date the resolution was achieved.

**Plan Name (ID Number)**  
**Grievance Log**  
**Month/Year: \_\_\_\_\_**

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

## 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 MCO.

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 MCO 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., Include enough information to provide SCDHHS with an understanding of how the appeal was resolved. If the grievance is pharmaceutical in nature, please provide the name of the medication and the date the prescription was filled by the member.

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

Date of Resolution: The date the resolution was achieved.

### Plan Name (ID Number)

### Appeals Log

Month/Year:     

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

Name of Health Plan (HMXXXXX)  
 Address  
 City, State Zip Code

HCK Monthly Maternity Notification Log  
 Month Year

| Count | DOB | Mother's  |            |             | Baby's    |            |     | Multiple | Eligible | Amount |
|-------|-----|-----------|------------|-------------|-----------|------------|-----|----------|----------|--------|
|       |     | Last Name | First Name | Medicaid ID | Last Name | First Name | Sex |          |          |        |
| 1     |     |           |            |             |           |            |     |          |          |        |
| 2     |     |           |            |             |           |            |     |          |          |        |
| 3     |     |           |            |             |           |            |     |          |          |        |
| 4     |     |           |            |             |           |            |     |          |          |        |
| 5     |     |           |            |             |           |            |     |          |          |        |
| 6     |     |           |            |             |           |            |     |          |          |        |
| 7     |     |           |            |             |           |            |     |          |          |        |
| 8     |     |           |            |             |           |            |     |          |          |        |
| 9     |     |           |            |             |           |            |     |          |          |        |
| 10    |     |           |            |             |           |            |     |          |          |        |
| 11    |     |           |            |             |           |            |     |          |          |        |
| 12    |     |           |            |             |           |            |     |          |          |        |
| 13    |     |           |            |             |           |            |     |          |          |        |
| 14    |     |           |            |             |           |            |     |          |          |        |
| 15    |     |           |            |             |           |            |     |          |          |        |
| 16    |     |           |            |             |           |            |     |          |          |        |
| 17    |     |           |            |             |           |            |     |          |          |        |
| 18    |     |           |            |             |           |            |     |          |          |        |
| 19    |     |           |            |             |           |            |     |          |          |        |
| 20    |     |           |            |             |           |            |     |          |          |        |
| 21    |     |           |            |             |           |            |     |          |          |        |
| 22    |     |           |            |             |           |            |     |          |          |        |
| 23    |     |           |            |             |           |            |     |          |          |        |
| 24    |     |           |            |             |           |            |     |          |          |        |
| 25    |     |           |            |             |           |            |     |          |          |        |

## HCK Monthly Maternity Notification Log Definitions

Multiple Births: Indicate with an “X” for multiple births. Otherwise, do not fill in this column.

Count: Numerical count of lines reported - 1, 2, 3....

Date of Birth: date of birth of newborn format – 00/00/00

Mother’s Last Name: Add the mothers last name

Mother’s First Name: Add the mother first name

Mother’s Medicaid ID Number: Mother’s Medicaid ID number – 10 digits

Newborn’s Last Name: Add the newborn’s last name. If name is not known, use “Baby Boy” or “Baby Girl”

Newborn’s First Name: Add the newborn’s first name. Not applicable if name is not known

Newborn’s Sex: Use M for male, F for female

\* These columns reserved for SCDHHS use

## Claims Payment Report

MCO Name  
Month /Year (MM-YYYY)

| Number of Enrollees                                |        |  |
|--|--------|--|
|  |        |  |
| Claims Volume                                      | Number |  |
| 1. Beginning Claims Inventory                      |        |  |
| 2. Number of Claims Received (Reporting Month)     |        |  |
| 3. Total Number of Claims Available for Processing |        |  |
| 4. Number of Paid Claims                           |        |  |
| 5. Number of Denied Claims                         |        |  |
| 5a. Number of Clean Denied Claims                  |        |  |
| 5b. Number of Unclean Denied Claims                |        |  |
| 6. Total Claims Processed                          |        |  |
| 7. Total Claims Unprocessed                        |        |  |

| Clean Claims Processing Time                 | Number | Percentage |
|--|--------|------------|
| 8. Number of Claims Processed Within 30 Days |        |            |
| 9. Number of Claims Processed 31-90 Days     |        |            |
| 10. Number of Claims Processed 91-365 Days   |        |            |
| 11. Number of Claims Processed over 365 Days |        |            |

| Claims Line Summary                                | Number | Dollar Amount |
|--|--------|---------------|
| 12a. Number of Denied Claim Lines (Administrative) |        |               |
| 12b. Number of Denied Claim Lines (Clinical)       |        |               |
| 12c. Number of Paid Claim Lines                    |        |               |
| 13. Total Claim Lines                              |        |               |

| Claims Payment Statistics                                  |  |  |
|--|--|--|
| 14. Average Paid Time (Stamped Received Date to Paid Date) |  |  |

| Denial Claim Reasons | Number | Percentage |
|----------------------|--------|------------|
| Describe             |        |            |

|          |  |  |
|----------|--|--|
| Describe |  |  |

## Definitions

Processed claims are defined as received (date stamped) and paid, denied or pended. If one or more lines of a claim are paid (but not the entire claim), the remaining unpaid lines are denied or pended. Denied lines are returned to the provider and become a new claim. Pended lines are retained by the MCO and remain in the “processing” category. If they are not resolved by the end of the month, pended claims become part of the next month’s beginning claims inventory.

1. Beginning Claims Inventory – The total number of unprocessed (including pended) claims from the previous month.
2. Number of Claims Received (Reporting Month) – The total number of claims received and date stamped during the reporting month.
3. Total Number of Claims Available for Processing – The sum of items 1 and 2 (add items 1 and 3).
4. Number of Paid Claims – Self-explanatory. By definition, these are clean claims.
5. Number of Denied Claims – The sum of items 5a and 5b (add items 5a and 5b).
- 5a. Number of Clean Denied Claims – Number of denied claims that met the contract definition of “clean”.
- 5b. Number of Unclean Denied Claims - Number of denied claims that did not meet the contract definition of “clean”.
6. Total Claims Processed – The sum of items 4 and 5 (add items 4 and 5).
7. Total Claims Unprocessed – The difference between items 6 and 3 (subtract item 6 from item 3).
8. Number of Claims Processed Within 30 Days – Day one is the date of stamped receipt. Days are calendar days, not business days. The date that the check is cut (paid) or the correspondence is dated denying the claim, is the end date.
9. Number of Claims Processed 31-90 Days –Self-explanatory.
10. Number of Claims Processed 91-365 Days – Self explanatory.
11. Number of Claims Processed over 365 Days – Self-explanatory.
- 12a. Number of Denied Claim Lines (Administrative) – Claim lines denied due to administrative reasons (forms filled out incorrectly, timeliness, etc)
- 12b. Number of Denied Claim Lines (Clinical) – Claim lines denied due to clinical reasons (service not covered, number of allowable visits exceeded, etc).
- 12c. Number of Paid Claim Lines – Self-explanatory.
13. Total Claim Lines – The sum of 12a, 12b and 12c.

14. Average Paid Time – For paid claims only, the average time from the stamped receipt of the claim to date the payment check is generated.
15. Denial Claim Reasons – please develop categories and group most frequent reasons. The total does not have to equal 100%. SCDHHS will develop standard reasons and codes based on MCO experience and submissions.

## **SCDHHS FILES TO MCOS**

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MANAGED CARE MLE RECORD DESCRIPTION  
(MCO MEMBER LISTING RECORD)**

| Field Number | Field Name           | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|----------------------|-----------------|-------------------|-----------------|-----|--|
| 1.           | MLE-RECORD-TYPE      | 1               | 1                 | 1               |     | Internal, H=HMO/MCO  |
| 2.           | MLE-CODE             | 1               | 2                 | 2               |     | Status in Managed Care:<br>A - AUTO ENROLLED<br>R - RETROACTIVE<br>N - NEW<br>P - PREVIOUSLY ENROLLED WITH SAME PHYSICIAN<br>C - CONTINUING<br>D - DISENROLLED |
| 3.           | MLE-PROV-NO          | 6               | 3                 | 8               |     | Physician recipient is enrolled with.  |
| 4.           | MLE-PROV-NAME        | 26              | 9                 | 34              |     | Provider Name  |
| 5.           | MLE-CAREOF           | 26              | 35                | 60              |     | Provider Address   |
| 6.           | MLE-STREET           | 26              | 61                | 86              |     | Provider Street  |
| 7.           | MLE-CITY             | 20              | 87                | 106             |     | City   |
| 8.           | MLE-STATE            | 2               | 107               | 108             |     | State  |
| 9.           | MLE-ZIP              | 9               | 109               | 117             |     | Zip code + 4   |
| 10.          | MLE-RECIP-NO         | 10              | 118               | 127             |     | Recipient identifying SCHIP number.  |
| 11.          | MLE-RECIP-LAST-NAME  | 17              | 128               | 144             |     | Recipient Last name  |
| 12.          | MLE-RECIP-FIRST-NAME | 14              | 145               | 158             |     | Recipient First name   |
| 13.          | MLE-RECIP-MI         | 1               | 159               | 159             |     | Recipient Middle initial   |
| 14.          | MLE-ADDR-CARE-OF     | 25              | 160               | 184             |     | Recipient address  |
| 15.          | MLE-ADDR-STREET      | 25              | 185               | 209             |     | Street   |
| 16.          | MLE-ADDR-CITY        | 23              | 210               | 232             |     | City   |
| 17.          | MLE-ADDR-STATE       | 2               | 233               | 234             |     | State  |
| 18.          | MLE-ADDR-ZIP         | 9               | 235               | 243             |     | Zip code + 4   |
| 19.          | MLE-ADDR-AREA-CODE   | 3               | 244               | 246             |     | Recipient phone number Area code   |
| 20.          | MLE-ADDR-PHONE       | 7               | 247               | 253             |     | Recipient phone number   |
| 21.          | MLE-COUNTY           | 2               | 254               | 255             |     | Recipient county where eligible  |
| 22.          | MLE-RECIP-AGE        | 3               | 256               | 258             |     | Recipient Age  |
| 23.          | MLE-AGE-SW           | 1               | 259               | 259             |     | Y=year, M=month, <=less than 1 month, U=unknown  |
| 24.          | MLE-RECIP-SEX        | 1               | 260               | 260             |     | M =Male, F=Female, U =Unknown  |
| 25.          | MLE-RECIP-PAY-CAT    | 2               | 261               | 262             |     | Recipient category of eligibility - see Table 01 for values  |
| 26.          | MLE-RECIP-DOB.       | 8               | 263               | 270             |     | Recipient date of birth CCYYMMDD   |
| 27.          | MLE-ENROLL-DATE      | 6               | 271               | 276             |     | Managed Care Enrollment Date YYMMDD  |
| 28.          | MLE-DISENROLL-DATE   | 6               | 277               | 282             |     | Managed Care Disenrollment Date  |

| Field Number | Field Name   | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|--|-----------------|-------------------|-----------------|-----|--|
| 29.          | MLE-DISENROLL-REASON   | 2               | 283               | 284             |     | YYMMDD<br>Reason Code for Disenrollment:<br>01 - NO LONGER IN HMO PROGRAM<br>02 - TRANSFERRED TO ANOTHER MANAGED CARE PROVIDER<br>03 - SCHIP ELIGIBILITY TERMINATED<br>04 - HAS MEDICARE<br>06 - MANAGED CARE PROVIDER TERMINATED<br>08 - RECIPIENT HAS TPL HMO POLICY |
| 30.          | MLE-PR-KEY   | 3               | 285               | 287             |     | Premium Rate Category  |
| 31.          | MLE-PREMIUM-RATE   | 9               | 288               | 296             |     | Amount of Premium paid   |
| 32.          | MLE-PREM-DATE.   | 6               | 297               | 302             |     | CCYYMM – Month for which the premium is paid.  |
| 33.          | MLE-MENTAL-HEALTH-ARRAY  | 3               | 303               | 305             |     | Obsolete   |
| 34.          | MLE-PREFERRED-PHYS   | 25              | 306               | 330             |     | Recipient's preferred provider   |
| 35.          | MLE-REVIEW-DATE-CCYYMMDD.  | 8               | 331               | 338             |     | CCYYMMDD – Date recipient will be reviewed for eligibility and/or managed care enrollment.   |
| 36.          | PREGNANCY-INDICATOR  | 1               | 339               | 339             |     | Pregnancy indicator  |
| 37.          | MLE-SSN  | 9               | 340               | 348             |     | Member's social security number  |
| 38.          | TPL-NBR-POLICIES   | 2               | 349               | 350             |     | Number of TPL policies   |
| 39.          | TPL INFORMATION below REPEATS 10 TIMES IF APPLICABLE This occurs only 5 times on the 834 | 4140            | 351               | 4490            |     |  |
| 40.          | POLICY-CARRIER-NAME  | 50              | 351               | 400             |     | Policy carrier name  |
| 41.          | POLICY-NUMBER  | 25              | 401               | 425             |     | Policy number  |
| 42.          | CARRIER-CODE   | 5               | 426               | 430             |     | Code to signify a carrier  |
| 43.          | POLICY-RECIP-EFFECTIVE DATE  | 8               | 431               | 438             |     | Recipient effective date of policy   |
| 44.          | POLICY-RECIP-LAST UPDATE   | 6               | 439               | 444             |     | Last update policy recipient record  |
| 45.          | POLICY-RECIP-OPEN DATE   | 8               | 445               | 452             |     | Recipient policy open date   |
| 46.          | POLICY-RECIP-LAPSE DATE  | 8               | 453               | 460             |     | Recipient lapse date policy  |
| 47.          | POLICY-RECIP-PREG-COV-IND  | 1               | 461               | 461             |     | Pregnancy coverage indicator   |
| 48.          | POLICY-TYPE  | 2               | 462               | 463             |     | Type of policy-health or casualty  |
| 49.          | POLICY-GROUP-NO  | 20              | 464               | 483             |     | Policy group number  |
| 50.          | POLICY-GROUP-NAME  | 50              | 484               | 533             |     | Policy group name  |
| 51.          | POLICY-GROUP-ATTN  | 50              | 534               | 583             |     | Policy group attention   |
| 52.          | POLICY-GROUP-ADDRESS   | 50              | 584               | 633             |     | Policy group address   |

| Field Number | Field Name                | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask                                   |
|--------------|---------------------------|-----------------|-------------------|-----------------|-----|--|
| 53.          | POL-GRP-CITY              | 39              | 634               | 672             |     | Policy group city                                  |
| 54.          | POL-GRP-STATE             | 2               | 673               | 674             |     | Policy group state                                 |
| 55.          | POL-GRP-ZIP               | 9               | 675               | 683             |     | Policy group zip code + 4                          |
| 56.          | POL-POST-PAVREC-IND       | 1               | 684               | 684             |     | 0-cost avoid, 1-no cost avoid                      |
| 57.          | POLICY-INSURED-LAST NAME  | 17              | 685               | 701             |     | Insured last name                                  |
| 58.          | POLICY-INSURED-FIRST NAME | 14              | 702               | 715             |     | Insured first name                                 |
| 59.          | POLICY-INSURED-MI-NAME    | 1               | 716               | 716             |     | Insured middle Initial                             |
| 60.          | POLICY-SOURCE-CODE        | 1               | 717               | 717             |     | Source of info about policy (ie. champus, highway) |
| 61.          | POLICY-LETTER-IND         | 1               | 718               | 718             |     | If present, pass group address info                |
| 62.          | POL-EFFECTIVE-DATE        | 8               | 719               | 726             |     | Effective date of policy CCYYMMDD                  |
| 63.          | POL-OPEN-DATE             | 8               | 727               | 734             |     | <b>First stored date</b>                           |
| 64.          | POL-COVER-IND-ARRAY       | 30              | 735               | 764             |     | 1 BYTE FIELDS X 30 What policy will cover          |
| 65.          | RECIPIENT-RACE            | 2               | 4491              | 4492            |     | Race code - Reference Table 13                     |
| 66.          | RECIPIENT-LANGUAGE        | 1               | 4493              | 4493            |     | Language code -Reference Table 21                  |
| 67.          | RECIPIENT-FAMILY--NUM     | 8               | 4494              | 4501            |     | Family Number                                      |
| 68.          | FILLER                    | 99              | 4502              | 4600            |     | Filler   |

**Special instruction:**

All records must be fixed length:

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

C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields

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

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

**Special instruction:**

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is ‘implied’ and will not be included.

C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields

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

| <b>Field Number</b> | <b>Field Name</b>        | <b>Number of Bytes</b> | <b>Starting Location</b> | <b>Ending Location</b> | <b>N/C</b> | <b>Description/Mask</b>  |
|---------------------|--------------------------|------------------------|--------------------------|------------------------|------------|--|
| 1.                  | DEC-ENC-KEY              | 23                     | 1                        | 23                     |            | The following 3 fields, though separate, combine to make a unique Encounter Control Number (ECN) within the SCDHHS system. |
| 2.                  | DEC-ENC-ID-NO            | 16                     | 1                        | 16                     | C          | MCO own reference number   |
| 3.                  | DEC-ENC-IND              | 1                      | 17                       | 17                     | C          | Value = 'E'  |
| 4.                  | DEC-PROV-NUMBER          | 6                      | 18                       | 23                     | C          | State assigned number of MCO   |
| 5.                  | DEC-INDIVIDUAL-NO        | 10                     | 24                       | 33                     | C          | Recipient Medicaid number  |
| 6.                  | DEC-INDIV-NO-CHECK-DIGIT | 1                      | 24                       | 24                     | C          | Check digit  |
| 7.                  | DEC-INDIV-NO             | 9                      | 25                       | 33                     | C          | Number   |
| 8.                  | DEC-ENC-DOC-TYPE         | 1                      | 34                       | 34                     | C          | Value 'A' = HIC<br>'D' = Drug<br>'Z' = Hospital<br>UB  |
| 9.                  | DEC-HMO-RECIP-ID         | 15                     | 35                       | 49                     | C          | HMO recipient number assigned by HMO   |
| 10.                 | DEC-PEP-HMO-IND          | 1                      | 50                       | 50                     | C          | Designates type of PEP/HMO<br>Value 'P' = PEP<br>'H' = HMO   |
| 11.                 | DEC-FORMAT               | 2                      | 51                       | 52                     | C          | FOR INTERNAL USE ONLY<br>Designates format of input encounter<br>Value '01 – 06'   |
| 12.                 | DEC-ENC-SUBMIT-DATE      | 7                      | 53                       | 59                     | C          | Julian date encounter submitted<br>Mask: CCYYDDD   |
| 13.                 | DEC-PROCESS-DATE-8       | 8                      | 60                       | 67                     | N          | Date encounter processed in MMIS<br>Mask: CCYYMMDD   |
| 14.                 | DEC-ENC-DATA-            | 1                      | 68                       | 68                     | C          | Status of encounter  |

| Field Number | Field Name                  | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-----------------------------|-----------------|-------------------|-----------------|-----|---|
|              | STATUS                      |                 |                   |                 |     | after edit<br>Value 'G' = good data<br>'F' = flawed data<br>'I' = ignore data<br>'T' = TPL data   |
| 15.          | DEC-HMO-PROV-INFO           | 28              | 69                | 96              | C   | Provider information  |
| 16.          | DEC-PROVIDER-TYPE           | 2               | 69                | 70              | C   | Managed Care provider type  |
| 17.          | DEC-PROVIDER-NAME           | 26              | 71                | 96              | C   | Managed Care provider name  |
| 18.          | DEC-ENC-RECIP-INFO          | 63              | 97                | 159             |     | Recipient information   |
| 19.          | DEC-RECIP-LAST-NM           | 17              | 97                | 113             | C   | Recipient Last Name   |
| 20.          | DEC-RECIP-FIRST-NM          | 14              | 114               | 127             | C   | Recipient First Name  |
| 21.          | DEC-RECIP-MIDDLE-INIT       | 1               | 128               | 128             | D   | Recipient Middle Initial  |
| 22.          | DEC-DOB-8                   | 8               | 129               | 136             | C   | Recipient date of birth<br>Mask: CCYYMMDD   |
| 23.          | DEC-SEX                     | 1               | 137               | 137             | C   | Sex   |
| 24.          | DEC-AGE                     | 3               | 138               | 140             | N   | Age in years  |
| 25.          | DEC-RACE                    | 2               | 141               | 142             | C   | Race code   |
| 26.          | DEC-COUNTY                  | 2               | 143               | 144             | C   | County Code   |
| 27.          | DEC-ASSIST-PAYMENT-CATEGORY | 2               | 145               | 146             | C   | Recipient category of payment assigned by DSS   |
| 28.          | DEC-QUALIFYING-CATEGORY     | 2               | 147               | 148             | C   | Status that qualifies recipient for benefits  |
| 29.          | DEC-QMB-IND                 | 1               | 149               | 149             | C   | Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level |

| Field Number | Field Name                        | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|-----------------------------------|-----------------|-------------------|-----------------|-----|--|
| 30.          | DEC-RSP-PGM-IND (occurs 6 times)  | 1               | 150               | 155             | C   | Indicates enrollment in special programs<br>This is an array field and occurs 6 times in this space.           |
| 31.          | FILLER                            | 4               | 156               | 159             | C   |  |
| 32.          | DEC-ENC-TPL-INFO (occurs 3 times) | 71              | 160               | 372             |     | Third party insurance information<br>Occurs 3 times  |
| 33.          | DEC-CARRIER-CODE                  | 5               | 160               | 164             | C   | Carrier Code   |
| 34.          | DEC-POLICY-NUMBER                 | 25              | 165               | 189             | C   | Policy number  |
| 35.          | DEC-INS-LAST-NAME                 | 17              | 190               | 206             | C   | Insured's Last Name  |
| 36.          | DEC-INS-FIRST-NAME                | 14              | 207               | 220             | C   | Insured's First Name   |
| 37.          | DEC-INS-MIDDLE-INITIAL            | 1               | 221               | 221             | C   | Insured's Middle Initial   |
| 38.          | DEC-CARRIER-PAID-INP              | 9               | 222               | 230             | C   | Mask: 9999999V99   |
| 39.          | FILLER                            | 1               | 373               | 373             | C   |  |
| 40.          | FILLER                            | 1               | 374               | 374             | C   |  |
| 41.          | DEC-PAYMENT-DENIED-IND            | 1               | 375               | 375             | C   | <b>FOR FUTURE USE</b><br>THIS FIELD IS NOT CURRENTLY BEING USED, PLEASE LEAVE THIS FIELD BLANK.                |
| 42.          | DEC-ADJUSTMENT-IND                | 1               | 376               | 376             | C   | Identifies as being voided or canceled<br>Value 'V' = void/cancel  |
| 43.          | DEC-ENC-IND-1                     | 1               | 377               | 377             | C   | Possible future use  |
| 44.          | DEC-CLAIM-PAID-DATE               | 4               | 378               | 381             | C   | Date claim paid<br>Mask: YYMM  |
| 45.          | DEC-ENCOUNTER-STATUS              | 1               | 382               | 382             | C   | Indicates if the encounter was accepted<br>Value 'A' = accepted<br>'R' = replacement needed<br>'D' = duplicate |

| Field Number | Field Name              | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-------------------------|-----------------|-------------------|-----------------|-----|---|
|              |                         |                 |                   |                 |     | 'T' = TPL<br>'V' = voided<br>'X' = deleted  |
| 46.          | DEC-REPLACED-ECN        | 17              | 383               | 399             | C   | Claim number of a replacement encounter   |
| 47.          | FILLER                  | 5               | 400               | 404             | C   |   |
| 48.          | FILLER                  | 2               | 400               | 401             | C   |   |
| 49.          | FILLER                  | 2               | 402               | 403             | C   |   |
| 50.          | FILLER                  | 1               | 404               | 404             | C   |   |
| 51.          | FILLER                  | 10              | 405               | 414             | C   |   |
| 52.          | FILLER                  | 35              | 415               | 449             | C   |   |
| 53.          | DEC-ERROR-COUNT         | 2               | 450               | 451             |     | Number of errors on the encounter<br>Mask: S9999 COMP (signed packed EBCDIC)                  |
| 54.          | DEC-ERROR-CODE-ARRAY    | 300             | 452               | 751             |     | This array allows for 50 entries, 6 bytes each  |
| 55.          | DEC-ERROR-LINE-NO       | 2               | 452               | 453             | C   | Line on which the error occurred  |
| 56.          | DEC-ERROR-CODE          | 3               | 454               | 456             | C   | Error code assigned   |
| 57.          | DEC-ENC-ERROR-STATUS    | 1               | 457               | 457             | C   | Type of error<br>Value 'C' = critical<br>'N' = non critical<br>'I' = ignore                   |
| 58.          | DEC-PAID-TO-PROVIDER-NO | 6               | 752               | 757             | C   | This is to whom the payment was made. This is usually the SERVICE PROVIDER NUMBER (pharmacy). |
| 59.          | DEC-PROV-COUNTY         | 2               | 758               | 759             | C   | Performing provider county  |
| 60.          | DEC-DRUG-CODE           | 11              | 760               | 770             | C   | National drug code number   |
| 61.          | DEC-DRUG-NAME           | 40              | 771               | 810             | C   | DESI drug name  |
| 62.          | DEC-ENC-PRESCRIPTION-NO | 15              | 811               | 825             | C   | Prescription number   |
| 63.          | DEC-DISPENSE-DATE-8     | 8               | 826               | 833             | C   | Date which prescription was dispensed   |

| Field Number | Field Name              | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-------------------------|-----------------|-------------------|-----------------|-----|---|
|              |                         |                 |                   |                 |     | Mask: CCYYMMDD  |
| 64.          | DEC-DAYS-SUPPLY-INPUT   | 3               | 834               | 836             | N   | Number of days supply   |
| 65.          | DEC-UNIT-TYPE           | 3               | 837               | 839             | X   |   |
| 66.          | DEC-QUANTITY-DISPENSED  | 6               | 840               | 845             | N   | Amount dispensed  |
| 67.          | DEC-THERAPEUTIC-CLASS   | 6               | 846               | 851             | C   | Therapeutic class from drug record  |
| 68.          | DEC-REIMBURSE-METHOD    | 1               | 852               | 852             | C   | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For Service<br>Value 'T' = Procedure/Service paid by TPL<br>Value 'Z' = Zero Billed/Provider did not charge |
| 69.          | DEC-TOT-AMT-HMO-BILLED  | 9               | 853               | 861             | N   | Amount billed for service<br>Mask: S9999999V99 (this is zone signed)  |
| 70.          | DEC-TOT-AMT-HMO-PAID    | 9               | 862               | 870             | N   | Amount paid for service rendered<br>Mask: S9999999V99 (this is zone signed)   |
| 71.          | DEC-PRESC-PROV-NO       | 6               | 871               | 876             | C   | Prescribing physician number  |
| 72.          | DEC-REFILL              | 2               | 877               | 878             | N   | Indicates new RX (blank) or number f refills used   |
| 73.          | DEC-PAY-TO-PROVIDER-NPI | 10              | 879               | 888             | C   | This is to whom the payment was made. This is usually the SERVICE PROVIDER NPI (Pharmacy).  |
| 74.          | DEC-PRESCRIBING-NPI     | 10              | 889               | 898             | C   | Prescribing Physician NPI   |
| 75.          | FILLER                  | 1366            | 899               | 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

This is also the same layout we use for our encounter void file. You identify that the record is a void by a 'V' in offset/byte 376.

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

| <b>Field Number</b> | <b>Field Name</b>        | <b>Number of Bytes</b> | <b>Starting Location</b> | <b>Ending Location</b> | <b>N/C</b> | <b>Description/Mask</b>  |
|---------------------|--------------------------|------------------------|--------------------------|------------------------|------------|--|
| 1.                  | HEC-ENC-KEY              | 23                     | 1                        | 23                     |            | The following 3 fields, though separate, combine to make a unique Encounter Control Number (ECN) within the SCDHHS system. |
| 2.                  | HEC-ENC-ID-NO            | 16                     | 1                        | 16                     | C          | MCO own reference number   |
| 3.                  | HEC-ENC-IND              | 1                      | 17                       | 17                     | C          | Value = 'E'  |
| 4.                  | HEC-PROV-NUMBER          | 6                      | 18                       | 23                     | C          | State assigned number of MCO   |
| 5.                  | HEC-INDIVIDUAL-NO        | 10                     | 24                       | 33                     | C          | Recipient Medicaid number  |
| 6.                  | HEC-INDIV-NO-CHECK-DIGIT | 1                      | 24                       | 24                     | C          | Check digit  |
| 7.                  | HEC-INDIV-NO             | 9                      | 25                       | 33                     | C          | Number   |
| 8.                  | HEC-ENC-DOC-TYPE         | 1                      | 34                       | 34                     | C          | Value 'A' = HIC<br>'D' = Drug<br>'Z' = Hospital UB   |
| 9.                  | HEC-HMO-RECIP-ID         | 15                     | 35                       | 49                     | C          | HMO recipient number assigned by HMO   |
| 10.                 | HEC-PEP-HMO-IND          | 1                      | 50                       | 50                     | C          | Designates type of PEP/HMO<br>Value 'P' = PEP<br>'H' = HMO   |
| 11.                 | HEC-FORMAT               | 2                      | 51                       | 52                     | C          | FOR INTERNAL USE ONLY<br>Designates format of input encounter<br>Value '01 – 06'   |
| 12.                 | HEC-ENC-SUBMIT-DATE      | 7                      | 53                       | 59                     | C          | Julian date encounter submitted<br>CCYYDDD   |
| 13.                 | HEC-PROCESS-DATE-8       | 8                      | 60                       | 67                     | N          | Date encounter processed in MMIS<br>Mask: CCYYMMDD   |
| 14.                 | HEC-ENC-DATA-STATUS      | 1                      | 68                       | 68                     | C          | Status of encounter after  |

| Field Number | Field Name                           | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|--------------------------------------|-----------------|-------------------|-----------------|-----|---|
|              |                                      |                 |                   |                 |     | edit<br>Value 'G' = good data<br>'F' = flawed data<br>'I' = ignore data<br>'T' = TPL data   |
| 15.          | HEC-HMO-PROV-INFO                    | 28              | 69                | 96              | C   | Provider information  |
| 16.          | HEC-PROVIDER-TYPE                    | 2               | 69                | 70              | C   | Managed Care provider type  |
| 17.          | HEC-PROVIDER-NAME                    | 26              | 71                | 96              | C   | Managed Care provider name  |
| 18.          | HEC-ENC-RECIP-INFO                   | 63              | 97                | 159             |     | Recipient information   |
| 19.          | HEC-RECIP-LAST-NM                    | 17              | 97                | 113             | C   | Recipient Last Name   |
| 20.          | HEC-RECIP-FIRST-NM                   | 14              | 114               | 127             | C   | Recipient First Name  |
| 21.          | HEC-RECIP-MIDDLE-INIT                | 1               | 128               | 128             | D   | Recipient Middle Initial  |
| 22.          | HEC-DOB-8                            | 8               | 129               | 136             | C   | Recipient date of birth<br>CCYYMMDD   |
| 23.          | HEC-SEX                              | 1               | 137               | 137             | C   | Sex   |
| 24.          | HEC-AGE                              | 3               | 138               | 140             | N   | Age in years  |
| 25.          | HEC-RACE                             | 2               | 141               | 142             | C   | Race code   |
| 26.          | HEC-COUNTY                           | 2               | 143               | 144             | C   | County Code   |
| 27.          | HEC-ASSIST-PAYMENT-CATEGORY          | 2               | 145               | 146             | C   | Recipient category of payment assigned by DSS   |
| 28.          | HEC-QUALIFYING-CATEGORY              | 2               | 147               | 148             | C   | Status that qualifies recipient for benefits  |
| 29.          | HEC-QMB-IND                          | 1               | 149               | 149             | C   | Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level |
| 30.          | HEC-RSP-PGM-IND<br>(occurs 6 times)  | 1               | 150               | 155             | C   | Indicates enrollment in special programs<br>This is an array field and occurs 6 times in this space.  |
| 31.          | FILLER                               | 4               | 156               | 159             | C   |   |
| 32.          | HEC-ENC-TPL-INFO<br>(occurs 3 times) | 71              | 160               | 372             |     | Third party insurance information   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|------------------------|-----------------|-------------------|-----------------|-----|--|
|              |                        |                 |                   |                 |     | Occurs 3 times   |
| 33.          | HEC-CARRIER-CODE       | 5               | 160               | 164             | C   | Carrier Code   |
| 34.          | HEC-POLICY-NUMBER      | 25              | 165               | 189             | C   | Policy number  |
| 35.          | HEC-INS-LAST-NAME      | 17              | 190               | 206             | C   | Insured's Last Name  |
| 36.          | HEC-INS-FIRST-NAME     | 14              | 207               | 220             | C   | Insured's First Name   |
| 37.          | HEC-INS-MIDDLE-INITIAL | 1               | 221               | 221             | C   | Insured's Middle Initial   |
| 38.          | HEC-CARRIER-PAID-INP   | 9               | 222               | 230             | C   | Mask: 9999999V99   |
| 39.          | FILLER                 | 1               | 373               | 373             | C   |  |
| 40.          | FILLER                 | 1               | 374               | 374             | C   |  |
| 41.          | HEC-PAYMENT-DENIED-IND | 1               | 375               | 375             | C   | <b>FOR FUTURE USE</b><br>THIS FIELD IS NOT CURRENTLY BEING USED, IT SHOULD BE BLANK.   |
| 42.          | HEC-ADJUSTMENT-IND     | 1               | 376               | 376             | C   | Identifies as being voided or canceled<br>Value 'V' = void/cancel  |
| 43.          | HEC-ENC-IND-1          | 1               | 377               | 377             | C   | Possible future use  |
| 44.          | HEC-CLAIM-PAID-DATE    | 4               | 378               | 381             | C   | Date claim paid<br>Mask: YYYYMM  |
| 45.          | HEC-ENCOUNTER-STATUS   | 1               | 382               | 382             | C   | Indicates if the encounter was accepted<br>Value 'A' = accepted<br>'R' = replacement needed<br>'D' = duplicate<br>'T' = TPL<br>'V' = voided<br>'X' = deleted |
| 46.          | HEC-REPLACED-ECN       | 17              | 383               | 399             | C   | Claim number of a replacement encounter  |
| 47.          | FILLER                 | 5               | 400               | 404             | C   |  |
| 48.          | FILLER                 | 2               | 400               | 401             | C   |  |
| 49.          | FILLER                 | 2               | 402               | 403             | C   |  |
| 50.          | FILLER                 | 1               | 404               | 404             | C   |  |
| 51.          | FILLER                 | 10              | 405               | 414             | C   |  |
| 52.          | FILLER                 | 35              | 415               | 449             | C   |  |

| Field Number | Field Name                | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|---------------------------|-----------------|-------------------|-----------------|-----|--|
| 53.          | HEC-ERROR-COUNT           | 2               | 450               | 451             |     | Number of errors on the encounter<br>Mask: S9999 COMP (signed packed EBCDIC) |
| 54.          | HEC-ERROR-CODE-ARRAY      | 300             | 452               | 751             |     | This array allows for 50 entries, 6 bytes each                               |
| 55.          | HEC-ERROR-LINE-NO         | 2               | 452               | 453             | C   | Line on which the error occurred   |
| 56.          | HEC-ERROR-CODE            | 3               | 454               | 456             | C   | Error code assigned  |
| 57.          | HEC-ENC-ERROR-STATUS      | 1               | 457               | 457             | C   | Type of error<br>Value 'C' = critical<br>'N' = non critical<br>'I' = ignore  |
| 58.          | HEC-PRIMARY-CARE-PROV     | 6               | 752               | 757             | C   | Primary care physician   |
| 59.          | HEC-PRIM-DIAG-CODE        | 6               | 758               | 763             | C   | Primary diagnosis  |
| 60.          | HEC-OTHER-DIAG-CODE-TABLE | 18              | 764               | 781             |     | Other diagnoses table contains 3 entries – 6 bytes each                      |
| 61.          | HEC-OTHER-DIAG-CODE       | 6               | 764               | 769             | C   | Other diagnoses code   |
| 62.          | HEC-TOTAL-NUM-LINES       | 2               | 782               | 783             | N   | Total number of encounter lines  |
| 63.          | HEC-HIC-ENC-LINE          | 76              | 784               | 1391            |     | Information for up to 8 lines (table has 8 entries)                          |
| 64.          | HEC-FDOS-CCYY             | 4               | 784               | 787             | C   | First date of service full year<br>CCYY                                      |
| 65.          | HEC-FDOS-mm               | 2               | 788               | 789             | C   | First date of service month<br>MM  |
| 66.          | HEC-FDOS-DD               | 2               | 790               | 791             | C   | First date of service day<br>DD  |
| 67.          | HEC-LDOS-CCYY             | 4               | 792               | 795             | C   | Last date of service full year<br>CCYY                                       |
| 68.          | HEC-LDOS-mm               | 2               | 796               | 797             | C   | Last date of service month<br>MM   |
| 69.          | HEC-LDOS-DD               | 2               | 798               | 799             | C   | Last date of service day<br>DD   |
| 70.          | HEC-PROC-CODE-6           | 6               | 800               | 805             |     | Full 6 byte code   |
| 71.          | HEC-PROC-                 | 1               | 800               | 800             | C   | For future use   |

| Field Number | Field Name              | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-------------------------|-----------------|-------------------|-----------------|-----|---|
|              | BYTE-1                  |                 |                   |                 |     |   |
| 72.          | HEC-PROCEDURE-CODE      | 5               | 801               | 805             | C   | HCPCS code  |
| 73.          | HEC-PROC-CODE-MODIFIER  | 3               | 806               | 808             | C   | Procedure code modifier   |
| 74.          | HEC-UNITS-OF-SERVICE    | 3               | 809               | 811             | C   | Number of visits or services<br>Mask: S999 (field is zone signed)   |
| 75.          | HEC-TWO-BYTE-POS        | 2               | 812               | 813             | C   | Location at which service was rendered<br>Field broke into byte 1 and byte 2  |
| 76.          | HEC-PAID-TO-PROV-NO     | 6               | 814               | 819             | C   | If this is a FQHC or RHC encounter, this is the provider number of the FQHC or RHC in this field. Otherwise it's the Medicaid number (if enrolled in Medicaid) or the unique number assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made. |
| 77.          | HEC-SERVICE-PROV-NO     | 6               | 820               | 825             | C   | Provider rendering service  |
| 78.          | HEC-PROV-COUNTY         | 2               | 826               | 827             | C   | County of service provider  |
| 79.          | HEC-SERVICE-PROV-TYPE   | 2               | 828               | 829             | C   | Service provider type   |
| 80.          | HEC-PRACTICE-SPECIALTY  | 2               | 830               | 831             | C   | Service provider specialty  |
| 81.          | HEC-CATEGORY-OF-SERVICE | 2               | 832               | 833             | C   | Service provider category of service  |
| 82.          | HEC-EPSDT-INDICATOR     | 1               | 834               | 834             | C   | Indicator showing screening follow up needed  |
| 83.          | HEC-REIMBURSE-METHOD    | 1               | 835               | 835             | C   | Indicates HMO method of reimbursement<br>Value 'C' = Capitated<br>Value 'F' = Fee For   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|------------------------|-----------------|-------------------|-----------------|-----|---|
|              |                        |                 |                   |                 |     | Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge |
| 84.          | HEC-AMT-BILLED-BY-PROV | 7               | 836               | 842             | N   | Amount billed for service Mask: S99999V99 (field is zone signed)                                  |
| 85.          | HEC-AMT-PAID-TO-PROV   | 7               | 843               | 849             | N   | Amount paid for service Mask: S99999V99 (field is zone signed)                                    |
| 86.          | HEC-HIC-LINE-IND       | 1               | 850               | 850             | C   | Indicates previous payment for service Value 'D' = duplicate line                                 |
| 87.          | FILLER                 | 9               | 851               | 859             | C   |   |
| 88.          | HEC-LINE-NPI-GROUP-1   |                 |                   |                 |     |   |
| 89.          | HEC-SERVICE-NPI-1      | 10              | 1392              | 1401            | C   | Servicing Provider's NPI  |
| 90.          | HEC-PAID-TO-NPI-1      | 10              | 1402              | 1411            | C   | Paid to's NPI   |
| 91.          | HEC-LINE-NPI-GROUP-2   |                 |                   |                 |     |   |
| 92.          | HEC-SERVICE-NPI-2      | 10              | 1412              | 1421            | C   |   |
| 93.          | HEC-PAID-TO-NPI-2      | 10              | 1422              | 1431            | C   |   |
| 94.          | HEC-LINE-NPI-GROUP-3   |                 |                   |                 |     |   |
| 95.          | HEC-SERVICE-NPI-3      | 10              | 1432              | 1441            | C   |   |
| 96.          | HEC-PAID-TO-NPI-3      | 10              | 1442              | 1451            | C   |   |
| 97.          | HEC-LINE-NPI-GROUP-4   |                 |                   |                 |     |   |
| 98.          | HEC-SERVICE-NPI-4      | 10              | 1452              | 1461            | C   |   |
| 99.          | HEC-PAID-TO-NPI-4      | 10              | 1462              | 1471            | C   |   |
| 100.         | HEC-LINE-NPI-GROUP-5   |                 |                   |                 |     |   |
| 101.         | HEC-SERVICE-NPI-5      | 10              | 1472              | 1481            | C   |   |
| 102.         | HEC-PAID-TO-NPI-5      | 10              | 1482              | 1491            | C   |   |
| 103.         | HEC-LINE-NPI-GROUP-6   |                 |                   |                 |     |   |
| 104.         | HEC-SERVICE-NPI-6      | 10              | 1492              | 1501            | C   |   |
| 105.         | HEC-PAID-TO-NPI-6      | 10              | 1502              | 1511            | C   |   |
| 106.         | HEC-LINE-NPI-GROUP-7   |                 |                   |                 |     |   |
| 107.         | HEC-SERVICE-NPI-7      | 10              | 1512              | 1521            | C   |   |
| 108.         | HEC-PAID-TO-NPI-7      | 10              | 1522              | 1531            | C   |   |
| 109.         | HEC-LINE-NPI-GROUP-8   |                 |                   |                 |     |   |
| 110.         | HEC-SERVICE-NPI-8      | 10              | 1532              | 1541            | C   |   |
| 111.         | HEC-PAID-TO-NPI-8      | 10              | 1542              | 1551            | C   |   |
| 112.         | HEC-PRIMARY-CARE-NPI   | 10              | 1552              | 1561            | C   | Primary Care Provider NPI   |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|------------------------|-----------------|-------------------|-----------------|-----|--|
| 113.         | HEC-PROC-CODE-EDIT-IND | 8               | 1562              | 1569            | C   | <b>OCCURS 8 TIMES (ONE FOR EACH LINE)</b><br><br>Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y' |
| 114.         | FILLER                 | 695             | 1570              | 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

This is also the same layout we use for our encounter void file. You identify that the record is a void by

a 'V' in offset/byte 376.

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

| <b>Field Number</b> | <b>Field Name</b>        | <b>Number of Bytes</b> | <b>Starting Location</b> | <b>Ending Location</b> | <b>N/C</b> | <b>Description/Mask</b>  |
|---------------------|--------------------------|------------------------|--------------------------|------------------------|------------|--|
| 1.                  | ZEC-ENC-KEY              | 23                     | 1                        | 23                     |            | The following 3 fields, though separate, combine to make a unique Encounter Control Number (ECN) within the SCDHHS system. |
| 2.                  | ZEC-ENC-ID-NO            | 16                     | 1                        | 16                     | C          | MCO own reference number   |
| 3.                  | ZEC-ENC-IND              | 1                      | 17                       | 17                     | C          | Value = 'E'  |
| 4.                  | ZEC-PROV-NUMBER          | 6                      | 18                       | 23                     | C          | State assigned number of MCO   |
| 5.                  | ZEC-INDIVIDUAL-NO        | 10                     | 24                       | 33                     | C          | Recipient Medicaid number  |
| 6.                  | ZEC-INDIV-NO-CHECK-DIGIT | 1                      | 24                       | 24                     | C          | CHECK digit  |
| 7.                  | ZEC-INDIV-NO             | 9                      | 25                       | 33                     | C          | Number   |
| 8.                  | ZEC-ENC-DOC-TYPE         | 1                      | 34                       | 34                     | C          | Value 'A' = HIC<br>'D' = Drug<br>'Z' = Hospital UB   |
| 9.                  | ZEC-HMO-RECIP-ID         | 15                     | 35                       | 49                     | C          | HMO recipient number assigned by HMO   |
| 10.                 | ZEC-PEP-HMO-IND          | 1                      | 50                       | 50                     | C          | Designates type of PEP/HMO<br>Value 'P' = PEP<br>'H' = HMO   |
| 11.                 | ZEC-FORMAT               | 2                      | 51                       | 52                     | C          | FOR INTERNAL USE ONLY<br>Designates format of input encounter<br>Value '01 – 06'   |
| 12.                 | ZEC-ENC-SUBMIT-DATE      | 7                      | 53                       | 59                     | C          | Julian date encounter submitted  |

| Field Number | Field Name                  | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-----------------------------|-----------------|-------------------|-----------------|-----|---|
|              |                             |                 |                   |                 |     | CCYYDDDD  |
| 13.          | ZEC-PROCESS-DATE-8          | 8               | 60                | 67              | N   | Date encounter processed in MMIS<br>CCYYMMDD  |
| 14.          | ZEC-ENC-DATA-STATUS         | 1               | 68                | 68              | C   | Status of encounter after edit<br>Value 'G' = good data<br>'F' = flawed data<br>'I' = ignore data<br>'T' = TPL data |
| 15.          | ZEC-HMO-PROV-INFO           | 28              | 69                | 96              | C   | Provider information  |
| 16.          | ZEC-PROVIDER-TYPE           | 2               | 69                | 70              | C   | Managed Care provider type  |
| 17.          | ZEC-PROVIDER-NAME           | 26              | 71                | 96              | C   | Managed Care provider name  |
| 18.          | ZEC-ENC-RECIP-INFO          | 63              | 97                | 159             |     | Recipient information   |
| 19.          | ZEC-RECIP-LAST-NM           | 17              | 97                | 113             | C   | Recipient Last Name   |
| 20.          | ZEC-RECIP-FIRST-NM          | 14              | 114               | 127             | C   | Recipient First Name  |
| 21.          | ZEC-RECIP-MIDDLE-INIT       | 1               | 128               | 128             | D   | Recipient Middle Initial  |
| 22.          | ZEC-DOB-8                   | 8               | 129               | 136             | C   | Recipient date of birth<br>CCYYMMDD   |
| 23.          | ZEC-SEX                     | 1               | 137               | 137             | C   | Sex   |
| 24.          | ZEC-AGE                     | 3               | 138               | 140             | N   | Age in years  |
| 25.          | ZEC-RACE                    | 2               | 141               | 142             | C   | Race code   |
| 26.          | ZEC-COUNTY                  | 2               | 143               | 144             | C   | County Code   |
| 27.          | ZEC-ASSIST-PAYMENT-CATEGORY | 2               | 145               | 146             | C   | Recipient category of payment assigned by DSS   |

| Field Number | Field Name                           | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|--------------------------------------|-----------------|-------------------|-----------------|-----|---|
| 28.          | ZEC-QUALIFYING-CATEGORY              | 2               | 147               | 148             | C   | Status that qualifies recipient for benefits  |
| 29.          | ZEC-QMB-IND                          | 1               | 149               | 149             | C   | Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level |
| 30.          | ZEC-RSP-PGM-IND<br>(occurs 6 times)  | 6               | 150               | 155             | C   | Indicates enrollment in special programs<br>This is an array field and occurs 6 times in this space.  |
| 31.          | FILLER                               | 4               | 156               | 159             | C   |   |
| 32.          | ZEC-ENC-TPL-INFO<br>(occurs 3 times) | 71              | 160               | 372             |     | Third party insurance information<br>Occurs 3 times   |
| 33.          | ZEC-CARRIER-CODE                     | 5               | 160               | 164             | C   | Carrier Code  |
| 34.          | ZEC-POLICY-NUMBER                    | 25              | 165               | 189             | C   | Policy number   |
| 35.          | ZEC-INS-LAST-NAME                    | 17              | 190               | 206             | C   | Insured's Last Name   |
| 36.          | ZEC-INS-FIRST-NAME                   | 14              | 207               | 220             | C   | Insured's First Name  |
| 37.          | ZEC-INS-MIDDLE-INITIAL               | 1               | 221               | 221             | C   | Insured's Middle Initial  |
| 38.          | ZEC-CARRIER-PAID-INP                 | 9               | 222               | 230             | C   | Mask:<br>9999999V99   |
| 39.          | FILLER                               | 1               | 373               | 373             | C   |   |
| 40.          | FILLER                               | 1               | 374               | 374             | C   |   |
| 41.          | ZEC-PAYMENT-DENIED-IND               | 1               | 375               | 375             | C   | <b>FOR FUTURE USE</b>   |

| Field Number | Field Name           | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|----------------------|-----------------|-------------------|-----------------|-----|--|
|              |                      |                 |                   |                 |     | THIS FIELD IS NOT CURRENTLY BEING USED, PLEASE LEAVE THIS FIELD BLANK.   |
| 42.          | ZEC-ADJUSTMENT-IND   | 1               | 376               | 376             | C   | Identifies as being voided or canceled<br>Value 'V' = void/cancel  |
| 43.          | ZEC-ENC-IND-1        | 1               | 377               | 377             | C   | Possible future use  |
| 44.          | ZEC-CLAIM-PAID-DATE  | 4               | 378               | 381             | C   | Date claim paid<br>Mask: YYMM  |
| 45.          | ZEC-ENCOUNTER-STATUS | 1               | 382               | 382             | C   | Indicates if the encounter was accepted<br>Value 'A' = accepted<br>'R' = replacement needed<br>'D' = duplicate<br>'T' = TPL<br>'V' = voided<br>'X' = deleted |
| 46.          | ZEC-REPLACED-ECN     | 17              | 383               | 399             | C   | Claim number of a replacement encounter  |
| 47.          | FILLER               | 5               | 400               | 404             | C   |  |
| 48.          | FILLER               | 2               | 400               | 401             | C   |  |
| 49.          | FILLER               | 2               | 402               | 403             | C   |  |
| 50.          | FILLER               | 1               | 404               | 404             | C   |  |
| 51.          | FILLER               | 10              | 405               | 414             | C   |  |
| 52.          | FILLER               | 35              | 415               | 449             | C   |  |
| 53.          | ZEC-ERROR-COUNT      | 2               | 450               | 451             |     | Number of errors on the encounter<br>Mask: S9999<br>COMP (signed)  |

| Field Number | Field Name              | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-------------------------|-----------------|-------------------|-----------------|-----|---|
|              |                         |                 |                   |                 |     | packed EBCDIC)  |
| 54.          | ZEC-ERROR-CODE-ARRAY    | 300             | 452               | 751             |     | This array allows for 50 entries, 6 bytes each  |
| 55.          | ZEC-ERROR-LINE-NO       | 2               | 452               | 453             | C   | Line on which the error occurred  |
| 56.          | ZEC-ERROR-CODE          | 3               | 454               | 456             | C   | Error code assigned   |
| 57.          | ZEC-ENC-ERROR-STATUS    | 1               | 457               | 457             | C   | Type of error<br>Value 'C' = critical<br>'N' = non critical<br>'I' = ignore                                 |
| 58.          | ZEC-PRIMARY-CARE-PROV   | 6               | 752               | 757             | C   | Primary care physician  |
| 59.          | ZEC-PAID-TO-PROV-NO     | 6               | 758               | 763             | C   | This is to whom the payment was made. This is usually the SERVICE PROVIDER NUMBER (Hospital's Medicaid ID). |
| 60.          | ZEC-SERVICE-PROV-TYPE   | 2               | 764               | 765             | C   | Service provider type   |
| 61.          | ZEC-SERVICE-PROV-COS    | 2               | 766               | 767             | C   | Service provider category of service  |
| 62.          | ZEC-SERVICE-PROV-COUNTY | 2               | 768               | 769             | C   | County of service provider  |
| 63.          | ZEC-ADMIT-DIAGNOSIS     | 6               | 770               | 775             | C   | Inpatient admission diagnosis   |
| 64.          | ZEC-ADMIT-DATE-8        | 8               | 776               | 783             | C   | Date of hospital admission<br>Mask:<br>CCYYMMDD   |
| 65.          | ZEC-DISCHARGE-DATE-8    | 8               | 784               | 791             | C   | Date of discharge from hospital   |
| 66.          | ZEC-PATIENT-STATUS      | 2               | 792               | 793             | C   | Status of patient upon discharge  |
| 67.          | ZEC-PRIM-DIAG-CODE      | 6               | 794               | 799             | C   | Primary diagnosis   |
| 68.          | ZEC-OTHER-DIAG-CODE     | 48              | 800               | 847             | C   | Other diagnoses   |
| 69.          | ZEC-FROM-DATE-8         | 8               | 848               | 855             | C   | Date service  |

| Field Number | Field Name             | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|------------------------|-----------------|-------------------|-----------------|-----|--|
|              |                        |                 |                   |                 |     | began<br>Mask:<br>CCYYMMDD   |
| 70.          | ZEC-TO-DATE-8          | 8               | 856               | 863             | C   | Last date of service<br>Mask:<br>CCYYMMDD  |
| 71.          | ZEC-PRIN-SURG-CODE     | 6               | 864               | 869             | C   | Principal surgical code  |
| 72.          | ZEC-PRIN-SURG-DATE-8   | 8               | 870               | 877             | C   | Date principal surgical procedure performed  |
| 73.          | ZEC-OTHER-SURG-DATA    | 14              | 878               | 947             | C   | Other surgical data (occurs 5 times)   |
| 74.          | ZEC-OTHER-SURG-CODE    | 6               | 878               | 883             | C   | Other surgical codes   |
| 75.          | ZEC-OTHER-SURG-DATE-8  | 8               | 884               | 891             | C   | Date other surgical procedure performed<br>Mask:<br>CCYYMMDD   |
| 76.          | ZEC-DRG-VALUE          | 3               | 948               | 950             | C   | DRG assigned to encounter  |
| 77.          | ZEC-TOT-AMT-HMO-BILLED | 9               | 951               | 959             | N   | Amount billed for hospital services<br>Mask<br>S9999999v99<br>(zone signed)  |
| 78.          | ZEC-TOT-AMT-HMO-PAID   | 9               | 960               | 968             | N   | Amount billed for hospital services<br>Mask<br>S9999999v99<br>(zone signed)  |
| 79.          | ZEC-REIMBURSE-METHOD   | 1               | 969               | 969             | C   | Indicates HMO method of reimbursement<br>Value 'C' =<br>Capitated<br>Value 'F' = Fee<br>For Service<br>Value 'T' =<br>Procedure/Service<br>paid by TPL |

| Field Number | Field Name               | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|--------------------------|-----------------|-------------------|-----------------|-----|--|
|              |                          |                 |                   |                 |     | Value 'Z' = Zero Billed/Provider did not charge  |
| 80.          | ZEC-TOTAL-NUM-LINES      | 2               | 970               | 971             | N   | Total number of revenue lines  |
| 81.          | ZEC-ENC-REV-LINE         | 1150            | 972               | 2121            | C   | Revenue line (occurs 50 times x 23 bytes)  |
| 82.          | ZEC-REVENUE-CODE-4       | 4               | 972               | 975             | C   | Revenue code<br>Mask: X – not used at this time<br>XXX – revenue code                            |
| 83.          | ZEC-PROCEDURE-CODE       | 5               | 976               | 980             | C   | Procedure code   |
| 84.          | ZEC-REV92-UNITS-SERV     | 4               | 981               | 984             | N   | Number of days or units of service   |
| 85.          | FILLER                   | 10              | 985               | 994             | C   |  |
| 86.          | ZEC-PRIMARY-CARE-NPI     | 10              | 2122              | 2131            | C   | Primary Care Physician NPI   |
| 87.          | ZEC-PAID-TO-PROVIDER-NPI | 10              | 2132              | 2141            |     | This is to whom the payment was made. This is usually the SERVICE PROVIDER NPI (Hospital's NPI). |
| 88.          | FILLER                   | 123             | 2142              | 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

This is also the same layout we use for our encounter void file. You identify that the record is a void by a 'V' in offset/byte 376.

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
RECORD FOR EPSDT (Wellcare) VISITS AND IMMUNIZATIONS**

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

**Special instruction:**

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.

C = Character – All character fields are left justified and space filled to the right  
Unless otherwise specified there will be no signed fields

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CLAIMS RECORD DESCRIPTION**

| Field Number | Field Name                    | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|-------------------------------|-----------------|-------------------|-----------------|-----|---|
| 1.           | Recipient ID                  | 10              | 1                 | 10              | C   |   |
| 2.           | Filler                        | 1               | 11                | 11              | C   |   |
| 3.           | Claim-Indicator               | 1               | 12                | 12              | C   | 'M' – Verified MHN claim – Recipient is member of a MHN on date of service on the claim. This will be the only indicator found in the sure MHN monthly files. Is not valid for MCO files, or history files.<br>'H' – Verified MCO claim – Recipient is a member of a MCO on the date of service on the claim. Is not valid for MHN files, or history files.<br>'S' - History Claim – Recipient was a current member of the MCO or MHN at run time. Their claims are provided for information. |
| 4.           | Filler                        | 1               | 13                | 13              | C   |   |
| 5.           | Recipient Pay Category        | 2               | 14                | 15              | C   | Table 01 – Assistance Pay Category – at time of claim   |
| 6.           | Filler                        | 1               | 16                | 16              | C   |   |
| 7.           | Recipient RSP code1           | 1               | 17                | 17              | C   | Table 02 – RSP (Recipient Special Program) Codes  |
| 8.           | Filler                        | 1               | 18                | 18              | C   |   |
| 9.           | Recipient RSP code2           | 1               | 19                | 19              | C   | Table 02 Note: If any of the RSP fields (3-9) = '5' then the recipient was in a   |
| 10.          | Filler                        | 1               | 20                | 20              | C   | MHN   |
| 11.          | Recipient RSP code3           | 1               | 21                | 21              | C   | Table 02 at the date of service of this claim.  |
| 12.          | Filler                        | 1               | 22                | 22              | C   |   |
| 13.          | Recipient RSP code4           | 1               | 23                | 23              | C   | Table 02  |
| 14.          | Filler                        | 1               | 24                | 24              | C   |   |
| 15.          | Recipient RSP code5           | 1               | 25                | 25              | C   | Table 02  |
| 16.          | Filler                        | 1               | 26                | 26              | C   |   |
| 17.          | Recipient RSP code6           | 1               | 27                | 27              | C   | Table 02  |
| 18.          | Filler                        | 1               | 28                | 28              | C   |   |
| 19.          | Recipient County              | 2               | 29                | 30              | C   | Table 03 - County Codes - residence county at time of claim   |
| 20.          | Filler                        | 1               | 31                | 31              | C   |   |
| 21.          | Recipient Qualifying Category | 2               | 32                | 33              | C   | Table 04 - Qualifying Category – at time of claim   |
| 22.          | Filler                        | 1               | 34                | 34              | C   |   |

| Field Number | Field Name                 | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|----------------------------|-----------------|-------------------|-----------------|-----|--|
| 23.          | Recipient Date of Birth    | 6               | 35                | 40              | C   | YYMMDD   |
| 24.          | Filler                     | 1               | 41                | 41              |     |  |
| 25.          | Recipient Sex              | 1               | 42                | 42              | C   | Table 12 – Gender  |
| 26.          | Filler                     | 1               | 43                | 43              |     |  |
| 27.          | Claim Control #            | 16              | 44                | 59              | C   |  |
| 28.          | Filler                     | 1               | 60                | 60              |     |  |
| 29.          | Claim Type                 | 1               | 61                | 61              | C   | see table 5 – Claim Type   |
| 30.          | Filler                     | 1               | 62                | 62              |     |  |
| 31.          | Type of Bill               | 1               | 63                | 63              | C   | X=Crossover S-SCHIP  |
| 32.          | Filler                     | 1               | 64                | 64              |     |  |
| 33.          | From Date of Service       | 6               | 65                | 70              | C   | YYMMDD Claim Type Z: Admit Date<br>Claim Type J: Premium Date<br>Claim Type G: First DOS = From<br>All others: Date of Service=FROM  |
| 34.          | Filler                     | 1               | 71                | 71              |     |  |
| 35.          | To Date of Service         | 6               | 72                | 77              | C   | YYMMDD Claim Type Z: Discharge Date = TO<br>Claim Type J: Effective Date of any change   |
| 36.          | Filler                     | 1               | 78                | 78              |     |  |
| 37.          | Date Paid                  | 6               | 79                | 84              | C   | YYMMDD   |
| 38.          | Filler                     | 1               | 85                | 85              |     |  |
| 39.          | Paid Amount                | 10              | 86                | 95              | N   | 9999999.99 Claim Type D,Z,J,G: Total Paid – Claim<br>All others: Total Paid – Line   |
| 40.          | Filler                     | 1               | 96                | 96              |     |  |
| 41.          | Charged Amount             | 10              | 97                | 106             | N   | 9999999.99 Claim Type D,Z,J,G: Total Charged – Claim<br>All others: Total Charged for Line   |
| 42.          | Filler                     | 1               | 107               | 107             |     |  |
| 43.          | Amt received - other (TPL) | 10              | 108               | 117             | N   | 9999999.99 Claim Type G (Nursing Home):<br>Patient income applied to bill. All others claim types – Any other amt received.<br>CLAIM Level field, not line i.e. for HIC & Dental, use only 1 per claim |
| 44.          | Filler                     | 1               | 118               | 118             |     |  |
| 45.          | Clm Copayment Amount       | 8               | 119               | 126             | N   | 999999.99 A(HIC), (B)Dental - Line Level<br>D(Drug), (Z)UB92 - Claim Level   |
| 46.          | Filler                     | 1               | 127               | 127             |     |  |
| 47.          | Line number                | 2               | 128               | 129             | C   | A (HIC) B (Dental) - Line number<br>D - Medically necessary (field 1) Values: Y=YES,<br>N or Blank or zero = NO<br>All others: not used, will be 01  |
| 48.          | Filler                     | 1               | 130               | 130             |     |  |

| Field Number | Field Name                | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask   |
|--------------|---------------------------|-----------------|-------------------|-----------------|-----|--|
| 49.          | Payment Message Indicator | 1               | 131               | 131             | C   | Table 16 – Payment Messages<br>HIC – Payment Message indicator (determines how surgical claim is paid.<br>DRUG – Brand name medically necessary code<br>DENTAL – Oral surgery indicator<br>UB92 - Reimbursement Type   |
| 50.          | Filler                    | 1               | 132               | 132             |     |  |
| 51.          | Service Code              | 11              | 133               | 143             | C   | A (HIC), B (DENTAL) – Procedure Subfile & Code (first 6 bytes)<br>Subfile = Table 6, Procedure Code – File 1<br>D (DRUG) - NDC code (all 11 bytes) - File 6 – NDC Drug Code<br>Z (UB92) – attending MD UPIN if present |
| 52.          | Filler                    | 1               | 144               | 144             |     |  |
| 53.          | Proc code modifier        | 3               | 145               | 147             | C   | A (HIC), B (DENT) – Procedure Code Modifier - Table 7<br>Z (UB92) - Type of Bill - Table 7Z  |
| 54.          | Filler                    | 1               | 148               | 148             |     |  |
| 55.          | Place of service          | 2               | 149               | 150             | C   | A (HIC) - 2 byte place of service Table 8<br>B (DENT) - 1 byte place of service Table 8<br>Z (UB92) - Patient Status Table 8Z<br>All others – not used   |
| 56.          | Filler                    | 1               | 151               | 151             |     |  |
| 57.          | Units                     | 4               | 152               | 155             | N   | A (HIC), B (DENT) - units<br>D (DRUG) – Quantity<br>Z (UB92) - Inpatient - Covered Days<br>G (NH) - Total days<br>All Others – not used  |
| 58.          | Filler                    | 1               | 156               | 156             |     |  |
| 59.          | Diagnosis code Primary    | 6               | 157               | 162             | C   | A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes<br>D (DRUG) - Therapeutic Class if present – Table 19   |
| 60.          | Filler                    | 1               | 163               | 163             |     |  |
| 61.          | Diagnosis code Second     | 6               | 164               | 169             | C   | A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes<br>D (DRUG) – Generic Class if present  |
| 62.          | Filler                    | 1               | 170               | 170             |     |  |
| 63.          | Diagnosis code Admit      | 6               | 171               | 176             | C   | Z (UB92) only - Admit diagnosis: File #2 – Diagnosis Codes   |
| 64.          | Filler                    | 1               | 177               | 177             |     |  |
| 65.          | Funding code-1            | 2               | 178               | 179             | C   | File # 3 Fund Codes – valid for all claim types  |
| 66.          | Filler                    | 1               | 180               | 180             |     |  |
| 67.          | Funding code-2            | 2               | 181               | 182             | C   | File # 3 Fund Codes - valid only for hospital claims   |
| 68.          | Filler                    | 1               | 183               | 183             |     |  |

| Field Number | Field Name               | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask  |
|--------------|--------------------------|-----------------|-------------------|-----------------|-----|---|
| 69.          | Funding code-3           | 2               | 184               | 185             | C   | File # 3 Fund Codes - valid only for hospital claims  |
| 70.          | Filler                   | 1               | 186               | 186             |     |   |
| 71.          | Paid Provider #          | 6               | 187               | 192             | C   | Provider Paid for the Services<br>File # 4 and # 8 – Provider and Provider Group Affiliations   |
| 72.          | Filler                   | 1               | 193               | 193             |     |   |
| 73.          | Paid Provider Type       | 2               | 194               | 195             | C   | Table # 9 – Provider Types  |
| 74.          | Filler                   | 1               | 196               | 196             |     |   |
| 75.          | Paid Provider Specialty  | 2               | 197               | 198             | C   | Table # 10 – Provider Specialty   |
| 76.          | Filler                   | 1               | 199               | 199             |     |   |
| 77.          | Servicing Provider #     | 6               | 200               | 205             |     | A (HIC) and B (DENT) – Provider of services<br>All others – same as Paid Provider<br>File # 4 and # 8 – Provider and Provider Group Affiliations  |
| 78.          | Filler                   | 1               | 206               | 206             |     |   |
| 79.          | Servicing Prov Type      | 2               | 207               | 208             | C   | A (HIC) and B (DENT): Provider of services<br>All others – same as Paid Provider<br>Table # 9 – Provider Types  |
| 80.          | Filler                   | 1               | 209               | 209             |     |   |
| 81.          | Servicing Prov Specialty | 2               | 210               | 211             | C   | For A (HIC) and B (DENT) – provider of services<br>UB92, BIO – Category of Service of Paid Provider – Table 20<br>All others – same as Paid Provider<br>Table # 10 – Provider Specialty |
| 82.          | Filler                   | 1               | 212               | 212             |     |   |
| 83.          | Prescriber ID            | 6               | 213               | 218             | C   | <b>Prescriber Medicaid # if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.</b>  |
| 84.          | Filler                   | 1               | 219               | 219             |     |   |
| 85.          | Prescriber ID-Type       | 2               | 220               | 221             | C   | <b>Prescriber Provider Type if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.</b>   |
| 86.          | Filler                   | 1               | 222               | 222             |     |   |
| 87.          | Prescriber ID-SSN        | 9               | 223               | 231             |     | Prescriber SSN if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:   |
| 88.          | Filler                   | 1               | 232               | 232             | C   |   |
| 89.          | Prescriber ID-NAPB       | 7               | 233               | 239             | C   | Prescriber NAPB if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:  |
| 90.          | Filler                   | 1               | 240               | 240             |     |   |
| 91.          | Refill # (blank if orig) | 2               | 241               | 242             | C   | Blank or zeroes if original RX, otherwise # refills   |
| 92.          | Filler                   | 1               | 243               | 243             |     |   |
| 93.          | Days Supply              | 3               | 244               | 246             | N   |   |
| 94.          | Filler                   | 1               | 247               | 247             |     |   |

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

**Special instruction:**

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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**  
MCO/MHN Recipient Review Recertification File

| Field Number | Field Name         | Number of Bytes | Starting Location | Ending Location | N/ C | Description/Mask                           |
|--------------|--------------------|-----------------|-------------------|-----------------|------|--|
| 1.           | REV-FAMILY -NUMBER | 8               | 1                 | 8               | C    | Recipient identifying family number.       |
| 2.           | Filler             | 1               | 9                 | 9               |      |  |
| 3.           | REV-RECIP-NO       | 10              | 10                | 19              | C    | Recipient identifying Medicaid number.     |
| 4.           | Filler             | 1               | 20                | 20              |      |  |
| 5.           | REV-RECIP-NAME     | 20              | 21                | 40              | C    | Recipient name, Last,First, Middle Initial |
| 6.           | Filler             | 1               | 41                | 41              |      |  |
| 7.           | REV-ADDR-STREET    | 25              | 42                | 66              | C    |  |
| 8.           | Filler             | 1               | 67                | 67              |      |  |
| 9.           | REV-ADDR-CITY      | 20              | 68                | 87              | C    |  |
| 10.          | Filler             | 1               | 88                | 88              |      |  |
| 11.          | REV-ADDR-STATE     | 2               | 89                | 90              | C    |  |
| 12.          | Filler             | 1               | 91                | 91              |      |  |
| 13.          | REV-ADDR-ZIP       | 5               | 92                | 96              | C    |  |
| 14.          | Filler             | 1               | 97                | 97              |      |  |
| 15.          | REV-ADDR-PHONE     | 15              | 98                | 112             | C    |  |
| 16.          | Filler             | 1               | 113               | 113             |      |  |
| 17.          | REV-REVIEW-DATE    | 10              | 114               | 123             | N    | CCYY-MM-DD                                 |
| 18.          | Filler             | 1               | 124               | 124             |      |  |
| 19.          | REV-REVIEW-MAILED  | 10              | 125               | 134             | N    | CCYY-MM-DD                                 |
| 20.          | Filler             | 1               | 135               | 135             |      |  |
| 21.          | REV-PROVIDER-NO    | 6               | 136               | 141             | C    |  |
| 22.          | Filler             | 1               | 142               | 142             |      |  |
| 23.          | REV-BOARD-PROV-NO  | 6               | 143               | 148             | C    | Applicable for medical home programs only  |
| 24.          | Filler             | 1               | 149               | 149             |      |  |
| 25.          | REV-PAYEE-NAME     | 25              | 150               | 174             | C    | Name of payee for family                   |

| Field Number | Field Name                    | Number of Bytes | Starting Location | Ending Location | N/C | Description/Mask                  |
|--------------|-------------------------------|-----------------|-------------------|-----------------|-----|-----------------------------------|
| 26.          | Filler                        | 1               | 175               | 175             |     |                                   |
| 27.          | REV-PAYEE-TYPE                | 3               | 176               | 178             | C   | Payee Type: See Note 1 below.     |
| 28.          | Filler                        | 1               | 179               | 179             |     |                                   |
| 29.          | REV-RECIP-PAY-CAT             | 2               | 180               | 181             | C   | Pay Categories: See Note 2 below. |
| 30.          | Filler                        | 1               | 182               | 182             |     |                                   |
| 31.          | COUNTY-WORKER-FIRST-NAME      | 17              | 183               | 199             | C   |                                   |
| 32.          | Filler                        | 1               | 200               | 200             |     |                                   |
| 33.          | COUNTY-WORKER-LAST-NAME       | 26              | 201               | 226             | C   |                                   |
| 34.          | Filler                        | 1               | 227               | 227             |     |                                   |
| 35.          | COUNTY-WORKER-PHONE           | 10              | 228               | 237             | C   |                                   |
| 36.          | Filler                        | 1               | 238               | 238             |     |                                   |
| 37.          | COUNTY-WORKER-PHONE-EXTENSION | 4               | 239               | 242             | C   |                                   |
| 38.          | Filler                        | 1               | 243               | 243             | C   |                                   |
| 39.          | HOUSEHOLD NUMBER              | 9               | 244               | 252             | C   | Ties households together.         |
| 40.          | Filler                        | 48              | 253               | 300             |     |                                   |

**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

**Note 1: Payee Types for Field 27.**

SEL SELF OR AFDC PAYEE

GDN LEGAL GUARDIAN

REL OTHER RELATIVE  
AGY SOCIAL AGENCY  
PPP PROTECTIVE PAYEE  
REP REPRESENTATIVE PAYEE  
FOS INDICATES FOSTER CHILD  
SPO SPOUSE  
INP LEGALLY INCOMPETENT, NO REPRESENT

**Note 2: Payment Categories for Field 29 = 99.**

**FILES EXCHANGED BETWEEN SCDHHS AND MCOs**

MCO/MAXIMUS Sync File Layout

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

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is ‘implied’ and will not be included.

C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields

## FORMS

## **Plan Initiated Member Disenrollment Form**

The South Carolina Department of Health and Human Services will determine if the Health Plan has shown a good cause to transfer or disenroll the Healthy Connections Kids member. The program manager will give written notification to the Health Plan of the decision. Members have the right to appeal enrollment and disenrollment decisions with the South Carolina Department of Health and Human Services.

The Health Plan shall not discriminate against any member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or natural origin.

Please contact your program manager for the most current form.

Mail the original and completed form to:  
South Carolina Department of Health and Human Services  
Department of Managed Care Enrollment, J8  
1801 Main Street  
Columbia, SC 29202

## SAMPLE WIC REFERRAL FORM

PL103-448, §204(e) requires States using managed care arrangements to serve their beneficiaries to coordinate with WIC. 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 female
- Female who is breast-feeding her infant(s) up to one year postpartum
- Female 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

## 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 or incest.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Both the completed Abortion Statement and appropriate medial records must be submitted with the claim. Form.

## **INSTRUCTIONS FOR COMPLETING ABORTION STATEMENT FORM**

1. Patient's Name: The name of the patient can be typed or handwritten.
2. Patient's SCHIP 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):<br><br> | 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: \_\_\_\_\_

SC Managed Care General Drug Request Form

Instructions to Physicians\*

|   |                    |  |                    |
|---|--------------------|--|--------------------|
| <b>I. Provider Information (Please Print)</b>   |                    | <b>II. Member Information</b>  |                    |
| Prescriber Name:  |                    | Member Name:   |                    |
| Prescriber Specialty:   |                    | Health Plan Member Identification Number:  |                    |
| Prescriber Address:   |                    | Health Plan Pharmacy Help Line Number:   |                    |
| Prescriber NPI#: _____ OR DEA#: _____   |                    | Click Arrow to Choose from a Plan Below  |                    |
| Fax: _____  | Phone: _____       | Date of Birth: _____   |                    |
| Office Contact Name: _____  |                    | Medication Allergies: _____  |                    |
| <b>III. Drug Information (ONE DRUG REQUEST PER FORM)</b>  |                    | Health Plan/Fax Number for Form Submission                                       |                    |
| Drug Name and Strength: _____   |                    | Click Arrow to Choose from a Plan Below  |                    |
| Specific Diagnosis for this Medication: _____   | Dosage Form: _____ | Dosage Interval: _____   | Qty per Day: _____ |
| Expected Length of Therapy: _____   |                    |  |                    |
| <b>IV. Medication History for this Diagnosis</b>  |                    | Number of Refills: _____   |                    |
| <p><b>A.</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Patient has previously tried and failed 2 (two) preferred products. One of which is in the same specific drug class; the other product has the same indication as the product requested. If yes, please indicate specific medications (products) below</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Patient has previously taken the requested product for _____ (give length of time). If yes, please indicate trial below</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Patient has a documented drug interaction. [PROVIDE FURTHER DETAIL IN SECTION V]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Patient has documented adverse drug experiences (side effects, adverse drug reaction). [PROVIDE FURTHER DETAIL IN SECTION V]</p> <p>Product 1: _____ Dates Tried: _____</p> <p>Product 2: _____ Dates Tried: _____</p> <p>B. Is this request for continuation of a previous approval: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>C. Has strength, dosage or quantity required per day increased or decreased? YES <input type="checkbox"/> [Indicate rationale for continuation in section V and submit form] NO <input type="checkbox"/></p> |                    |  |                    |
| <p><b>V. Rationale for Request/Pertinent Clinical Information (ATTACH ADDITIONAL SHEET IF MORE SPACE IS REQUIRED)</b></p> <p>Appropriate Clinical information to support the request on the basis of medical necessity must be submitted. Include copies of dates and values of pertinent lab tests. *Additional Information may be needed for this drug request</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>  |                    |  |                    |
| Provider Signature: _____   |                    | Date: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                    |
| <p><b>MCO USE ONLY</b></p> <p><input type="checkbox"/> Approved      Comments: _____</p> <p><input type="checkbox"/> Denied      Date: ____/____/____      Signature: _____</p> <p>DISCLAIMER: This review does not constitute approval of payment for services. The member must be eligible for services at the time services are rendered.</p>  |                    |  |                    |

\*Regardless of the method (verbal, prescription form, PA form, generic drug request form) a provider uses to request a drug requiring prior authorization, it does not influence the ability to apply the plan's criteria in making decisions. Please consult the specific MCO's Provider manual or Website for additional requirements or information.

## **DEFINITION OF TERMS**

## DEFINITION OF TERMS

The following terms, as used in this guide, shall be construed and interpreted as follows unless the context clearly requires otherwise.

**AAFP** – Academy of Family Physicians

**Abuse** – Means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the SCHIP 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 SCHIP 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.

**Applicant** - An individual seeking SCHIP eligibility through written application.

**CAHPS** - The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of patients' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality.

**CFR** - Code of Federal Regulations.

**CPT-4** - Current Procedural Terminology, most current edition.

**Capitation Payment** - The monthly payment which is paid by SCDHHS to a MCO for each enrolled 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 members.

**Care Coordinator** - The individual responsible for planning, directing and coordinating services to meet identified health care needs of MCO Program members.

**Case Manager** - The individual responsible for identifying and coordinating services necessary to meet service needs of members.

**Certificate of Coverage** - The term which describes services and supplies provided to a 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 MCOs 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 member is responsible.

**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) Well Care services; (7) physician services; and (8) Home health services.

**Contract Dispute** - A circumstance whereby the MCO 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 SCHIP.

**Core Benefits** - A schedule of health care benefits provided to members enrolled in the MCO'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 SCHIP Plan.

**MCO** - The domestic licensed MCO that has executed a formal agreement with SCDHHS to enroll and serve SCHIP Program members under the terms of the Contract. The term MCO shall include all employees, subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a MCO.

**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 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 an SCHIP Program member from the MCO'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 for SCHIP or the SCHIP MCO Program.

**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 XXI SC State SCHIP 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** – any service provided to a Medicaid MCO Program member regardless of how the service was reimbursed and regardless of provider type, practice specialty, or place of services. This would include expanded services/benefits as defined in this contract.

**Enrollment** - The process in which an SCHIP eligible is assigned to a plan or chooses a plan and goes through an educational process as provided by either SCDHHS or its agent.

**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 subcontractors furnish to members.

**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 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 MCO which is currently a non-covered service(s) by the State SCHIP Plan or is an additional covered service furnished by the MCO to members for which the MCO 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 provides a wide range of primary care and enhanced services in a Medically underserved 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 or 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) ( MCO)** - 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. Standards for the measures are set by the NCQA.

**HHS** - United States Department of Health and Human Services.

**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.

**Infant**- See Newborn

**ICD-9** - International Classification of Disease, Clinical Modification, 9<sup>th</sup> Edition, 2008.

**Incentive Arrangement** – Any payment mechanism under which a MCO 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.

**Inquiry** – A routine question/s about a benefit. An inquiry does not automatically invoke a plan sponsor's grievance or coverage determination process.

**Insolvency** - A financial condition in which a MCO's assets are not sufficient to discharge all its liabilities or when the MCO 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 SCHIP members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other SCHIP 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 MCOs.

**Managed Care Plan** - The term "Managed Care Plan" is interchangeable with the terms "MCO", "Plan", or "HMO/MCO".

**Marketing** – Any communication approved by SCDHHS, from an MCO to an SCHIP 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 product, or either to not enroll, or to disenroll from, another MCO 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 SCHIP 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 MCO, its subcontractor, or any out of plan providers.

**Medically Necessary Service** - A service or supply that is:

- Required to identify or treat an illness or injury and
- Prescribed or ordered by a physician and
- Consistent with the covered person's illness, injury or condition and in accordance with proper medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered and
- Required for reasons other than the convenience of the patient. The fact that a service is prescribed does not automatically define the service as medically necessary.

**Member or SCHIP MCO Program member** - An eligible person(s) who voluntarily enrolls with a SCDHHS approved SCHIP MCO.

**Mental Retardation** – This mental disorder is diagnosed in individuals who, from whatever cause, have **intelligence** below an arbitrary level beginning before adulthood and whose adaptive functioning is impaired in any of a variety of areas. The diagnostic criteria for Mental Retardation are as follows:

- A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication,

self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is before age 18 years.

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C. The onset is before age 18 years.

**NCQA**- The National Committee for Quality Assurance is a private, non-for-profit organization founded in 1990, which sets Medicare, Medicaid, and private insurance HEDIS measurements. They have accreditation and certification programs for a different types of health providers and health assessment products.

**NDC** - National Drug Code.

**National Practitioner Data Bank** - A central repository for adverse action and medical malpractice payments. (1-800-767-6732)

**Newborn/Infant** - A live child eligible for enrollment under the Contract under the age of one.

**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 MCO to provide health care services.

**Non-Covered Services** - Services not covered under the Title XXI SC State SCHIP Plan.

**Non-Emergency** - An encounter by a 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 MCO to provide health care services.

**Non-Risk Contract** – A contract under which the MCO—(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.

**Ownership Interest** - The possession of stock, equity in the capital, or any interest in the profits of the MCO. For further definition see 42 CFR 455.101 (1992).

**Plan** - The term " MCO" 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 XXI 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 MCO before they are rendered.

**Provider** – 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 desired 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 XXI SC State SCHIP Plan.

**Referral Services** - Health care services provided to members outside the MCO's designated facilities or its subcontractors when ordered and approved by the MCO, including, but not limited to out-of-plan services which are covered by the MCO.

**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 provides a wide range of primary care and enhanced services in a medically underserved area.

**Risk** - A chance of loss assumed by the MCO which arises if the cost of providing core benefits and covered services to members exceeds the capitation payment by SCDHHS to the MCO under the terms of the Contract.

**Risk Corridor** – A risk sharing mechanism in which States and MCOs share in both profits and losses under the Contract outside predetermined threshold amounts, so that after an initial Corridor in which the MCO 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 MCO is authorized to accept enrollment of eligible members into the MCO'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.

**Social Security Act** - Title 42, United States Code, Chapter 7, as amended.

**South Carolina State Plan for SCHIP** - 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 XXI.

**Subcontract** - A written Contract agreement between the MCO and a third party to perform a specified part of the MCO's obligations as specified under the terms of the Contract.

**Subcontractor** - Any organization or person who provides any functions or service for the MCO specifically related to securing or fulfilling the MCO's obligations to SCDHHS under the terms of the Contract.

**Termination** - The member's loss of eligibility for the S.C. SCHIP MCO Program and therefore automatic disenrollment from the MCO's plan.

**Third Party Resources** - Any entity or funding source other than the SCHIP 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.

**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.

**Title XXI** - 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: Medical visit, routine follow-up to a previously treated condition or illness, and/or any other routine visit for other than the treatment of an illness.

**WIC** - The Supplemental Food Program for Women, Infants, and Children which

provides nutrition counseling, nutrition education, and nutritious foods to pregnant and postpartum women, infants, and children up to the age of two or children deemed nutritional deficient are covered up to age five who have a low income and who are determined to be at nutritional risk.

## **Appendix 1**

## Members' and Potential Members' Bill of Rights

Each Member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, and request that they be amended or corrected.
- To receive 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 MCO 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 MCO's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the MCO's services, to include, but not limited to:
  - Benefits covered.
  - Procedures for obtaining benefits, including any authorization 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 MCO 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 MCO'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 MCO, its providers or SCDHHS treat the members.

## **Appendix 2**

## PROVIDERS' BILL OF RIGHTS

Each Health Care Provider who contracts with SCDHHS or subcontracts with the MCO 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 MCO's policies and procedures covering the authorization of services.
- To be notified of any decision by the MCO 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 members, the denial of coverage of, or payment for, medical assistance.
- The MCO's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification

### **Appendix 3**

## Vision Care Codes

| Optometry<br>Current<br>Procedures |   |
|------------------------------------|---|
| Procedure                          | Procedure Description                     |
| 65205                              | REMOV FB EXTERN EYE CONJUNCT SUPERFICIAL  |
| 65210                              | REMOV FB EXTER EYE CONJUN EMBED NONPERFO  |
| 65220                              | REMOV FB EXT EYE CORNEAL W/O SLIT LAMP    |
| 65222                              | REMOV FB EXT EYE W/SLIT LAMP CORNEAL      |
| 65430                              | SCRAP CORNEA DIAGNOS SMEAR AND/OR CULTUR  |
| 65435                              | REMOV CORNEA EPITHEL W/WO CHEMOCAUTER     |
| 66821                              | DISCISS 2ND CATARCT LASER(YAG) 1+ STAGES  |
| 66825                              | REPOSITION INTRAOC LENS PROSTHES INCIS    |
| 66983                              | REPOSITION INTRAOC LENS PROSTHES INCIS    |
| 66984                              | CATARACT SURG W/LENS INSERTION, 1 STAGE   |
| 66985                              | INSERT INTRAOC LEN PRO NOT W CAT REM      |
| 67820                              | CORRECT TRICHIASIS EPILAT FORCEPS ONLY    |
| 68040                              | EXPRESSION CONJUNCT FOLLICLES(EG TRACHOM  |
| 68761                              | CLOSURE OF THE LACRIMAL PUNCTUM PLUG, EA  |
| 68801                              | DILATION LACRIMAL PUNCTUM,W W/O IRRIGATI  |
| 68840                              | PROB LACRIM CANALICULI W/WO IRRIGATION    |
| 68899                              | UNLISTED PROCEDURE LACRIMAL SYSTEM        |
| 76511                              | OPHTHAL ULTRPSO ECHO A-MODE AMPLIT QUANT  |
| 76512                              | OPHTHAL ULTRASO ECHO CONTRACT B-SCAN      |
| 76516                              | OPHTHALMIC BIOMETRY ULTRA ECHOG A-SCAN    |
| 76519                              | OPHTAL BIOMET ULTRA ECHO A-MOD W LENS CA  |
| 76529                              | OPHTHALMIC ULTRASONIC FOB LOCALIZATION    |
| 87075                              | CULT BACT ANY SOURC ANAEROB W/ID/ISOLATE  |
| 87181                              | SUSCEPT STUD ANTIMICR AGNT AGAR DILUTION  |
| 87205                              | SMEAR,PRIM SOURC W/INTERP;GM/GIEMSA STA   |
| 92002                              | OPHTHALMOLOGICAL SVC INTERMEDIATE NEW PT  |
| 92004                              | OPHTHALMOLOGICAL SVC COMPREHENS NEW PT    |
| 92012                              | OPHTHALMOLOGICAL SVC ESTAB PT INTERMED    |
| 92014                              | OPHTHALMOLOGICAL SVC ESTAB PT COMPHREHENS |
| 92015                              | DETERMINATION OF REFRACTIVE STATE         |
| 92018                              | OPHTHAL EXAM W/ANEST W/WO MANIP.COMPLETE  |
| 92019                              | OPHTHAL EXAM W/ANEST W/WO MANIP..LIMITED  |
| 92020                              | GONIOSCOPY (SEPARATE PROCEDURE)           |
| 92025                              | COMPUTERIZED CORNEAL TOPOGRAPHY           |
| 92060                              | SENSORIMOTOR EXAM W/MULTI MEASUR OCULAR   |
| 92070                              | FITTING/SUPPLY CONTACT LENS TX DISEASE    |

|       |   |
|-------|---|
| 92081 | VISUAL FLD W/DIAG EVALUATION LIMITED EXA  |
| 92082 | VISUAL FLD W/DIAG EVAL INTERMED 2ISOPTER  |
| 92083 | VISUAL FLD W/DIAG EVAL EXTEND EXAM,3+ISO  |
| 92100 | SERIAL TONOMETRY MULTI MEAS INTRAOCULAR   |
| 92120 | TONOGRAPHY W/INTERP/REPORT RECORD INDENT  |
| 92130 | TONOGRAPHY W WATER PROVOCATION            |
| 92135 | SCANNING COMPUTER OPHTHALMIC DIAG IMAGIN  |
| 92136 | OPHTH BIOMETRY,INTERFEROMETRY W/PWR CALC  |
| 92140 | PROVOC TESTS GLAUCOMA W/INTERP/RRT W/O T  |
| 92225 | OPHTHALMOSCOPY EXT W/RETINAL DRAWING INIT |
| 92226 | OPHTHALMOSCOPY SUBSEQUENT                 |
| 92230 | FLUORESCEIN ANGIOSCOPY W/INTERPRET/REPOR  |
| 92235 | FLUORESCEIN ANGIOGRAPHY(INC IMAG) INTERP  |
| 92240 | INDOCYANINE-GREEN ANGIOGR W/INTERP&REPR   |
| 92250 | FUNDUS PHOTOGRAPHY W/INTERP AND REPORT    |
| 92260 | OPHTHALMODYNAMOMETRY                      |
| 92265 | NEEDLE OCULO-ELECTROMYOGRAPHY, 1/2 EYES   |
| 92270 | ELECTRO OCULOGRAPHY                       |
| 92275 | ELECTRORETINOGRAPHY                       |
| 92285 | EXT OCULAR PHOTO W/I&R RPT DOCU OF MED    |
| 92286 | SPEC ANTERIOR SEG PHOTOG W/INTERP & REPO  |
| 92287 | SPECIAL ANTER SEG PHOTO MED DIAG FLU ANG  |
| 92310 | PRESC OPTICAL/PHYSICAL CHARAC FITTING CO  |
| 92311 | RX CORNEAL LENS APHAKIA ONE EYE           |
| 92312 | RX CORNEAL LENS APHAKIA BOTH EYES         |
| 92313 | PRESCRIPTION & FITTING CORNEOSCLERAL LEN  |
| 92330 | RX OCULAR PROSTHESIS                      |
| 92335 | RX OCULAR PROSTHESIS                      |
| 92340 | FITTING OF SPECTACLES EXC FOR APHAKIA MO  |
| 92504 | BINOCULAR MICROSCOPY                      |
| 92541 | SPONTANEOUS NYSTAGMUS TEST INC FIX/RECOR  |
| 92542 | POSITIONAL NYSTAGMUS TEST MINI 4 RECORDI  |
| 92544 | OPTOKINETIC NYSTAGMUS BIDIREC/FOVAL/PERI  |
| 92545 | OSCILLATING TRACKING TEST WITH RECORDING  |
| 92546 | SINUSOIDAL VERTICAL AXIS ROTATIONAL TEST  |
| 92547 | USE OF VERTICAL ELECTRODES-SEP-PRIM PROC  |
| 95060 | OPHTHALMIC MUCOUS MEMBRANE TESTS          |
| 95999 | UNLISTED NEUROLOGICAL PROCEDURE           |
| 96110 | DEVELOP TESTING LIMITED W/INTERP & REPOR  |
| 96111 | DEVELOPMENTAL TESTING; EXTENDED (INCLUDE  |
| 96115 | NEUROBEHAVIORIAL STATUS EXAM W/I&R PR HOU |
| 96116 | NEUROBEHAV STAT EXM,DOC,HOUR,F/F,INT&RPT  |

|       |  |
|-------|--|
| 99050 | SVS PROVIDED O/SIDE CORE HRS-8 TO 5,M-F  |
| 99058 | OFFICE SERVICES ON EMERGENCY BASIS       |
| 99070 | SUPPLIES AND MATERIALS (EXCEPT SPECTACLE |
| 99071 | EDUCATIONAL SUPPLIES COST TO PHYSICIAN   |
| 99080 | SPECIAL REPORTS SUCH AS INSURANCE FORMS  |
| 99082 | UNUSUAL TRAVEL EG TRANSPORT OR ESCORT PT |

## **Appendix 4**



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John D. Meerschaert, FSA  
Principal and Consulting Actuary

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October 30, 2009

Ms. Emma Forkner  
Director  
Department of Health and Human Services  
1801 Main Street  
Columbia, SC 29202-8206

**Re: October 1, 2009 – March 31, 2010 Healthy Connections Kids Rate Calculation and Certification**

Dear Emma:

Thank you for the opportunity to assist the South Carolina Department of Health and Human Services (SC DHHS) with this important project. Our report summarizes the development and actuarial certification of the October 1, 2009 – March 31, 2010 capitation rates for Healthy Connections Kids. Please call me if you have questions. We look forward to discussing the report with you.

Sincerely,

A handwritten signature in black ink, appearing to read "John D. Meerschaert", with a long, sweeping horizontal stroke extending to the right.

John D. Meerschaert, FSA, MAAA  
Principal and Consulting Actuary

JDM/vrr

Attachment



**State of South Carolina  
Department of Health and Human Services  
October 1, 2009 – March 31, 2010  
Capitation Rate Development for  
Healthy Connections Kids**

Prepared for:  
**The State of South Carolina  
Department of Health and Human Services**

Prepared by:  
**Milliman, Inc.**

**Mathieu Doucet, FSA, MAAA**  
Actuary

**John D. Meerschaert, FSA, MAAA**  
Principal and Consulting Actuary

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- I: October 1, 2009 – March 31, 2010 Adjusted Prescription Drug PMPM Cost Estimates
  
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**Fiscal Impact Exhibit:**

K: Fiscal Impact

**Actuarial Certification:**

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**Other Attachments:**

Attachment 1: Data Adjustment Specifications - Standard Managed Care - In-Rate Criteria

Attachment 2: Healthy Connections Kids Benefit Exclusions

## I. EXECUTIVE SUMMARY

This report documents the development of October 1, 2009 – March 31, 2010 capitation rates for the South Carolina Healthy Connections Kids program.

The South Carolina Department of Health & Human Services (SC DHHS) retained Milliman to calculate, document, and certify its capitation rate development. Milliman developed the capitation rates using the methodology described in this report. Milliman’s role is to certify the October 1, 2009 – March 31, 2010 capitation rates produced by the rating methodology are actuarially sound to comply with CMS regulations.

In general, the Healthy Connections Kids rating methodology relies on Medicaid fee-for-service data for the TANF population adjusted to the covered benefits and expected acuity level of the Healthy Connections Kids population. The Healthy Connections Kids methodology is consistent with the Medicaid MCO rating methodology that was implemented for the October 2009 – March 31, 2010 Medicaid MCO rates with several adjustments to reflect differences between the Medicaid managed care program and Healthy Connections Kids.

Appendices A – F document the development of the October 1, 2009 – March 31, 2010 capitation rates for medical benefits. Appendices G – J document the development of the October 1, 2009 – March 31, 2010 capitation rates for prescription drug benefits. Appendix K calculates the fiscal impact of the October 1, 2009 – March 31, 2010 capitation rates. Appendix L contains our actuarial certification.

Section II of the report provides a short background regarding Healthy Connections Kids. Sections III – V document the Healthy Connections Kids capitation rate methodology. Section VI of the report provides information regarding the assignment of service categories. Section VII discusses issues related to the CMS rate setting checklist.

### OCTOBER 1, 2009 – MARCH 31, 2010 CAPITATION RATES AND ACTUARIAL CERTIFICATION

Table 1 shows the statewide rate change from the June 30, 2009 – March 31, 2010 MCO capitation rates to the October 1, 2009 – March 31, 2010 capitation rates.

| <b>Table 1</b><br><b>South Carolina Department of Health and Human Services</b><br><b>October 1, 2009 – March 31, 2010 Healthy Connections Kids Capitation Rate Change</b><br><b>Based on August 2009 Enrollment by Rate Cell</b> |  |                          |
|---|--|--------------------------|
| <b>June 30, 2009 – March 31, 2010 Rate</b>  | <b>October 1, 2009 – March 31, 2010 Rate</b> | <b>Percentage Change</b> |
| \$115.52  | \$122.50                                     | 6.0%                     |

Approximately 2.7% of the 6.0% increase is the result of an update to the MCO selection factor. The rest of the 6.0% increase is the result of updated exclusion logic and provider reimbursement changes. Please refer to pages 5 and 6 of this report for a comprehensive list of changes.

Table 2 provides a comparison of the rate cell specific changes.

| <b>Table 2</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Healthy Connections Kids</b><br><b>October 1, 2009 – March 31, 2010 Capitation Rates</b> |  |                         |                                   |                                  |                           |
|--|--|-------------------------|-----------------------------------|----------------------------------|---------------------------|
| <b>Rate Cell</b>   | <b>June 2009 –<br/>March 2010<br/>Rate</b> | <b>Medical<br/>Rate</b> | <b>Prescription<br/>Drug Rate</b> | <b>Total<br/>Capitation Rate</b> | <b>Percent<br/>Change</b> |
| HCK: 2 - 3 months  | \$1,909.77                                 | \$581.38                | \$15.69                           | \$597.07                         | N/A                       |
| HCK: 4 - 12 months   | 249.52                                     | 235.63                  | 28.47                             | 264.10                           | 5.8%                      |
| HCK: Age 1 – 6   | 119.30                                     | 105.36                  | 21.03                             | 126.39                           | 5.9%                      |
| HCK: Age 7 – 13  | 103.39                                     | 77.67                   | 31.45                             | 109.12                           | 5.5%                      |
| HCK: Age 14 - 18 Male  | 108.74                                     | 86.77                   | 29.26                             | 116.03                           | 6.7%                      |
| HCK: Age 14 - 18 Female  | 136.77                                     | 118.25                  | 27.99                             | 146.24                           | 6.9%                      |
| HCK: Maternity Kicker  | 5,678.80                                   | 5,998.04                | N/A                               | 5,998.04                         | 5.6%                      |

The actuarial certification of the October 1, 2009 – March 31, 2010 Healthy Connections Kids capitation rates is included as Appendix L. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted MCO's situation and experience.

#### **DATA RELIANCE AND IMPORTANT CAVEATS**

We used Medicaid fee-for-service cost and eligibility data for SFY 0607 and SFY 0708, historical reimbursement information, TPL recoveries, fee schedules, and several provider reimbursement analyses to calculate the Healthy Connections Kids capitation rates shown in this report. If the underlying data used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Our report is intended for the internal use of SC DHHS to develop October 1, 2009 – March 31, 2010 Healthy Connections Kids capitation rates. It may not be appropriate for other purposes. We anticipate the report will be shared with contracted MCOs and other interested parties. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. It should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The terms of Milliman's contract with SC DHHS signed on May 2, 2008 apply to this report and its use.

## II. BACKGROUND

SC DHHS is the single state agency in South Carolina responsible for the administration of a program of medical assistance under Title XXI of the Social Security Act known as the SCHIP Program. Title XXI is jointly financed by the Federal and State governments and administered by States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides to States a capped amount of funds at a higher match rate to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children. States may provide coverage by expanding Medicaid, creating a separate program, or a combination of the two.

South Carolina began SCHIP coverage through an expansion of children's Medicaid on August 1, 1997. Partners for Healthy Children (PHC) was created to cover children up to age 19 with income up to 150% of Federal Poverty Level (FPL). By Proviso, 2007 legislation established a separate, stand-alone SCHIP Program named Healthy Connections Kids to expand eligibility for qualifying children under age 19 with income above 150% but less than 200% FPL.

Healthy Connections Kids enrollees are served by four managed care organizations (MCOs) that contract with SC DHHS.

### Who is Eligible?

A child is eligible for Healthy Connections Kids who:

- > Is under 19 years of age
- > Has family income greater than 150% of the Federal Poverty Level and less than 200%
- > Has family countable resources at or below a certain level
- > Does not have comprehensive health coverage (defined as coverage with at minimum, hospitalization, doctor visits, x-ray, and lab coverage)
- > Has been uninsured for three months if comprehensive health coverage was voluntarily dropped
- > Meets non-financial requirements
  - State residency
  - Identity
  - Citizenship
  - Social Security Number
  - Assign rights to medical support

**MCO Covered Services**

- > Autism Spectrum Disorder Benefits
- > Behavioral Health Disorders
- > Chiropractor Services
- > Durable Medical Equipment
- > Emergency Transportation
- > Home Health Care Services
- > Hospice
- > Immunizations
- > Inpatient Hospital Services
- > Lab and X-ray
- > Occupational, Speech, and Physical Therapy
- > Outpatient Services
- > Pap Smear
- > Physician Services:
- > Podiatry Services
- > Prescription Drugs
- > Rehabilitative Care
- > Skilled Nursing Care
- > Transplants
- > Vision Care
- > Well Care

**Non-Covered Services**

- > Family Planning
- > Treatment of Mental Retardation and Developmental Disorders
- > Diet Treatments and Weight Loss Surgery
- > Audiology and Hearing Aids

Dental services are covered outside the MCO benefit package and are reimbursed at the Medicaid fee-for-service rate.

Please refer to the Policy and Procedures Guide for Healthy Connections Kids MCOs for more information.

### III. METHODOLOGY AND RESULTS - GENERAL

This section of the report describes general aspects of the October 1, 2009 – March 31, 2010 South Carolina Healthy Connections Kids capitation rate methodology.

In general, the Healthy Connections Kids rating methodology relies on Medicaid fee-for-service data for the TANF population adjusted to the covered benefits and expected acuity level of the Healthy Connections Kids population. The Healthy Connections Kids methodology is consistent with the Medicaid MCO rating methodology with several adjustments to reflect differences between Medicaid and Healthy Connections Kids.

The Healthy Connections Kids rate methodology is designed to estimate the cost of covering the Healthy Connections Kids population for all covered benefits. The rate methodology is consistent with the Healthy Connections Kids Policy and Procedures Guide.

#### SUMMARY OF CHANGES FROM JUNE 30, 2009 – MARCH 31, 2010 CAPITATION RATES

The October 1, 2009 – March 31, 2010 Healthy Connection Kids capitation rates documented in this report reflect the following changes to the June 30, 2009 – March 31, 2010 Healthy Connections Kids capitation rates documented in our July 6, 2009 report. The changes are further documented within this report on the pages referenced below.

- > Removed the first month of life from the claims and eligibility data used to develop the age 1 – 3 month rate cell and renamed the rate cell age 2 – 3 months. SC DHHS indicated that newborns cannot be enrolled in Healthy Connections Kids until the second month of life.
- > Updated BabyNet and Sickle Cell exclusion logic to reflect current coding (see page 10).
- > Updated the hospital inpatient reimbursement adjustment to reflect the October 1, 2009 hospital specific reimbursement levels (see page 10-11).
- > Updated the hospital outpatient reimbursement adjustment to reflect the October 1, 2009 hospital specific multipliers (see page 11-12).
- > Updated the physician reimbursement adjustment to reflect private rehabilitation therapist reimbursement of 95% of the applicable Medicare fee schedule (see page 12-13).
- > Updated the DME reimbursement adjustment to remove the reduction related to a program to transfer diabetic strips and monitors to a pharmacy point of sale program.
- > Updated the injectible drug reimbursement adjustment to reflect DHHS' October 1, 2009 allowable reimbursement schedule (see page 15).
- > Updated the MCO Selection Factors based on Milliman's August 28, 2009 analysis of the relative risk scores of the SFY 0607 and SFY 0708 Medicaid TANF FFS population compared to the overall (FFS + MCO) population (see page 20).
- > Updated prescription drug costs to add back the cost of expectorants and cough medicines and remove the cost of over the counter (OTC) medications.

- 
- > Implemented several minor revisions to the in-rate criteria in Attachment 1.

Note the trend period is the same as used in the development of the June 30, 2009 – March 31, 2010 capitation rates. The October 1, 2009 – March 31, 2010 rates continue to reflect the same trend period because the June 30, 2009 – September 30, 2009 rate period trend assumed a nine month effective period (through March 31, 2010).

## BASE DATA

SC DHHS provided detailed Medicaid fee-for-service claims and eligibility data from SFY 0405 through October 2008. For the purpose of the October 1, 2009 – March 31, 2010 capitation rate calculation, we used Medicaid fee-for-service data from the two most recent complete state fiscal years available: SFY 0607 and SFY 0708.

Neither fee-for-service data nor credible MCO encounter data is available from the Healthy Connections Kids program.

## RETROACTIVE ELIGIBILITY PERIODS AND ENROLLMENT LAG

Healthy Connections Kids does not allow retroactive eligibility. The Medicaid fee-for-service base used in the Healthy Connections Kids rating methodology must be adjusted to remove the retroactive eligibility period in the same way as the Medicaid MCO rating methodology.

Retroactive exposure and claims were included in the data provided to Milliman by SC DHHS. A beneficiary's retroactive eligibility period is not directly retained in the enrollment data, therefore an estimate of the retroactive exposure and claims were removed for the purposes of the capitation calculations using the following criteria:

- > Newborns are not able to enroll in Healthy Connections Kids until the month after their birth month, therefore claims and eligibility data are removed for a newborn's month of birth,
- > The first two months of claims and eligibility are removed for all other payment categories.
- > Exceptions to the above retroactivity rules are recipients who have coverage that does not lapse for more than one year. In these cases, all eligible months are used after the individual re-enters the Medicaid program. After a one year or longer lapse in Medicaid coverage, an individual is again subject to the retroactivity rules.

**ELIGIBILITY CATEGORY ASSIGNMENT**

The Healthy Connections Kids capitation rates are based on Medicaid FFS data for the Medicaid MCO eligible TANF population. The assignment of payment categories to eligibility category was provided by SC DHHS and is summarized in Table 3 below.

| <b>Table 3</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Eligibility Category Assignment</b> |                             |
|---|-----------------------------|
| <b>Payment Category Code</b>  | <b>Eligibility Category</b> |
| 11  | TANF                        |
| 12  | TANF                        |
| 13  | TANF                        |
| 30  | TANF                        |
| 31  | TANF                        |
| 51  | TANF                        |
| 58  | TANF                        |
| 59  | TANF                        |
| 60  | TANF                        |
| 68  | TANF                        |
| 88  | TANF                        |
| 91  | TANF                        |
| 87  | OCWI                        |

Individuals assigned to the Optional Coverage for (Pregnant) Women and Infants (OCWI) under the age of 7 years old are reclassified as *Temporary Assistance for Needy Families (TANF)*.

Not all Medicaid recipients are eligible to enroll in the Medicaid Managed Care program as defined by Payment Categories and Waiver programs. Table 4 below shows the ineligible payment categories.

| <b>Table 4</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Excluded Payment Category Codes</b> |                         |                         |                            |
|---|-------------------------|-------------------------|----------------------------|
| <b>Payment Category</b>   | <b>Description</b>      | <b>Payment Category</b> | <b>Description</b>         |
| 10  | MAO (Nursing Home)      | 50                      | Qualified Working Disabled |
| 14  | MAO (General Hospital)  | 52                      | SLMB                       |
| 15  | MAO (CLTC Waiver)       | 54                      | SSI Nursing Home           |
| 33  | ABD Nursing Home        | 55                      | Family Planning            |
| 41  | Reinstatement           | 56                      | COSY / ISCEDC              |
| 42  | Silver Card and SLMB    | 70                      | Refugee Entrant            |
| 43  | Silver Card and S2 SLMB | 90                      | QMB                        |
| 48  | S2 SLMB                 | 92                      | Silver Card                |
| 49  | S3 SLMB                 |                         |                            |

Table 5 shows the only waiver programs eligible for Medicaid Managed Care. All other waiver program enrollees are excluded.

| <b>Table 5</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Included Waiver Programs</b> |  |
|--|--|
| <b>Waiver Program Code</b>   | <b>Description</b>                               |
| HRHI   | At Risk Pregnant Women – High                    |
| CHPC   | Children’s Personal Care Aid                     |
| HRLO   | At Risk Pregnant Women – Low                     |
| COSY   | Emotionally Disturbed Children in Beaufort       |
| HREX   | At Risk Pregnant Women – Ex                      |
| ISED   | Emotionally Disturbed Children                   |
| MPCP   | Integrated Personal Care Service CRCF Recipients |

## IV. METHODOLOGY AND RESULTS – MEDICAL BENEFITS

This section of our report describes the October 1, 2009 – March 31, 2010 South Carolina Healthy Connections Kids capitation rate methodology for medical benefits.

### CAPITATION RATE METHODOLOGY – MEDICAL BENEFITS

The methodology used to calculate the medical component of the capitation rates can be outlined in the following steps:

1. Extract TANF fee-for-service experience data for the Medicaid Managed Care eligible population by eligibility category and apply service exclusions.
2. Apply adjustments for reimbursement, benefit limitations, trend, managed care impact, and incurred but not reported (IBNR) claims.
3. Calculate estimated October 1, 2009 – March 31, 2010 managed care costs by eligibility category.
4. Adjust for third party liability (TPL) recoveries, administrative days, selection, autism benefits, and administrative expenses.

Each of the above steps is described in detail below.

#### **Step 1: Extract TANF Fee-For-Service Experience Data**

In this step the TANF fee-for-service experience for SFY 0607 and SFY 0708 is summarized by eligibility category and service category for populations eligible to enroll in the Medicaid Managed Care program. Adjustments are made to account for benefit exclusions. Milliman used Attachment 1 to determine which services were to be excluded from the capitation rate methodology.

Note that additional adjustments to reflect Healthy Connections Kids covered services are applied later in Step 2 of the process.

Appendices A and B show the impact of the Step 1 adjustments.

#### **Cost Sharing**

South Carolina's fee-for-service Medicaid program includes several member copayment amounts that Healthy Connections Kids members are not required to pay, including:

- > \$1.00 copay for podiatrist services.
- > \$2.00 copay for optometrist services, doctor's office visit, home health visits, FQHC / RHC visits, and outpatient surgery services.
- > \$3.00 copay for durable medical equipment, dentist services, prescriptions (per script), and outpatient hospital services.
- > \$25.00 copay for inpatient hospital admissions.

The member copayment amounts are added to the Healthy Connections Kids capitation rate calculation. Copay amounts are insignificant for the age 18 and under population.

**Dental Exclusion:**

All dental services are excluded from the Healthy Connections Kids MCO contract and will be reimbursed on a fee-for-service basis based on the Medicaid benefit level.

**Baby Net and Sickle Cell Exclusion:**

Claims relating to Baby Net and Sickle Cell services are removed from the capitation rate calculation because they are not covered under Healthy Connections Kids.

Baby Net Claims were identified as:

- > Procedure codes T1016, T1017, and T1027
- > Primary diagnosis in the COMDHEC table
- > Provider type 22 (medical clinics) and provider specialty of 51 (DHEC)
- > Provider number of DHEC01 – DHEC 46, DHEC59

Sickle cell claims were identified as:

- > Procedure codes 99204, 99213, 99214, 99215, S0315, S0316, S9445, T1016, and T1017
- > Provider type of 22 (medical clinics) and provider specialty of 96 (family planning, maternal, and child health)
- > Provider number of MC0008, MC0009, MC0010, MC0011, MC0021, or MC0040

**Step 2: Apply Adjustment Factors for Reimbursement, Benefit Limitations, Trend, Managed Care Impact, and IBNR Claims**

In this step we apply adjustment factors to reflect differences between the base period Medicaid fee-for-service data and the Healthy Connections Kids program. Each adjustment factor is explained in detail below.

The base data reflects Medicaid fee-for-service provider reimbursement levels, including GME payments to inpatient facilities and encounter rates paid to FQHCs and RHCs.

Appendices C and D show the impact of the Step 2 adjustments.

**Hospital Inpatient Reimbursement Adjustment:**

SC DHHS implemented reimbursement changes for inpatient facilities on October 1, 2007 and October 1, 2008. To develop the hospital inpatient adjustment factors by rate cell, we separated hospital inpatient claims by facility for each state fiscal year between claims prior to October 1, 2007 and claims after October 1, 2007.

- > Claims prior to October 1, 2007 were adjusted to account for the October 1, 2007 change (the claims after October 1, 2007 already reflect the October 1, 2007 rate change). The October 1, 2007 composite change factor is an increase of 20.1% across all facilities. SC DHHS provided a list of percentage changes by facility. Reimbursement adjustment factors were developed by rate cell based on the mix of expenses incurred at each facility for each rate cell. Facilities not having an explicit percentage change received the average 20.1% increase.

- 
- > All hospital inpatient claims were adjusted to account for the October 1, 2008 rate change. The October 1, 2008 composite change factor is an increase of 16.6% across all facilities. SC DHHS provided a list of percentage changes by facility. Reimbursement adjustment factors were developed by rate cell based on the mix of expenses incurred at each facility for each rate cell. Facilities not having an explicit percentage change received the average 16.6% increase.
  
  - > All hospital inpatient claims were adjusted to account for the October 1, 2009 rate change. The October 1, 2009 composite change factor in an increase of 9.2% across all facilities. SC DHHS provided a list of percentage changes by facility. Reimbursement adjustment factors were developed by rate cell based on the mix of expenses incurred at each facility for each rate cell. Facilities not having an explicit percentage change received the average 9.2% increase.

The impact of the hospital inpatient reimbursement adjustments are shown in Appendices C1 and D1.

**Hospital Outpatient Reimbursement Adjustment:**

SC DHHS implemented reimbursement changes for outpatient facilities on October 1, 2007 and October 1, 2008. Effective October 1, 2007, SC DHHS increased hospital outpatient reimbursement for all facilities. Retroactive to October 1, 2007 and revised on October 1 2008, SC DHHS adjusted outpatient claims reimbursement rates from the statewide fee schedule payment to a hospital specific reimbursement methodology. Outpatient claims are now priced using a hospital specific multiplier to the statewide rate.

To develop the hospital outpatient adjustment factors by rate cell, we separated hospital outpatient claims by facility for each state fiscal year between claims prior to October 1, 2007 and claims after October 1, 2007.

- > Claims prior to October 1, 2007 were adjusted to account for the October 1, 2007 change (the claims after October 1, 2007 already reflect the October 1, 2007 rate change). The October 1, 2007 composite change factor is an increase of 112.9% across all facilities. SC DHHS provided a list of percentage changes by facility. Reimbursement adjustment factors were developed by rate cell based on the mix of expenses incurred at each facility for each rate cell. Facilities not having an explicit percentage change received the average 112.9% increase.
  
- > All hospital outpatient claims were adjusted to account for the October 1, 2008 and October 1, 2009 hospital specific multipliers. The composite change factor is an increase of 36.4% across all facilities. SC DHHS provided a list of percentage changes by facility. Reimbursement adjustment factors were developed by rate cell based on the mix of expenses incurred at each facility for each rate cell. Facilities not having an explicit multiplier received a 1.00 adjustment (consistent with how FFS claims are administered).

The impact of the hospital outpatient reimbursement adjustments are shown in Appendices C1 and D1.

**Physician Reimbursement Adjustment:**

The original capitation rates for the June 30, 2009 – March 31, 2010 rate setting period reflected two physician fee schedules:

1. Effective October 1, 2008, physician reimbursement is 84% of the 2008 South Carolina Medicare fee schedule. Private rehabilitation therapists will be reimbursed at 95% of the Medicare fee schedule for physical therapy, occupational therapy, and speech therapy services. Pediatric sub-specialists will be reimbursed at 117% of the Medicare fee schedule for CPT codes 99201 – 99290 and 99301 – 99477, 120% of the Medicare fee schedule for CPT codes 99291 – 99300, and at 100% of the Medicare fee schedule for all other codes.
2. Effective October 1, 2009, the Medicare fee basis will change from 2008 to April 2009 for all services. Physician reimbursement will be 86% of the South Carolina Medicare fee schedule. Private rehabilitation therapists will be reimbursed at 95% of the Medicare fee schedule for physical therapy, occupational therapy, and speech therapy services. Pediatric sub-specialists will be reimbursed at 120% of the Medicare fee schedule for CPT codes 99201 – 99477 and at 100% of the Medicare fee schedule for all other codes.

The physician reimbursement adjustments for the June 30, 2009 – March 31, 2010 MCO capitation rates reflected three months of the 2008 Medicare fee schedule and October 1, 2008 percentage multipliers and six months of the April 2009 Medicare fee schedule and October 1, 2009 percentage multipliers. The October 1, 2009 – March 31, 2010 rates continue to reflect the blend of three months of 2008 Medicare fees and October 1, 2008 percentage multipliers and six months of April 2009 Medicare fees and October 1, 2009 multipliers because the June 30, 2009 – September 30, 2009 rate period included funding a portion of the increase to the April 2009 Medicare fee schedule basis and October 1, 2009 percentage multipliers.

To develop the adjustment factors shown in Appendices C1 and D1, we summarized physician services by provider type for each rate cell. We also separated the data into fee schedule periods consistent with when SC DHHS changed physician reimbursement rates. We developed reimbursement change factors from the fee schedule period projected to the June 30, 2009 – March 31, 2010 reimbursement levels and applied those factors to each provider type by service category. We then compared the original paid amount by service category to the adjusted amounts to develop the physician reimbursement factor.

The reimbursement change factors reflect two components:

- > A fee schedule percentage change, and
- > A fee schedule RBRVS change

The fee schedule percentage change reflects the change in the percentage of Medicare fees used to reimburse physicians. For example, from October 1, 2007 to September 30, 2008 physicians were reimbursed at 86% of the 2007 Medicare fee schedule and from June 30, 2009 – September 30, 2009 are reimbursed at 84% of the 2008 Medicare fee schedule. The fee schedule percentage change is the ratio of 84% and 86%.

The fee schedule Resource Based Relative Value Scale (RBRVS) change reflects the overall change in unit values and conversion factors between two Medicare fee schedules for a select basket of services. These factors were developed using the various Medicare fee schedules published by CMS and the services used in each fee schedule period for the Medicaid fee-for-service population. For example, we compared the 2007 Medicare fee schedule to the 2008 Medicare fee schedule using the mix of services used between October 1, 2007 and June 30, 2008 to develop the fee schedule RBRVS change factor for the October 1, 2007 through June 30, 2008 period used in our rate setting methodology.

We estimate April 2009 Medicare fees to be 101.1% of 2008 Medicare fees. We adjusted fees by 0.7% to reflect three months of the 2008 Medicare fee schedule and six months of the 2009 Medicare fee schedule.

Table 6 below shows the two components of the physician reimbursement change by time period and provider type.

| <b>Table 6</b>  |                          |                             |  |                       |
|---|--------------------------|-----------------------------|--|-----------------------|
| <b>South Carolina Department of Health and Human Services</b> |                          |                             |  |                       |
| <b>Physician Reimbursement Change Factors</b>                 |                          |                             |  |                       |
| <b>Provider Type</b>  | <b>Percentage Change</b> | <b>RBRVS Change to 2008</b> | <b>Adjustment to Reflect October 2009 change to April 2009 RBRVS</b> | <b>Overall Factor</b> |
| <b>July 2006 – August 2006 Fee Schedule Period</b>            |                          |                             |  |                       |
| Physician   | 1.0667                   | 1.0463                      | 1.0070   | 1.1238                |
| Private Providers   | 1.1875                   | 1.0416                      | 1.0070   | 1.2456                |
| Pediatric Sub-Specialists                                     | 0.9963                   | 1.0244                      | 1.0072   | 1.0279                |
| <b>September 2006 – September 2007</b>                        |                          |                             |  |                       |
| Physician   | 1.0039                   | 1.0268                      | 1.0071   | 1.0381                |
| Private Providers   | 0.9500                   | 1.0307                      | 1.0071   | 0.9861                |
| Pediatric Sub-Specialists                                     | 0.9962                   | 1.0009                      | 1.0073   | 1.0125                |
| <b>October 2007 – June 2008</b>                               |                          |                             |  |                       |
| Physician   | 0.9922                   | 1.0053                      | 1.0073   | 1.0048                |
| Private Providers   | 0.9500                   | 1.0081                      | 1.0073   | 0.9647                |
| Pediatric Sub-Specialists                                     | 0.9959                   | 1.0016                      | 1.0073   | 1.0048                |

The adjustment factors range from 0.977 to 1.058.

**Durable Medical Equipment Reimbursement Adjustment:**

DME services are reimbursed at 100% of the applicable Medicare fee for supplies and 90% for equipment. Manually priced codes will be reimbursed at the lesser of:

- > 90% of the manufacturer’s suggested retail, or
- > 100% of provider’s net cost plus 25%.

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We used the category codes assigned by CMS to differentiate between supplies and equipment. The following categories were considered supplies:

- > Inexpensive and Other Routinely Purchased Items,
- > Surgical Dressings, and
- > Supplies

The original capitation rates for the June 30, 2009 – March 31, 2010 rate setting period reflected two different Medicare fee schedules:

1. Effective October 1, 2008, DME reimbursement is based on the April 2008 Medicare fee schedule.
2. Effective October 1, 2009, DME reimbursement is based on the April 2009 Medicare fee schedule.

The DME reimbursement adjustments for the June 30, 2009 – March 31, 2010 MCO capitation rates reflected three months of the 2008 Medicare fee schedule and six months of the April 2009 Medicare fee schedule. The October 1, 2009 – March 31, 2010 rates continue to reflect the blend of three months of 2008 Medicare fee schedule and six months of April 2009 Medicare fee schedule because the June 30, 2009 – September 30, 2009 rate period included funding a portion of the increase to the April 2009 Medicare fee schedule basis.

Similar to the process used to calculate the physician reimbursement adjustment factors, we summarized DME services by rate cell and separated the data into fee schedule periods consistent with when SC DHHS changed DME reimbursement rates. We developed reimbursement change factors from the fee schedule period projected to the June 30, 2009 – March 31, 2010 reimbursement levels and applied those factors to each provider type by service category. We then compared the original paid amount by service category to the adjusted amounts to develop the DME reimbursement factor.

The reimbursement change factors reflect two components:

- > A fee schedule percentage change, and
- > A fee schedule level change

The fee schedule percentage change reflects the change in the percentage of Medicare fees used to reimburse DME products. Since the percentage of Medicare reimbursement did not change, this component is 1.00.

The fee schedule level reflects the overall change in the Medicare fee schedule. These factors were developed using the 2004 and 2008 Medicare fee schedules published by CMS for DME products and the services used in each fee schedule period for the Medicaid fee-for-service population (the SC Medicaid DME fee schedule in the base period was based on the 2004 Medicare fee schedule). The

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Medicare DME fee schedule increased 5.6% from 2004 to 2008 for equipment codes and decreased 0.3% for supply codes.

We estimate 2009 Medicare DME fees to be 4.7% higher on average than 2008 Medicare DME fees. We adjusted fees by 3.1% to reflect three months of the 2008 Medicare fee schedule and six months of the 2009 Medicare fee schedule.

**Injectible Drugs Reimbursement Adjustment:**

Effective October 2008 physician administered injectible drugs and J-codes are reimbursed at the Average Wholesale Price (AWP) minus 18%. SC DHHS provided Milliman with its historical and current allowable reimbursement schedules for impacted J-codes and National Drug Codes (NDC).

We extracted the Medicaid fee-for-service injectible drug claims and adjusted them to reflect the October 1, 2009 allowable reimbursement schedule. We summarized our results by rate cell and service category. The adjustment factors are between 0.998 and 1.058.

**MCO Contractual Adjustment:**

The MCO contractual adjustment recognizes that MCOs may contract with providers at rates higher than currently paid by Medicaid fee-for-service. The Healthy Connections Kids rating methodology uses the same factors used in the Medicaid MCO rating methodology:

- > Hospital inpatient and hospital outpatient services: 1.00
- > Physician services: 1.02
- > Other services: 1.00

We believe the large hospital inpatient and hospital outpatient reimbursement increases on October 2008 (to 100% of estimated cost) that are built into the MCO rates mitigate the need for an MCO contractual adjustment for these services.

**Mental Health and Substance Abuse Services Exclusion:**

Mental health and substance abuse services are included in the MCO contract for Healthy Connections Kids. Inpatient services provided state agencies (such as the Department of Alcohol and Other Drug Abuse Services and the Department of Mental Health) are excluded to better approximate the services that are expected to be delivered to the Healthy Kids Connections population. Hospital inpatient services provided under the fund codes shown in Attachment 2 are excluded as part of the Healthy Connections Kids Benefit Exclusion adjustment.

All services classified as “Professional Mental Health / Substance Abuse” are included in the Healthy Connections Kids rate development. All fund codes are retained for Professional Mental Health / Substance Abuse” services to better approximate the services that are expected to be delivered to the Healthy Kids Connections population.

The total utilization and cost of mental health and substance abuse services retained in the Healthy Connections Kids rates are consistent with Milliman benchmarks and experience in other states. SC DHHS should monitor encounter data experience to validate the pricing assumptions for future rate calculations.

**Healthy Connections Kids Benefit Exclusions:**

We developed adjustment factors by rate cell and service category to reflect the benefit differences between the Medicaid FFS base data and the Healthy Connections Kids program. Attachment 2 provides an exhaustive list of the excluded fund codes, diagnosis codes, and procedure codes. The major differences are summarized below:

- > Excluded obesity diagnoses
- > Excluded mental retardation and developmental delay diagnoses
- > Excluded family planning fund codes
- > Limited speech therapy services to one speech evaluation per year (defined as 92506-HA and S9152)
- > Excluded dental services (paid fee-for-service under Healthy Connections Kids)
- > Excluded CLTC / Transportation services
- > Excluded services performed by other agencies based on fund codes listed in Attachment 2

The benefit exclusions are consistent with the Standard State Health Plan benefit exclusions as described in the State Health Plan Health Insurance manual.

**IBNR Adjustment:**

The adjustment for Incurred But Not Reported (IBNR) claims uses completion factors developed as part of the SC DHHS budget projection as of October 14, 2008 including claims paid through June 30, 2008. The claims data used in developing the Medicaid Managed Care rates includes claims paid through October 31, 2008 allowing for four months of run-out to SFY 0708. The IBNR adjustment reflects an estimate of the claims that will be paid after October 31, 2008 for SFY 0708 incurred claims.

The annual completion factors was developed using a composite of the lag 4 through 15 completion factors for SFY 0708. This methodology assumes that claims processing did not experience a significant change since June 30, 2008.

**Trend SFY 0607 to SFY 0708:**

We summarized cost and eligibility data for Medicaid Managed Care eligible services and individuals using fee-for-service data from SFY 0405 through SFY 0708. The data extract is consistent with Attachment 1. Attachment 1 lists all of the appropriate claim exclusion and inclusion criteria for the Medicaid Managed Care program. The data was summarized by incurred month allowing for up to 48 data points to be analyzed.

We used the “least squares” regression method to calculate a straight line that best fits the data under an exponential model. With this technique, the slope of the line can be used to determine the trend rate. This technique is widely used and recognized in the actuarial field. We also performed sensitivity analysis by removing outliers with different tolerance threshold.

Because the capitation rate methodology adjusts the average charge per service for medical services to current reimbursement levels, we applied a utilization trend only.

We used the results of this analysis and our judgment to select the estimated trend rates to trend SFY 0607 experience to SFY 0708. We examined the trended SFY 0607 costs compared to the SFY 0708 costs and made further adjustments to promote general consistency.

Table 7 below summarizes the estimated fee-for-service trend rates by major service category for the Medicaid Managed Care program eligible populations.

| <b>Table 7</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Medicaid Fee-For-Service Historical Trends for SFY 0607 to SFY 0708</b><br><b>Medical Benefits</b> |             |                       |
|--|-------------|-----------------------|
| <b>Service Category</b>  | <b>TANF</b> | <b>Maternity Kick</b> |
| Hospital Inpatient   | 12.0%       | 4.0%                  |
| Hospital Outpatient  | 10.0%       | N/A                   |
| Physician  | 9.0%        | 0.0%                  |
| Other  | 4.0%        | N/A                   |

**Managed Care Savings Adjustment:**

The managed care savings adjustments were developed based on a comparison of the fee-for-service Medicaid utilization levels to Milliman’s *Medicaid Health Cost Guidelines* and other research data. The *Medicaid Health Cost Guidelines* are developed as internal tools for Milliman consultants.

The *Medicaid Health Cost Guidelines* includes utilization targets for fee-for-service, loosely managed, and well managed delivery systems as well as a range of observed utilization levels for actual Medicaid MCOs. We selected the managed care savings adjustments to target an “average observed” level of utilization. We considered the impact of DRG hospital contracting and the selection factor when setting the managed care savings adjustments. The managed care savings adjustments are shown in Table 8 below.

**Table 8**  
**South Carolina Department of Health and Human Services**  
**Managed Care Savings Assumptions**

| <b>Service Category</b>  | <b>Savings Percentage</b> |
|--|---------------------------|
| Hospital Inpatient – Medical / Surgical                          | 15%                       |
| Hospital Inpatient – Mental Health / Substance Abuse             | 15%                       |
| Hospital Inpatient – Maternity Non-Deliveries and Newborn        | 15%                       |
| Hospital Inpatient – Maternity Delivery                          | 0%                        |
| Hospital Inpatient – SNF   | 0%                        |
| Hospital Outpatient  | 15%                       |
| Emergency Room   | 20%                       |
| Professional   | 15%                       |
| Professional – Office Visits for Age <14 Rate Cells              | 0%                        |
| Professional – Office Visits for Other Rate Cells                | 15%                       |
| Professional – Injection and Immunization for Age <14 Rate Cells | 0%                        |
| Professional – Injection and Immunization for Other Rate Cells   | 15%                       |
| Professional – Maternity Delivery                                | 0%                        |
| Other  | 20%                       |

**Step 3: Calculate Estimated October 1, 2009 – March 31, 2010 Managed Care Costs**

In Step 3, SFY 0607 and SFY 0708 costs are combined to develop the estimated costs for each eligibility category. The Step 3 procedure is summarized below:

1. Summarize the trended and adjusted SFY 0607 fee-for-service data by eligibility category and service category for all covered service categories.
2. Summarize the adjusted SFY 0708 fee-for-service data by eligibility category and service category for all covered service categories.
3. Calculate the composite SFY 0708 PMPM costs by eligibility category. The composite is calculated as a weighted average of projected SFY 0607 and SFY 0708 costs based on each year's eligibility category specific member months.
4. Trend the composite SFY 0708 costs to October 1, 2009 – March 31, 2010 using projected inflation factors.

The inflation factors used to project expenditures from SFY 0708 to October 1, 2009 – March 31, 2010 are based on inflation factors used for South Carolina’s most recent Medicaid budget projection and represent “best estimate” utilization trends. Table 9 below shows the annual inflation factors from SFY 0708 to October 1, 2009 – March 31, 2010. The annual rates are applied for the 22.5 month projection period.

Note the trend period is the same as used in the development of the June 30, 2009 – March 31, 2010 capitation rates. The October 1, 2009 – March 31, 2010 rates continue to reflect the same trend period because the June 30, 2009 – September 30, 2009 rate period trend assumed a nine month effective period (through March 31, 2010).

| <b>Table 9</b>   |                              |
|--|------------------------------|
| <b>South Carolina Department of Health and Human Services</b>                            |                              |
| <b>Annual Utilization Inflation Rates – SFY 0708 to October 1, 2009 – March 31, 2010</b> |                              |
| <b>Service Category</b>  | <b>Annual Inflation Rate</b> |
| Hospital Inpatient   | 4.0%                         |
| Hospital Outpatient  | 4.0%                         |
| Professional   | 4.0%                         |
| Home Health  | 4.0%                         |

Appendices E1 and E2 present the detailed October 1, 2009 – March 31, 2010 Managed Care cost estimates.

**Step 4: Adjust for TPL Recoveries, Administrative Days, Selection, Autism Benefits, and Administrative Expenses**

**Third Party Liability Recoveries:**

SC DHHS provided Milliman with a summary of aggregate third party liability (TPL) recoveries that are not included in the claims data by incurred calendar year quarter. Milliman summarized paid claims data by state fiscal year for all Medicaid fee-for-service programs to develop the TPL adjustment factor of 0.996 for SFY 0607 and SFY 0708. This adjustment is shown in Appendix F.

**Administrative Days:**

SC DHHS provided Milliman with a summary of aggregate administrative hospital day payments that are not included in the claims data by incurred calendar year quarter. Milliman summarized paid hospital inpatient claims data by state fiscal year for all Medicaid fee-for-service programs to develop an administrative days adjustment factor of 1.0008 for SFY 0607 and SFY 0708. This adjustment is shown in Appendix F.

**Selection:**

SC DHHS uses a selection adjustment to adjust the TANF FFS base data to the morbidity level of the Healthy Connections Kids population anticipated to be enrolled in MCOs during the contract period.

Based on analysis of Medicaid Rx risk scores and our experience in other states with voluntary managed care enrollment, we calculated selection adjustments shown in Table 10. Please refer to Milliman’s August 28, 2009 letter to SC DHHS for the detailed calculation of the selection adjustments.

We used the results of the August 28, 2009 letter to SC DHHS in the following manner to calculate the Healthy Connections Kids selection adjustment:

- > We assumed the Healthy Connections Kids population would have an acuity level similar to the overall (FFS + MCO) Medicaid population.
- > The relative risk scores of the SFY 0607 and SFY 0708 FFS population compared to the overall (FFS + MCO) population are shown in Table 4 of our August 28, 2009 letter
  - Infants = 1.000
  - Children = 1.010
- > The selection adjustment to adjust the costs of the underlying FFS Medicaid population to the total (FFS + MCO) Medicaid population is  $1 / \text{FFS risk score}$

| <b>Table 10</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Selection Adjustment</b> |                      |
|---|----------------------|
| Rate Cell   | Selection Adjustment |
| TANF: 2 - 3 months old  | 1.000                |
| TANF: 4 - 12 months old   | 1.000                |
| TANF: Age 1 – 6   | 0.990                |
| TANF: Age 7 – 13  | 0.990                |
| TANF: Age 14 - 18 Male  | 0.990                |
| TANF: Age 14 - 18 Female  | 0.990                |
| Maternity Kicker Payment  | 1.000                |

**Autism Spectrum Disorder Benefit:**

The cost of the Autism Spectrum Disorder covered by Healthy Connections Kids is calculated using the most recent assumptions from the State Employees Health Plan. However, instead of spreading the cost of the benefit evenly across all rate cells, we calculated a rate cell specific autism add-on as shown in Table 11 below.

| <b>Table 11</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Autism Spectrum Disorder Benefit Cost Development</b> |        |                  |                       |                       |              |                     |           |                     |                    |
|--|--------|------------------|-----------------------|-----------------------|--------------|---------------------|-----------|---------------------|--------------------|
| Eligibility Category   | Gender | Penetration Rate | Severity Level        | Severity Distribution | Take Up Rate | Annual Therapy Cost | PMPM Cost | Age Band Adjustment | Adjusted PMPM Cost |
| Age 1 - 6  | Unisex | 0.65%            | Intense – 2 - 5       | 56%                   | 90%          | \$50,000            | \$13.65   | 67%                 | \$9.10             |
|  |        |                  | Less Intense – 2 - 5  | 44%                   | 75%          | 37,500              | 6.70      | 67%                 | 4.47               |
|  |        |                  | Intense – 6 - 15      | 56%                   | 80%          | 40,000              | 9.71      | 17%                 | 1.62               |
|  |        |                  | Less Intense – 6 - 15 | 44%                   | 50%          | 20,000              | 2.38      | 17%                 | 0.40               |
|  |        |                  | <b>Total</b>          | <b>100%</b>           |              |                     |           |                     | <b>\$15.58</b>     |
| Age 7 - 13   | Unisex | 0.65%            | Intense               | 56%                   | 80%          | \$40,000            | \$9.71    | 100%                | \$9.71             |
|  |        |                  | Less Intense          | 44%                   | 50%          | 20,000              | 2.38      | 100%                | 2.38               |
|  |        |                  | <b>Total</b>          | <b>100%</b>           |              |                     |           |                     | <b>\$12.09</b>     |
| Age 14 - 18  | Male   | 0.65%            | Intense               | 56%                   | 80%          | \$40,000            | \$9.71    | 40%                 | \$3.88             |
|  |        |                  | Less Intense          | 44%                   | 50%          | 20,000              | 2.38      | 40%                 | 0.95               |
|  |        |                  | <b>Total</b>          | <b>100%</b>           |              |                     |           |                     | <b>\$4.84</b>      |
| Age 14 - 18  | Female | 0.65%            | Intense               | 56%                   | 80%          | \$40,000            | \$9.71    | 40%                 | \$3.88             |
|  |        |                  | Less Intense          | 44%                   | 50%          | 20,000              | 2.38      | 40%                 | 0.95               |
|  |        |                  | <b>Total</b>          | <b>100%</b>           |              |                     |           |                     | <b>\$4.84</b>      |

The calculation assumes that 0.65% of children between the ages of 2 and 15 are diagnosed with the autism spectrum disorder and that 56% of diagnosed children require intensive services. A take up rate is applied to the estimated annual therapy cost before calculating the PMPM cost of the benefit. Each cell is then adjusted to reflect the proportion of each age band to which it applies.

**Administration:**

Table 12 shows the administrative allowances for medical and pharmacy services by rate cell as a percentage of capitation revenue:

| <b>Table 12</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Administrative Allowance as a Percent of Revenue</b> |                         |                          |
|---|-------------------------|--------------------------|
| <b>Rate Cell</b>  | <b>Medical Services</b> | <b>Pharmacy Services</b> |
| HCK: 2 - 3 months old   | 13%                     | 9%                       |
| HCK: 4 - 12 months old  | 13%                     | 9%                       |
| HCK: Age 1 - 6  | 13%                     | 9%                       |
| HCK: Age 7 - 13   | 13%                     | 9%                       |
| HCK: Age 14 - 18 Male   | 13%                     | 9%                       |
| HCK: Age 14 - 18 Female   | 13%                     | 9%                       |
| Maternity Kicker Payment  | 7%                      | NA                       |

The total administration allowance is 12.0% of the final capitation rates (medical and pharmacy). The 12.0% administration allowance includes a 1.0% allowance for MCO profit and contribution to margin. The details of our calculations are shown in Appendix F.

**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 not included in the MKP for Healthy Connections Kids.

MKP cases are counted as women who have either a maternity delivery DRG or a physician maternity delivery claim (or both). The case counting logic is consistent with how SC DHHS administers the MKP. The MKP cases are distributed in the following manner:

- > Both a maternity delivery DRG and a physician claim = 91%
- > A maternity delivery physician claim only = 5%
- > A maternity delivery DRG only = 4%

Milliman used the following criteria as to identify claims information to calculate the MKP. The MKP includes hospital inpatient delivery services, hospital outpatient and emergency room delivery services as well as professional delivery services. Deliveries with sterilization services are not included in the Healthy Connections Kids MKP.

- > Hospital Inpatient providers, with DRG codes of 370 – 373 and 375
- > Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5<sup>th</sup> digit being 1 or 2) and reimbursement type equal to 1

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For the following providers only delivery services are included (CPT codes 59409, 59514, 59612, 59620, 00850, 00857, 00946, 00955, 01960, 01961, 01967, and 01968)

- > Physician providers
- > Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- > Department of Health and Environmental Control (DHEC)
- > Federally Funded Health Clinics (FFHC)
- > Nurse Midwife and Nurse Practitioner

The Maternity Kicker Payment is developed consistent with the methodology outlined in Steps 1 through 5 in Section IV of this report.

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## V. METHODOLOGY AND RESULTS – PRESCRIPTION DRUG BENEFITS

This section of our report describes the October 1, 2009 – March 31, 2010 Healthy Connections Kids capitation rate methodology for prescription drug benefits.

### CAPITATION RATE METHODOLOGY – PRESCRIPTION DRUG BENEFITS

The methodology used to calculate the prescription drug component of the capitation rate can be outlined in the following steps:

1. Extract TANF fee-for-service experience data for the Medicaid Managed Care eligible population by eligibility category.
2. Apply adjustments for reimbursement, benefit limitations, trend, managed care impact, and incurred but not reported (IBNR) claims.
3. Calculate estimated October 1, 2009 – March 31, 2010 managed care costs by eligibility category.
4. Adjust for third party liability (TPL) recoveries, selection, and administrative expenses.

Each of the above steps is described in detail below.

#### **Step 1: Extract Fee-For-Service Experience Data**

In this step the TANF fee-for-service experience for SFY 0607 and SFY 0708 is summarized by eligibility category and script tier for populations eligible to enroll in the Medicaid Managed Care program. Milliman used Attachment 1 to determine populations eligible to enroll in the Managed Care program. Over the counter (OTC) medications are excluded for Healthy Connections Kids.

Appendices G1 – G2 show Step 1.

#### **Cost Sharing**

South Carolina's fee-for-service Medicaid program includes several member copayment amounts that MCO members are not required to pay, including a \$3.00 copay for prescriptions (per script).

The member copayment amounts are added to the Healthy Connections Kids capitation rate calculation. Copay amounts are insignificant for the age 18 and under population.

#### **Step 2: Apply Adjustments for Reimbursement, Benefit Limitations, Trend, Managed Care Impact, and IBNR Claims**

In this step we apply adjustment factors to reflect differences between the Medicaid fee-for-service data and the Healthy Connections Kids program. Each adjustment factor is explained in detail below.

Appendices H1 – H2 show the impact of the Step 2 adjustments.

#### **MCO Contractual Adjustment:**

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The MCO contractual adjustment recognizes that most MCOs contract with pharmacies at rates different than currently paid under Medicaid fee-for-service. We used information regarding prescription drug contracting collected as part of Milliman's confidential reimbursement survey to evaluate the relative cost of providing prescription drug coverage under SC DHHS contractual arrangements compared the average of the participating MCO's contractual terms.

Milliman determined that a 0.93 adjustment factor is appropriate to reflect the MCOs' higher discounts and lower dispensing fees compared to SC DHHS.

**Pharmacy Benefit Limit:**

The pharmacy benefit limit change reduces the 34 day supply per prescription to a 31 day supply.

To develop the adjustment factors, we summarized script day supplies by individual and applied the limits mentioned above to calculate a dollar impact. We summarized the results by rate cell and applied the adjustment factor to the prescription drug service categories.

Because of the high maintenance drug usage for chronic conditions, savings due to the change in days supply limit would be minimal. For that reason, we took the square root of the calculated adjustment to reflect the fact that calculated savings would not all materialize.

The adjustment factors vary from 0.996 to 0.999 by rate cell and drug tier.

**Pharmacy Rebate:**

An adjustment was made to reflect an average MCO pharmacy rebate of about 8% of allowed drug cost rather than the typical 30%+ that SC DHHS collects in the fee-for-service program. The 8% rebate assumption was derived from Milliman's survey of all participating MCOs' contractual arrangements and our experience in other states.

**IBNR Adjustment:**

Due to the electronic processing of prescription drug claims, there are usually very few outstanding claims even after only one month. Therefore, the IBNR factor for both fiscal years is 1.000.

**Trend SFY 0607 to SFY 0708:**

We summarized cost and eligibility data for prescription drug claims and individuals using fee-for-service data from SFY 0405 through SFY 0708. Similar to the medical trend analysis, the data extract is consistent with Attachment 1. The data was summarized by incurred month allowing for up to 48 data points to be analyzed.

We used the "least squares" regression method to calculate a straight line that best fits the data under an exponential model. With this technique, the slope of the line can be used to determine the trend rate. This technique is widely used and recognized in the actuarial field. We also performed sensitivity analysis by removing outliers with different tolerance threshold.

We used the results of this analysis and our judgment to select the estimated trend rates to trend the SFY 0607 experience to SFY 0708.

Table 13 below summarizes the estimated fee-for-service trend rates by service category for the Medicaid Managed Care program eligible populations.

**Table 13**  
**South Carolina Department of Health and Human Services**  
**Medicaid Fee-For-Service Historical Trends**  
**Prescription Drug Benefits**

| Service Category    | TANF  |
|---------------------|-------|
| Generic             | 12.0% |
| Multi-Source Brand  | 10.0% |
| Single-Source Brand | 10.0% |
| Over-The-Counter    | 6.0%  |
| Unidentified        | 10.0% |

**Managed Care Savings Adjustment:**

The managed care savings adjustment was developed based on a target generic dispensing rate of 70% of prescriptions and a reduction in the prescription utilization rates. Fee-for-service Medicaid achieves a generic dispensing rate of approximately 60%. The 70% generic target is consistent with the MCOs' generic dispensing rate as reported in Milliman's survey of all participating MCOs' contractual arrangements.

Based on Milliman's Prescription Drug Rating model, moving from a 60% to a 70% generic dispensing rate results in 15% savings. We assumed an additional 5% savings due to reduced utilization rates under managed care. We used a 0.80 combined managed care adjustment.

**Step 3: Calculate Estimated October 1, 2009 – March 31, 2010 Managed Care Costs**

In Step 3, SFY 0607 and SFY 0708 costs are combined to develop the estimated costs for each eligibility category. The Step 3 procedure is summarized below:

1. Summarize the trended and adjusted SFY 0607 fee-for-service data by eligibility category and prescription drug tier.
2. Summarize the adjusted SFY 0708 fee-for-service data by eligibility category and prescription drug tier.
3. Calculate the composite SFY 0708 PMPM costs by eligibility category. The composite is calculated as a weighted average of projected SFY 0607 and SFY 0708 costs based on each year's eligibility category specific member months.
4. Trend the composite SFY 0708 costs to October 1, 2009 – March 31, 2010 using projected inflation factors.

The inflation factors used to project expenditures from SFY 0708 to October 1, 2009 – March 31, 2010 are based on inflation factors used for South Carolina's most recent Medicaid budget projection and represent "best estimate" PMPM cost trends. Table 14 below shows the annual inflation factors from SFY 0708 to October 1, 2009 – March 31, 2010. The annual rates are applied for the 22.5 month projection period.

Note the trend period is the same as used in the development of the June 30, 2009 – March 31, 2010 capitation rates. The October 1, 2009 – March 31, 2010 rates continue to reflect the same trend period

because the June 30, 2009 – September 30, 2009 rate period trend assumed a nine month effective period (through March 31, 2010).

| <b>Table 13</b><br><b>South Carolina Department of Health and Human Services</b><br><b>Medicaid Fee-For-Service Historical Trends</b><br><b>Prescription Drug Benefits</b> |             |
|--|-------------|
| <b>Service Category</b>  | <b>TANF</b> |
| Generic  | 6.0%        |
| Multi-Source Brand   | 8.5%        |
| Single-Source Brand  | 8.5%        |
| Over-The-Counter   | 4.0%        |

Appendix I presents the detailed October 1, 2009 – March 31, 2010 Managed Care cost estimates.

**Step 4: Adjust for TPL Recoveries, Selection, and Administrative Expenses**

**Third Party Liability Recoveries:**

SC DHHS provided Milliman with a summary of aggregate third party liability (TPL) recoveries that are not included in the claims data by incurred calendar year quarter. Milliman summarized paid claims data by state fiscal year for all Medicaid fee-for-service programs to develop the TPL adjustment factor of 0.996 for SFY 0607 and SFY 0708. This adjustment is shown in Appendices M1 and M2.

**MCO Selection:**

We assumed the same MCO selection factors shown in Table 10.

**Administration:**

We used the administrative allowances shown in Table 12.

The total administration allowance is 12.0% of the final capitation rates (medical and pharmacy). The 12.0% administration allowance includes a 1.0% allowance for MCO profit and contribution to margin.

The details of our calculations are shown in Appendix J.

## VI. SERVICE CATEGORY ASSIGNMENT

This section of the report provides information about the service category assignment used to create the cost models included in the Healthy Connections Kids capitation rate development. This information can be used by participating MCOs to monitor their experience in a format and detail similar to the rate development process. MCOs are encouraged to monitor their emerging experience and take corrective actions when necessary.

To prepare the attached cost models, we grouped claims into Milliman's standard service categories used in Milliman's market leading *Health Cost Guidelines*. We then regrouped certain service categories into broader groups to allow easier summarization and evaluation of each eligibility category's cost. The service category assignment described below does not account for excluded or limited services. Please refer to Sections III – V of the report for a detailed description of how excluded and limited services were handled. The next few paragraphs detail how the claim level detail is assigned to the service categories shown in Appendices A – J.

### HOSPITAL INPATIENT

Hospital inpatient 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 MCO and approved by SC DHHS is met. Among other services, hospital inpatient 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 hospital inpatient services would include room and board, miscellaneous hospital services, medical supplies, and equipment.

The hospital inpatient claims are assigned a service category based on Diagnostic Related Group (DRG) codes. Milliman's algorithm classifies hospital inpatient claims using the following groupings of 2007 DRG codes.

**Table 15**  
**South Carolina Department of Health & Human Services**  
**Hospital Inpatient Service Groupings by DRG Code**

| Service Category                | Diagnosis Related Group  |
|---------------------------------|--|
| Medical / Surgical              | 001 - 003, 006 - 019, 021 - 023, 026 - 106, 108, 110 - 111, 113 - 114, 117 - 147, 149 - 153, 155 - 208, 210 - 213, 216 - 220, 223 - 230, 232 - 369, 376 - 377, 385 - 390, 392 - 399, 401 - 414, 417 - 424, 439 - 455, 461 - 468, 471, 473, 476 - 477, 479 - 482, 484 - 513, 515, 518 - 520, 524 - 525, 528 - 579 |
| Mental Health / Substance Abuse | 425 - 433, 521 - 523   |
| Maternity                       | 370 - 375, 378 - 384   |
| Normal Newborn                  | 391  |
| Invalid DRGs                    | 004 - 005, 020, 024 - 025, 107, 109, 112, 115 - 116, 148, 154, 209, 214 - 215, 221 - 222, 231, 400, 415 - 416, 434 - 438, 456 - 460, 469 - 470, 472, 474 - 475, 478, 483, 514, 516 - 517, 526 - 527  |

## HOSPITAL OUTPATIENT

Hospital 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 (ESRD) clinics, and outpatient pediatric AIDS clinics (OPAC). Costs include facility charges only and do not include professional charges unless performed by staff of the facility and billed on a UB-92 (hospital) claims form. All facility-billed items not part of an inpatient admission are considered hospital outpatient services.

The hospital outpatient claims are assigned a service category based on revenue codes. Milliman's algorithm classifies hospital outpatient claims using the following groupings of revenue codes.

**Table 16**  
**South Carolina Department of Health & Human Services**  
**Hospital Outpatient Service Groupings by Revenue Code**

| <b>Service Category</b> | <b>Revenue Code</b>  |
|-------------------------|--|
| Emergency Room          | '0450'-'0459','0681'-'0689','0981'   |
| Surgery                 | '0360'-'0369','0490'-'0499','0790'-'0799','0975'<br>'0255','0320'-'0329','0330','0331'-'<br>'0332','0333','0335','0339','0340','0341','0342', '0343','0344','0349','0350'-<br>'0352','0359','0371','0400'-'0403','0404','0405'-'0409', '0610'-<br>'0612','0613','0614'-'0616','0617','0618'-'0619','0621','0972','0973','0974'   |
| Radiology               |  |
| Pathology               | '0300'-'0309','0310'-'0319','0923','0925','0971'   |
| Pharmacy & Blood        | '0250'-'0253','0256'-'0257','0259','0380'-'0389','0390'-'0399','0630'-<br>'0633','0636'-'0639'   |
| Cardiovascular          | '0480'-'0489','0730'-'0739','0921','0943','0985'   |
| PT / OT / ST            | '0420'-'0449','0931'-'0932','0977'-'0979'  |
| Other                   | '0100'-'0219','0220'-'0229','0230'-'0239','0240'-'0249','0254','0258','0260'-<br>'0269', '0270'-'0279','0280'-'0289','0370','0372','0374','0379','0410'-<br>'0419','0460'-'0469', '0470'-'0479','0500'-'0509','0510','0511'-<br>'0518','0519','0520'-'0521','0522'-'0529', '0530'-'0539','0540'-'0549','0560'-<br>'0569','0622'-'0629','0634'-'0635','0670'-'0679', '0700'-'0709','0710'-<br>'0719','0720'-'0729','0740'-'0749','0750'-'0759','0760'-'0769', '0770'-<br>'0789','0800'-'0809','0810'-'0819','0820'-'0889','0890'-'0899','0900'-'0919',<br>'0920','0922','0924','0929','0940'-'0942','0944'-'0945','0946'-'0949','0951'-<br>'0960', '0961','0962','0963'-<br>'0964','0969','0976','0980','0982','0983','0984','0986','0987'-'0988','0990'-<br>'9999' |

**PROFESSIONAL**

Professional 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, and 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.

Physician services are assigned to a service category using Current Procedural Terminology (CPT) codes. Place-of-service information is used to assign surgery codes to the inpatient or outpatient categories.

## OTHER

The other service category includes the following services:

- > Home health services including intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies.
- > Emergency transportation or acute care situation where normal transportation would potentially endanger the life of the patient.
- > Durable medical 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.
- > Hearing aids and hearing aid accessories.
- > Dental services.
- > Pharmaceutical as ordered by licensed prescribers.

Other services are also assigned a service category using CPT codes. Prescription drugs however are identified by the presence of a National Drug Code (NDC) in the claims file. Other, unidentifiable services are assigned an “unknown” category of service.

## **VII. CMS RATE SETTING CHECKLIST ISSUES**

This section of the report lists each item in the CMS checklist and either discusses how SC DHHS addresses each issue or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

### **AA.1.0 – Overview of rate setting methodology**

In general, the Healthy Connections Kids rating methodology relies on Medicaid fee-for-service data for the TANF population adjusted to the covered benefits and expected acuity level of the Healthy Connections Kids population. The Healthy Connections Kids methodology is consistent with the Medicaid MCO rating methodology that will be implemented for the October 2009 – March 31, 2010 Medicaid MCO rates with several adjustments to reflect differences between Medicaid and Healthy Connections Kids.

#### **AA.1.1 – Actuarial certification**

Please refer to Appendix L for our actuarial certification of the October 1, 2009 – March 31, 2010 capitation rates. The October 1, 2009 – March 31, 2010 Healthy Connections Kids capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

#### **AA.1.2 – Projection of expenditures**

Appendix K includes a projection of total expenditures and Federal-only expenditures based on actual August 2009 MCO enrollment, June 30, 2009 – September 30, 2009 capitation rates and October 1, 2009 – March 31, 2010 capitation rates.

#### **AA.1.3 – Procurement, prior approval, and rate setting**

SC DHHS develops state set rates. Please refer to Sections III – V of this report for details.

**Note – there is no item AA.1.4 in the checklist**

#### **AA.1.5 – Risk contracts**

Healthy Connection Kids meets the criteria of a risk contract.

#### **AA.1.6 – Limit on payment to other providers**

It is our understanding no payment is made to a provider other than the participating MCOs for services available under the contract.

#### **AA.1.7 – Rate modifications**

The October 1, 2009 – March 31, 2010 rates documented in this report are an update to the initial capitation rates for the June 30, 2009 – March 31, 2010 Medicaid Managed Care contracts.

### **AA.2.0 – Base year utilization and cost data**

The base year utilization and cost data is SFY 0607 and SFY 0708 fee-for-service data for the TANF population that is eligible to enroll in a Medicaid MCO.

Only services that are covered under the Healthy Connections Kids contract have been included in the rate development.

#### **AA.2.1 – Medicaid eligibles under the contract**

Data for fee-for-service populations not eligible to enroll in the South Carolina Medicaid Managed Care program has been excluded from the base data used in rate development.

#### **AA.2.2 – Dual eligibles**

Dual eligibles are excluded from Healthy Connections Kids and the capitation rate development.

#### **AA.2.3 – Spend down**

The spend down population is excluded from Healthy Connections Kids and the capitation rate development.

#### **AA.2.4 – State Plan services only**

The base utilization and cost data is SFY 0607 and SFY 0708 fee-for-service data and includes only State Plan services.

#### **AA.2.5 – Services that may be covered by a capitated entity out of contract savings**

Services that may be covered by a capitated entity out of contract savings are not included in the data used to develop the October 1, 2009 – March 31, 2010 capitation rates.

#### **AA.3.0 – Adjustments to base year data**

All adjustments to the base year data are discussed in Sections III – V of this report. In addition, each item in the checklist is addressed in items AA.3.1 – AA.3.14 below.

#### **AA.3.1 – Benefit differences**

The base data used to calculate the capitation rates has been adjusted to only include services covered under the managed care contract.

#### **AA.3.2 – Administrative cost allowance calculations**

The MCO capitation rates include explicit administrative allowances by rate cell. Please see Section IV and V of the report for more details regarding the administrative cost calculation.

#### **AA.3.3 – Special population adjustments**

The fee-for-service base data used to calculate the capitation rates is consistent with the managed care population. No special population adjustment was necessary.

#### **AA.3.4 – Eligibility adjustments**

SC DHHS uses a selection adjustment to adjust the FFS base data to the morbidity level of the population anticipated to be enrolled in MCOs during the contract period.

#### **AA.3.5 – DSH payments**

DSH payments are not included in the capitation rates.

#### **AA.3.6 – Third party liability (TPL)**

The managed care organizations are responsible for the collection of any TPL recoveries. The capitation rates include a 0.9960 adjustment to reflect additional TPL recoveries that are not reflected in the base year fee-for-service data.

#### **AA.3.7 – Copayments, coinsurance, and deductibles in capitated rates**

The Healthy Connections Kids program does not include member cost sharing. All fee-for-service member cost sharing amounts were added back into the capitation rate calculation,

#### **AA.3.8 – Graduate medical education (GME)**

GME payments are included in the base data in the capitation rate calculation.

#### **AA.3.9 – FQHC and RHC reimbursement**

The Healthy Connections Kids rates include the encounter rates paid to FQHCs and RHCs under FFS Medicaid. SC DHHS does not pay supplemental payments to the FQHCs and RHCs for services provided to Healthy Connections Kids enrollees.

#### **AA.3.10 – Medical cost trend inflation**

Trend rates from SFY 0607 to SFY 0708 were developed by rate category and type of service for Medicaid Managed Care eligible services and individuals using fee-for-service data from SFY 0405 through SFY 0708. A “least squares” regression method was used to calculate a straight line that best fits the data under an exponential model. With this technique, the slope of the line can be used to determine the trend rate. This technique is widely used and recognized in the actuarial field. We also performed sensitivity analysis by removing outliers with different tolerance thresholds.

The inflation factors used to project expenditures from SFY 0708 to October 1, 2009 – March 31, 2010 are based on inflation factors used for South Carolina’s most recent Medicaid budget projection.

We are comfortable that the trend rates and inflation factors represent the expected change in per capita cost between SFY 0607 and October 1, 2009 – March 31, 2010.

#### **AA.3.11 – Utilization adjustments**

Utilization trend is included in AA.3.10.

#### **AA.3.12 – Utilization and cost assumptions**

The October 1, 2009 – March 31, 2010 capitation rates for the Healthy Connections Kids program are risk adjusted using age and gender only.

#### **AA.3.13 – Post-eligibility treatment of income (PETI)**

Not applicable.

#### **AA.3.14 – Incomplete data adjustment**

The capitation rates include an adjustment to reflect IBNR claims. Please refer to Section IV of this report for more information on the development of these adjustment factors.

#### **AA.4.0 – Establish rate category groupings**

Please refer to Sections III – V of this report.

##### **AA.4.1 – Age**

Please refer to Sections III – V of this report.

##### **AA.4.2 – Gender**

Please refer to Sections III – V of this report.

##### **AA.4.3 – Locality / Region**

Region is not used as a rating variable.

##### **AA.4.4 – Eligibility categories**

Please refer to Section III of this report.

#### **AA.5.0 – Data Smoothing**

We did not perform any data smoothing.

##### **AA.5.1 – Special populations and assessment of the data for distortions**

We did not identify any material distortions caused by special populations.

##### **AA.5.2 – Cost-neutral data smoothing adjustment**

We did not perform any data smoothing.

##### **AA.5.3 – Risk adjustment**

None

#### **AA.6.0 – Stop loss, reinsurance, or risk sharing arrangements**

None

##### **AA.6.1 – Commercial reinsurance**

SC DHHS does not require entities to purchase commercial reinsurance.

**AA.6.2 – Simple stop loss program**

None

**AA.6.3 – Risk corridor program**

None

**AA.7.0 – Incentive arrangements**

None

**Appendices A - F**

**State of South Carolina  
Department of Health & Human Services  
October 1, 2009 – March 31, 2010  
Healthy Connections Kids Capitation Rate Development  
Medical Services**

**Appendices G - J**

**State of South Carolina  
Department of Health & Human Services  
October 1, 2009 – March 31, 2010  
Healthy Connections Kids Capitation Rate Development  
Prescription Drug Services**

## **Appendix K**

**State of South Carolina  
Department of Health & Human Services  
October 1, 2009 – March 31, 2010  
Fiscal Impact Exhibit**

## **Appendix L**

**State of South Carolina  
Department of Health & Human Services  
Actuarial Certification  
October 1, 2009 – March 31, 2010  
Healthy Connections Kids Capitation Rates**



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**October 30, 2009**

**South Carolina Department of Health and Human Services  
Capitated Contracts Ratesetting  
Actuarial Certification  
October 1, 2009 – March 31, 2010 Healthy Connection Kids Capitation Rates**

I, John D. Meerschaert, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the South Carolina Department of Health & Human Services (SC DHHS) to perform an actuarial certification of the Healthy Connections Kids capitation rates for October 1, 2009 – March 31, 2010 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the capitation rates development and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS "Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting."

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for October 1, 2009 – March 31, 2010. To the best of my information, knowledge and belief, for the period from October 1, 2009 to March 31, 2010, the capitation rates offered by SC DHHS are in compliance with 42 CFR 438.6(c). The attached actuarial report describes the capitation rate setting methodology.

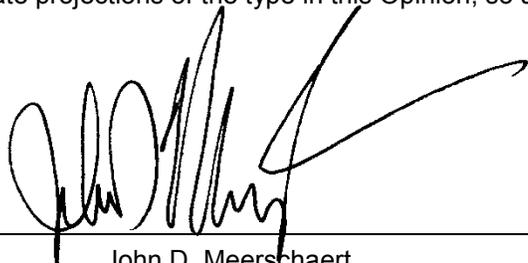
In my opinion, the capitation rates are actuarially sound, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying claims and eligibility data records and other information. A copy of the reliance letter received from SC DHHS is attached and constitutes part of this opinion. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted managed care organization's situation and experience.

This Opinion assumes the reader is familiar with the South Carolina Medicaid program, Medicaid managed care programs, and actuarial rating techniques. The Opinion is intended for the State of South Carolina and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



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John D. Meerschaert  
Member, American Academy of Actuaries

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October 30, 2009

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**Attachment 1**  
**Data Adjustment Specifications – Standard Managed Care**  
**In-Rate Criteria**

## Eligibility Criteria

| Eligibility File Type | Criteria  | Notes  |
|-----------------------|---|--|
| Recipient             | Exclude Recipient Payment<br>Categories: 10,14,15,33,41,42,43,48,49,50,52,54,55,56,70,90,92 |  |
| Recipient             | Exclude if age >= 21 on date of service   |  |
| Recipient             | Exclude Dual eligible members   |  |
| Recipient             | Retroactive Eligibility   | See Methodology and Results - General          |
| Recipient             | Long Term Care Exclusion  | See Methodology and Results - Medical Benefits |
| RSP                   | Exclude where RSP Program in:<br>A,F,G,J,K,L,M,N,Q,R,S,T,U,V,W,X,Y, 1,2,3,4,5,7,8,9         |  |

Note: The in-rate criteria only includes claims with a valid member record at the time services were rendered.

## Claim Criteria

### Nursing Home Claims

| Claim Type | Provider Type | Provider Specialty | Criteria  | Notes |
|------------|---------------|--------------------|---|-------|
| G          | 00            | Any                | Include claims where the last 2 bytes of Billing Provider Number = SB |       |

Note only provider type 00 are included in rate setting for D claim types.

### UB-04 Claims

| Claim Type | Provider Type | Provider Specialty | Criteria   | Notes |
|------------|---------------|--------------------|--|-------|
| Z          | 01            | Any                | Exclude if Provider Control Facility in (010, 011)                                   |       |
| Z          | 02            | Any                | Exclude if Provider Control Facility in (010, 011)                                   |       |
| Z          | 02            | Any                | Exclude if Principle Surgical Procedures in (96.54, 23.01-24.99)                     |       |
| Z          | 02            | Any                | Exclude if Reimbursement Type = 1 <b>AND</b> Surg Proc in (D0120-D9999, 41800-41899) |       |

Note only provider type (01, 02) are included in rate setting for Z claim types.

### HIC Claims

| Claim Type | Provider Type | Provider Specialty                   | Criteria   | Notes |
|------------|---------------|--------------------------------------|--|-------|
| A or B     | All           | Any                                  | Exclude all Procedure Codes that begin with "D"                    |       |
| A          | 19            | Only specialties: 04, 06, 25, 86, 99 | Exclude if Procedure Code = 99420 <b>AND</b> Modifier in (TG, OTG) |       |
| A          | 19            | Only specialties: 04, 06, 25, 86, 99 | Exclude if Procedure Code = S3260                                  |       |
| A          | 20 or 21      | Any                                  | Exclude if Provider Control Facility in (010, 011)                 |       |

|   |                        |  |  |  |
|---|------------------------|--|--|--|
| A | 22                     | Only specialties:<br>95, 96, 51, 21, 50, 58, 93, 94, 97,<br>98 | Exclude if Procedure Code in (X2040, X2041, S3260,<br>T1002, T1003)  |  |
| A | 22                     | Only specialty: 95   | Exclude claims where the last 2 bytes of Billing<br>Provider Number = SD   |  |
| A | 22                     | Only specialty: 95   | Exclude if Provider Control Facility in (010, 011, 021)  |  |
| A | 22                     | Only specialty: 96   | Exclude if Provider Number = MC0015  |  |
| A | 22                     | Only specialty: 96   | Exclude if Provider Number = MC0015 <b>AND</b> Procedure<br>Code in (99241-99245) <b>AND</b> Modifier in (TF, 0TF)   |  |
| A | 22                     | Only specialty: 96   | Exclude if Provider Number in (MC0008, MC0009,<br>MC0010, MC0011, MC0021, MC0040) <b>AND</b> Procedure<br>Code in (T1016, T1017, S0315, S0316, S9445, 99204,<br>99213, 99214, 99215) | Sickle cell<br>services                    |
| A | 22                     | Only specialty: 51   | Exclude if Primary Diagnosis in COMDHEC table <b>AND</b><br>Procedure Code in (T1016, T1017, T1027) <b>AND</b><br>Provider Number in (DHEC01-DHEC46, DHEC59)                         | BabyNet<br>services                        |
| A | 35, 36, 37, 38, 60, 76 | Any  | Include all claims   |  |
| A | 81                     | Any  | Include all claims   |  |
| A | 82                     | Any  | Exclude if Procedure Code in (X0401, X0402, A0430,<br>A0431, A0435, A0428, A0999, A0420, A0424, A0998)   | Non-<br>emergency<br>ambulance<br>services |
| A | 19 or 21               | 01, 84, 85, 87   | Include All claims   |  |
| A | 22                     | 89   | Include All claims   |  |

Note only provider types (19,20,21,22,35,36, 37, 38, 60,76,80,81,82) are included in rate setting for A claim types.

Pharmacy Claims

| Claim Type | Provider Type | Provider Specialty | Criteria                                  | Notes |
|------------|---------------|--------------------|---|-------|
| D          | 70            | Any                | Exclude over-the-counter (OTC) medication |       |

Note only provider type 70 is included in rate setting for D claim types.

Family Planning Claim Identification

| Claim Type | Provider Type | Provider Specialty | Criteria  | Notes |
|------------|---------------|--------------------|---|-------|
| A, D, Z    | All           | Any                | Exclude if Fund Code in the Family Planning Table |       |
| Z          | 01            | Any                | Exclude if DRG = 374 <b>AND</b> Fund Code = CA    |       |

**State of South Carolina Department of Health and Human Services  
Data Adjustment Specifications  
STANDARD MANAGED CARE - Claim Type**

| <u>Claim Type</u> | <u>Claim Type Description</u> |
|-------------------|-------------------------------|
| A                 | HCFA 1500 Form Claims         |
| B                 | Dental Claims                 |

|   |                               |
|---|-------------------------------|
| C | Medical Transportation Claims |
| D | Prescription Drug Claims      |
| G | Nursing Home Claims           |
| Z | UB92 Claims                   |

**State of South Carolina Department of Health and Human Services**

**Data Adjustment Specifications**

**STANDARD MANAGED CARE - Provider Type**

| <u>Provider Type</u> | <u>Provider Type Description</u> |
|----------------------|----------------------------------|
| 00                   | NURSING HOME                     |
| 01                   | INPATIENT HOSPITAL               |
| 02                   | OUTPATIENT HOSPITAL              |
| 04                   | MENTAL HEALTH (PVT)              |
| 10                   | MENTAL/REHAB                     |
| 15                   | BUY-IN                           |
| 16                   | EPSDT                            |
| 19                   | OTHER MEDICAL PROF               |
| 20                   | PHYSICIAN,OSTEOPATH IND          |
| 21                   | PHYSICIAN,OSTEOPATH GRP          |
| 22                   | MEDICAL CLINICS                  |
| 30                   | DENTIST, IND                     |
| 31                   | DENTAL, GRP                      |
| 32                   | OPTICIANS                        |
| 33                   | OPTOMETRIST, IND                 |
| 34                   | OPTOMETRIST, GRP                 |
| 35                   | PODIATRIST, IND                  |
| 36                   | PODIATRIST, GRP                  |
| 37                   | CHIROPRACTOR, IND                |
| 38                   | CHIROPRACTOR, GRP                |
| 41                   | OPTICIAN, GRP                    |
| 60                   | HOME HEALTH AGENCY               |
| 61                   | CLTC, INDIVIDUAL                 |
| 62                   | CLTC, GROUP                      |
| 70                   | PHARMACY                         |
| 76                   | DURABLE MEDICAL EQUIPMENT        |
| 80                   | INDEPENDENT LABORATORY           |
| 81                   | X-RAY                            |
| 82                   | AMBULANCE SERVICE                |
| 84                   | MEDICAL TRANSPORTATION           |
| 85                   | CAP AGENCIES                     |
| 89                   | MCCA                             |

96 MISCELLANEOUS  
 97 DUR  
 98 WITHOUT VALID PROV TYPE

**State of South Carolina Department of Health and Human Services  
 Data Adjustment Specifications  
 STANDARD MANAGED CARE - Provider Specialty**

| <u>Provider Specialty Code</u> | <u>Provider Specialty Code Description</u> |
|--------------------------------|--|
| AA                             | PEDIATRIC SUB-SPECIALIST                   |
| EN                             | DENTAL - ENDODONTIST                       |
| PE                             | DENTAL - PERIODONTIST                      |
| 00                             | NO SPECIFIC MEDICAL SPECIALTY              |
| 01                             | THERAPIST/MULTIPLE SPECIALTY GROUP         |
| 02                             | ALLERGY AND IMMUNOLOGY                     |
| 03                             | ANESTHESIOLOGY                             |
| 04                             | AUDIOLOGY                                  |
| 05                             | CARDIOVASCULAR DISEASES                    |
| 06                             | MIDWIFE                                    |
| 07                             | CHIROPRACTIC                               |
| 08                             | DENTISTRY                                  |
| 09                             | DERMATOLOGY                                |
| 10                             | EMERGENCY MEDICINE                         |
| 11                             | ENDOCRINOLOGY AND METAB                    |
| 12                             | FAMILY PRACTICE                            |
| 13                             | GASTROENTEROLOGY                           |
| 14                             | GENERAL PRACTICE                           |
| 15                             | GERIATRICS                                 |
| 16                             | GYNECOLOGY                                 |
| 17                             | HEMATOLOGY                                 |
| 18                             | INFECTIOUS DISEASES                        |
| 19                             | INTERNAL MEDICINE                          |
| 20                             | PVT MENTAL HEALTH                          |
| 21                             | NEPHROLOGY/ESRD                            |
| 22                             | NEUROLOGY                                  |
| 23                             | NEUROPATHOLOGY                             |
| 24                             | NUCLEAR MEDICINE                           |
| 25                             | NURSE ANESTHETIST                          |
| 26                             | OBSTETRICS                                 |
| 27                             | OBSTETRICS AND GYNECOLOGY                  |
| 28                             | SCDMH                                      |
| 29                             | OCCUPATIONAL MEDICINE                      |
| 30                             | ONCOLOGY                                   |

|    |                                     |
|----|-------------------------------------|
| 31 | OPHTHALMOLOGY                       |
| 32 | OSTEOPATHY                          |
| 33 | OPTICIAN                            |
| 34 | OPTOMETRY                           |
| 35 | ORTHODONTICS                        |
| 36 | OTORHINOLARYNGOLOGY                 |
| 37 | HOSPITAL PATHOLOGY                  |
| 38 | PATHOLOGY                           |
| 39 | PATHOLOGY, CLINICAL                 |
| 40 | PEDIATRICS                          |
| 41 | PEDIATRICS, ALLERGY                 |
| 42 | PEDIATRICS, CARDIOLOGY              |
| 43 | PEDODONTICS                         |
| 44 | INDEPENDENT LAB - PRICING ONLY      |
| 45 | PHYSICAL MEDICINE & REHABILITATION  |
| 46 | XRAY - LAB - PRICING ONLY           |
| 47 | PODIATRY                            |
| 48 | PSYCHIATRY                          |
| 49 | PSYCHIATRY, CHILD                   |
| 50 | FEDERALLY QUALIFIED HEALTH CLINICS  |
| 51 | DHEC                                |
| 52 | PULMONARY MEDICINE                  |
| 53 | NEONATOLOGY                         |
| 54 | RADIOLOGY                           |
| 55 | RADIOLOGY, DIAGNOSTIC               |
| 56 | RADIOLOGY, THERAPEUTIC              |
| 57 | RHEUMATOLOGY                        |
| 58 | FEDERALLY FUNDED HEALTH CLINICS (FF |
| 59 | SUPPLIER (DME)                      |
| 60 | HOME HEALTH - PRICING ONLY          |
| 61 | SURGERY, CARDIOVASCULAR             |
| 62 | SURGERY, COLON AND RECTAL           |
| 63 | SURGERY, GENERAL                    |
| 64 | AMBULANCE - PRICING ONLY            |
| 65 | SURGERY, NEUROLOGICAL               |
| 66 | SURGERY, ORAL (DENTAL ONLY)         |
| 67 | SURGERY, ORTHOPEDIC                 |
| 68 | SURGERY, PEDIATRIC                  |
| 69 | SURGERY, PLASTIC                    |
| 70 | SURGERY, THORACIC                   |
| 71 | SURGERY, UROLOGICAL                 |
| 72 | CLINIC SCREENERS - PRICING ONLY     |
| 73 | PHYSICIAN SCREENERS - PRICING ONLY  |
| 74 | PROSTHETICS & ORTHOTICS PRICE ONLY  |
| 75 | INDIVIDUAL TRANS - PRICING ONLY     |
| 76 | CAP - PRICING ONLY                  |

|    |                                     |
|----|-------------------------------------|
| 77 | CLTC                                |
| 78 | MULTIPLE SPECIALTY GROUP            |
| 79 | CLTC - ALTERNATE                    |
| 80 | OUTPATIENT-PRICING ONLY             |
| 81 | OUTPATIENT-ALTERNATE PRICING SPECIA |
| 82 | PSYCHOLOGIST                        |
| 83 | SOCIAL WORKER                       |
| 84 | SPEECH THERAPIST                    |
| 85 | PHYSICAL/OCCUPATIONAL THERAPIST     |
| 86 | NURSE PRACTITIONER                  |
| 87 | OCCUPATIONAL THERAPIST              |
| 88 | HOSPICE                             |
| 89 | CORF                                |
| 90 | ALCOHOL & DRUG ABUSE                |
| 91 | MENTAL RETARDATION                  |
| 92 | SED CHILDREN                        |
| 93 | AMBULATORY SURGERY                  |
| 94 | DIABETES EDUCATOR                   |
| 95 | DEVELOPMENTAL REHABILITATION        |
| 96 | FAMILY PLANNING, MATERNAL & CHILD H |
| 97 | RURAL HEALTH CLINICS (RHC)          |
| 98 | PRIVATE DUTY NURSING                |
| 99 | PEDIATRIC NURSE PRACTITIONER        |

**South Carolina Department of Health and Human Services**  
**Data Adjustment Specifications**  
**STANDARD MANAGED CARE – Payment Category**

| <b><u>Payment Category</u></b> | <b><u>Payment Category Description</u></b> |
|--------------------------------|--|
| 10                             | MAO (NURSING HOMES)                        |
| 11                             | MAO (EXTENDED TRANSITIONAL)                |
| 12                             | OCWI (INFANTS UP TO AGE 1)                 |
|                                | MAO (FOSTER CARE/SUBSIDIZED                |
| 13                             | ADOPTION)                                  |
| 14                             | MAO (GENERAL HOSPITAL)                     |
| 15                             | MAO (CLTC WAIVERS)                         |
| 16                             | PASS-ALONG ELIGIBLES                       |
| 17                             | EARLY WIDOWS/WIDOWERS                      |
| 18                             | DISABLED WIDOWS/WIDOWERS                   |
| 19                             | DISABLED ADULT CHILD                       |
| 20                             | PASS-ALONG CHILDREN                        |
| 30                             | AFDC (FAMILY INDEPENDENCE)                 |
| 31                             | TITLE IV-E FOSTER CARE                     |

|    |                                   |
|----|-----------------------------------|
| 32 | AGED, BLIND, DISABLED             |
| 33 | ABD NURSING HOME                  |
| 40 | WORKING DISABLED                  |
| 41 | REINSTATEMENT                     |
| 42 | Silver Card and SLMB              |
| 43 | Silver Card and S2 SLMB           |
| 48 | S2 SLMB                           |
| 49 | S3 SLMB                           |
| 50 | QUALIFIED WORKING DISABLED (QWDI) |
| 51 | TITLE IV-E ADOPTION ASSISTANCE    |
| 52 | SLMB                              |
| 54 | SSI NURSING HOMES                 |
| 55 | FAMILY PLANNING                   |
| 56 | COSY/ISCEDC                       |
| 57 | KATIE BECKETT CHILDREN - TEFRA    |
| 58 | FAMILY INDEPENDENCE SANCTIONED    |
| 59 | LOW INCOME FAMILIES               |
| 60 | REGULAR FOSTER CARE               |
| 68 | FI-MAO WORK SUPPLEMENTATION       |
| 70 | REFUGEE ENTRANT                   |
| 71 | BREAST AND CERVICAL CANCER        |
| 80 | SSI                               |
| 81 | SSI WITH ESSENTIAL SPOUSE         |
| 85 | OPTIONAL SUPPLEMENT               |
| 86 | OPTIONAL SUPPLEMENT & SSI         |
| 87 | OCWI (PREGNANT WOMEN and INFANTS) |
| 88 | OCWI (CHILDREN UP TO AGE 19) PHC  |
| 90 | QUALIFIED MEDICARE BENEF (QMB)    |
| 91 | RIBICOFF CHILDREN                 |
| 92 | SILVERCARD                        |

**South Carolina Department of Health and Human Services  
Data Adjustment Specifications  
STANDARD MANAGED CARE – RSP Codes**

| <b>RSP Code</b> | <b>RSP Indicator</b> | <b>RSP Indicator 2</b> | <b>RSP Description</b> |
|-----------------|----------------------|------------------------|------------------------|
| MCPL            | 1                    | -                      | PEP Lead               |
| LEAD            | 2                    | -                      | Non-PEP Lead           |
| SCCH            | 3                    | S                      | SC Choice              |
| NHTR            | 4                    | N                      | Nursing Home           |
|                 |                      |                        | Transition             |
| MCCM            | 5                    | -                      | Primary Care Case      |
|                 |                      |                        | Management             |
| CLTC            | A                    | E                      | (Medical Care          |
|                 |                      |                        | Home)                  |
|                 |                      |                        | CLTC Elderly           |

|      |   |   |                    |
|------|---|---|--------------------|
|      |   |   | Disabled           |
|      |   |   | Cosy Project -     |
| COSY | B | 6 | Beaufort County    |
| HREX | C | - | High Risk/Exempt   |
| HRLO | D | - | High Risk/LO       |
| HRHI | E | - | High Risk/HI       |
| HIVA | F | B | CLTC HIV AIDS      |
|      |   |   | Physicians         |
|      |   |   | Enhanced           |
| MCPD | G | - | Program            |
|      |   |   | CLTC Children's    |
| CHPC | H | C | PCA                |
|      |   |   | Interagency Sys.   |
|      |   |   | of Care for Emot.  |
| ISED | I | 6 | Dist. Ch.          |
|      |   |   | Palmetto Senior    |
| PSCA | J | P | Care               |
| MCHS | K | 7 | Hospice            |
| DMRN | L | 5 | DMR Waiver/New     |
|      |   |   | DMR                |
| DMRE | M | 5 | Waiver/Established |
| MCHM | N | 8 | HMO                |
|      |   |   | High Risk          |
| HRHT | O | - | High/Transitions   |
|      |   |   | Waiver Healthy     |
| WAHS | P | - | Start              |
|      |   |   | CLTC Assisted      |
| ALVG | Q | L | Living Waiver      |
|      |   |   | Rural Behavioral   |
| MCRH | R | R | Health Services    |
|      |   |   | Head and Spinal    |
| HSCE | S | H | Cord/Established   |
|      |   |   | Head and Spinal    |
| HSCN | T | H | Cord/New           |
|      |   |   | Medically Fragile  |
| MCFC | U | 9 | Children's Program |
|      |   |   | CLTC Ventilator    |
| VENT | V | V | Waiver             |
|      |   |   | Medically Fragile  |
| MCNF | W | 9 | Non-Foster Care    |
| MCPA | X | - | PEP Asthma         |
| ASTH | Y | - | Non-PEP Asthma     |
|      |   |   | Integrated         |
|      |   |   | Personal Care      |
| MCPC | Z | - | Services           |

**State of South Carolina Department of Health and Human  
Services  
Data Adjustment Specifications  
STANDARD MANAGED CARE - COMDHEC Range Table**

| <u>Min Diagnosis Code</u> | <u>Max Diagnosis Code</u> |
|---------------------------|---------------------------|
| V011                      | V011                      |
| V6544                     | V6545                     |
| V745                      | V745                      |
| 01400                     | 01486                     |
| 0310                      | 0319                      |
| 07998                     | 07998                     |
| 1330                      | 1330                      |
| 7955                      | 7955                      |
| V016                      | V017                      |
| V692                      | V692                      |
| 01000                     | 01096                     |
| 01500                     | 01596                     |
| 042                       | 042                       |
| 0900                      | 0999                      |
| 1370                      | 1374                      |
| 79571                     | 79571                     |
| V026                      | V028                      |
| V712                      | V712                      |
| 01100                     | 01196                     |
| 01600                     | 01696                     |
| 05410                     | 05419                     |
| 1121                      | 1122                      |
| 6071                      | 6071                      |
| V08                       | V08                       |
| V726                      | V726                      |
| 01200                     | 01286                     |
| 01700                     | 01796                     |
| 0780                      | 07811                     |
| 13100                     | 13109                     |
| 6149                      | 6149                      |
| V0970                     | V0971                     |
| V741                      | V741                      |
| 01300                     | 01396                     |
| 01800                     | 01896                     |
| 07950                     | 07959                     |
| 1322                      | 1322                      |
| 6160                      | 61610                     |

**State of South Carolina Department of Health and Human  
Services  
Data Adjustment Specifications  
STANDARD MANAGED CARE - Family Planning Fund Codes**

**Family Planning Fund Codes**

BD  
BY  
CF  
DD  
DN  
J1  
J2  
YR  
T%  
AS  
AT  
BC  
BS  
DC  
DM  
EB  
EL  
EQ  
MD  
MH  
Q2  
Q3  
Q4  
QG  
QK  
T5  
TF  
TW  
Y+  
YL  
YQ  
YX  
AB  
AD  
AN  
AO  
MG  
6T  
TL  
TO

T<sup>3</sup>  
T<sup>3</sup>  
TU  
TR  
TV  
T>  
T6  
TI

**Attachment 2**  
**Healthy Connections Kids Benefit Exclusions**

**Attachment 2A**  
**South Carolina Department of Health and Human Services**  
**Excluded Fund Codes\***

| <b>Code</b> | <b>Code</b> |
|-------------|-------------|
| 1B          | MF          |
| 3T          | MG          |
| 4T          | OF          |
| 5T          | QG          |
| 6C          | T!          |
| 6T          | T\$         |
| AA          | T(          |
| AB          | T.          |
| AC          | T@          |
| AD          | T\          |
| AP          | T=          |
| AQ          | T1          |
| AR          | T5          |
| AU          | T7          |
| B+          | T8          |
| B0          | T9          |
| BT          | TL          |
| BU          | TQ          |
| C\$         | TY          |
| C%          | VC          |
| C(          | XC          |
| C{          | XF          |
| C0          | XG          |
| C1          | XN          |
| C3          | XU          |
| C5          | XV          |
| CD          | Y=          |
| CH          | Y#          |
| CR          | Y\$         |
| CU          | Y%          |
| DB          | Y&          |
| DE          | Y@          |
| DP          | Y>          |
| EF          | Y1          |
| EK          | Y3          |
| FA          | Y8          |
| FJ          | YA          |

|    |    |
|----|----|
| IH | ZQ |
| JE | ZV |
| JI |    |

\*Only includes Fund Codes with expenditures in SFY0607 or SFY0708

**Attachment 2B**  
**South Carolina Department of Health and Human Services**  
**Excluded Diagnostic and Fund Codes Codes**

| <b>Exclusion</b>      | <b>Definition</b>  |
|-----------------------|--|
| Mental Retardation    | ICD-9 Diagnostic Codes 317.xx to 319.xx  |
| Obesity               | ICD-9 Diagnostic Code 27801  |
| Developmental Delay   | ICD-9 Diagnostic Codes 315.xx  |
| Speech Therapy        | CPT-4 Code 92508   |
| Dental                | All dental services  |
| CLTC / Transportation | CPT-4 / HCPCS Codes<br>C1000,A0080,A0110,A0140,A0200,I2000,I2002,I2003,I2010,X0271,LTC10,X0203,X0261,<br>LTC40,X0264,X0273,X0265 |