South Carolina Medicaid Managed Care Program

Policy and Procedure Guide
for
Managed Care Organizations

April 1, 2010

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MANAGED CARE ORGANIZATION PROGRAMS

INTRODUCTION

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

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

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

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

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

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

The Department of Managed Care, located within the Division of Care Management, Bureau of Care Management and Medical Support Services, is responsible for the formulation of medical and program policy, interpretation of these policies and oversight of quality and utilization management requirements set forth in this chapter. 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.

THE CONTRACT PROCESS

This section of the guide is designed to provide the information necessary for preparing to initiate an MCO contract with SCDHHS. SCDHHS will furnish potential 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. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a risk-based contract with any qualified MCO that has been issued a Certificate of Authority to operate as a domestic insurer in state by the South Carolina Department of Insurance (DOI). Potential 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

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

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

Upon receipt of this letter and the Certificate of Authority, SCDHHS will verify the license and date of issue with the DOI. Upon confirmation, SCDHHS will mail an Enrollment Package to the potential 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 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 the Readiness Review has been completed, the EQRO has submitted its final report to SCDHHS and SCDHHS finds the MCO to be in compliance with all requirements, the contract is submitted to CMS for approval. Upon receiving approval from CMS, the Managed Care staff will review county networks submitted by the MCO and determine network adequacy. Along with the county network submission, the MCO will provide an attestation that all provider contracts are in compliance with the following state requirements:

- All contracts and amendments have been prior approved by SCDHHS,
- All contracts have been properly signed and have an effective date,
- 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.
- All contracts are at a minimum one year (12 months) in term, with the option to renew after the first term using a contract amendment, for a period of up to five (5) years.

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

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

Required Submissions

The following items/documents must be submitted by the MCO with the signed Signature Pages of the official contract. The contract sections indicated are intended as a guide only

and may not be the only contract requirements related to the required submission listed. This information is being provided as a guide only and does not relieve the 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 10.13 -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 5.1.34)

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 10.15)

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 . (Only executed contracts). (CONTRACT SECTION 4.12.2) .

2. A copy of any Notice of Intent of Subcontractors Termination. (CONTRACT SECTION 5.1.31)

3. A copy of model subcontracts for each health-care provider type.(limited to six specified contract types)

The MCO must provide documentation that it has checked the Excluded Parties List Service administered by the General Services Administration. This requirement can be

accomplished by including a short written statement to the record/file that is dated and states the Excluded Parties list has been checked on a specific date and the findings contained.

C. Service Delivery Requirements

1. A description of expanded services, if any, offered for Medicaid members. (CONTRACT SECTION 4.9)

2. A listing of the service area(s) as approved by SCDOI & Medicaid service area (if different). (CONTRACT SECTION 4.12.1)

3. A copy of the referral/monitoring process, policies and procedures, as well as forms, process for in/out of plan services to include Medicaid fee-for-service referrals. (4.10.1, 4.1, 4.10.8)

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 Review section of this document)

5. A copy of PCP selection procedures and forms. (CONTRACT SECTION 4.12)

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).

E. Marketing

1. The MCO's maximum Medicaid member enrollment (projected) levels. (CONTRACT SECTION 6.11)

2. 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 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. SCDHHS must agree to any modifications(format, claims or encounter submission reports etc) prior to MCO implementation.

Readiness Review

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

Provider Network Adequacy Determination Process

Medicaid enrolled MCOs are responsible for providing all core services specified in the contract between SCDHHS and the MCO. The MCO may provide the services directly, enter into subcontracts with providers who will provide services to the members in exchange for payment by the MCO or enter in to other short-term agreements for services which require an attestation. Subcontracts are required with all providers of service unless otherwise approved by SCDHHS. SCDHHS will not accept Letters of Agreements (LOA), Memorandum of Understanding (MOU) or any variations of these types of agreements. .

The MCO and its network providers/subcontractors shall ensure access to health care services in accordance with the Medicaid contract. 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. A number of Medicaid beneficiaries receive their durable medical equipment and supplies through mail delivery. 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. Specialty care arrangements must meet normal service patterns as determined by SCDHHS. Exceptions may be made if the travel distance for medical care exceeds the mileage guidelines.

Contracts for Subcontractors

If the MCO decides to subcontract service provision, it must have a properly executed contract with the provider of those services. The contract must be for at least 12 months (one year). SCDHHS will not accept Letters of Agreement (LOA), Memorandum of Understanding (MOU) or any variations of these types of agreements. Single case agreements are not prohibited under this section..

Payment of Non-Participating Pediatric Providers

There may be cases where a non- participating pediatrician provides services to a newborn due to institutional/business relationships. Examples include post-delivery treatment prior to discharge, by a pediatrician who is under contract with a hospital. In the interest of continuity of care, MCO's are encouraged to fairly compensate these non-participating providers until such time that the infant can be served by a participating physician.

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.
- All reimbursement must be included in both the redline and final black-line submitted sub-contracts

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 subcontractor may execute the sub-contract. SCDHHS reserves the right to examine credentialing information prior to execution of the sub-contract. MCOs must provide proof that it has checked the Excluded Parties List Service administered by the General Services Administration. This documentation shall be kept in the provider's file maintained by the MCO.

MCOs are required to update their contract boilerplate on an annual basis and/or after changes have been made to the SCDHHS contract. These updates must be submitted to

SCDHHS for approval within forty-five (45) calendar days after the new contract or amendment with SCDHHS has been signed by the MCO.

Contract Update Process

MCOs must update existing operating (signed) contracts no less than every five years from their effective date, to current contract standards.. MCOs will identify the contracts in need of updating and provide a list to their SCDHHS program manager quarterly. MCOs are allowed no more than twelve months (12) to complete this update process and report the final disposition to SCDHHS. Any contract that is identified as being five years old and beyond the one year negotiation period (six years from the date of original effective date) will be out of compliance with SCDHHS contract standards and subject to corrective action, including sanctions

MCO Communications to Providers Regarding Contract Termination

Should an MCO terminate a contract with an MCO provider(s) who is 1) a status number one (#1) on the Network Provider and Subcontractor Listing Spreadsheet or 2) are the sole network provider of that service in a county or surrounding area, the SCDHHS program manager for that MCO shall be included in all termination notification correspondence (either written or electronic). Also, should an MCO receive notice of termination from a provider who meets the qualifications listed above, the SCDHHS program manager shall be notified immediately (written or electronic).

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 Medicaid 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 model attestation must be executed and provided with all new and/ or resubmitted Network Provider and Subcontractor Listing Spreadsheets.

The MCO is responsible for ensuring that all enrolled providers are eligible to participate in the Medicaid Program. If a subcontractor is **not** accepting new members, the subcontractor cannot be listed on the Spreadsheet. Additionally if a PCP or specialist do not have admitting privileges to at least one of the contracted Hospital (s) listed on the Spreadsheet the MCO must provide a detailed description of the mechanisms that will be used to provide to MCO members. SCDHHS reserves the right to disapprove any Provider Network submission based on the information provided. The MCO shall check the LEIE and other applicable federal reporting sources to ensure compliance with the MCO contract. (See section 5 of the contract)

The MCO shall only submit enrolled providers who have completed the MCO's contract, met the credentialing process and credentialed by the MCO:

1. Using the Network Provider and Subcontractor 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 Spreadsheet in the "status" column. Those listed as a status "1" are required and a contract with the provider must be completed and be contracted for a period of no less that one (1) year.. Status "2" services are optional. For status "3" services a contract is not required but the MCO must provide a signed statement attesting the service will be arranged and provided through any necessary means, including the use of out-of-network providers. Status "4" services are those that are not mandated by Medicaid but are optional services provided by the MCO. If they are offered and a contract does not exist, there must be a statement of attestation as described for status "3" services.

3. As appropriate, SCDHHS staff will utilize access-to-care trends. The goal is to ensure the approval of a network that will guarantee appropriate access to care for Medicaid 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 determines that a network is not adequate, the MCO will be notified, in writing (either electronic or paper format), the network is not approved and the specific reasons for that decision. The MCO may resubmit this network for consideration once the reasons for disapproval have been corrected.

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. Also, both the enrollment and transportation brokers are informed of the addition of approved counties.

   Upon SCDHHS approval of a network, the MCO must maintain its adequacy and can not Refuse to accept new members; change their member assignment formula; or limit member choice of providers <u>without prior approval by SCDHHS</u>, under penalty of sanctions and/or damages.

SCDHHS may modify the auto assignment, or member choice processes, at its discretion. If an MCO requests to limit auto assignment and/or member choice SCDHHS, will re-evaluated the adequacy of the county network. As a result of this review, SCDHHS reserves the right to rescind its approval of the affected county(ies) and institute a transition plan to move the MCO's members to other managed care options. The affected MCO will pay all cost associated with the transition plan.

7. SCDHHS reserves the right to perform a site review at the MCO's location or require the MCO to provide copies of the provider subcontracts, including any applicable approved amendments, credentialing, Hold Harmless Agreements and any other documentation SCDHHS deems as necessary for review. Should SCDHHS exercise its right to review, subcontracts, credentialing applications, approved credentialing meeting notes and Hold Harmless Agreements are reviewed to determine whether the language in the subcontracts and standards have been met and those that have been previously approved by SCDHHS are properly executed and the provider subcontractors have been properly credentialed.

   SCDHHS at its discretion may request and the MCO will provide to SCDHHS copies of all original contracts, credentialing material and rates. SCDHHS may ,at its discretion, contact subcontractors to verify the accuracy of the information submitted by the MCO. Renewals of existing contracts maybe not be for a time period of less than twelve (12) months.

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

Orthopedics	1	
Otorhinolaryngology	1	
Pathology	3	
Pediatrics, Allergy	3	South Carolina Medical Service Area (SCMSA)*
Pediatrics, Cardiology	3	SCMSA
Podiatry	3	
Psychiatry (private)	3	
Pulmonary Medicine	1	
Radiology, Diagnostic	3	
Radiology, Therapeutic	3	
Rheumatology	1	
Surgery - General	1	
Surgery - Thoracic	3	
Surgery - Cardiovascular	3	
Surgery - Colon and Rectal	3	
Surgery - Neurological	3	
Surgery - Pediatric	3	
Surgery - Plastic	3	
Urology	1	
Private Physical Therapy	3	
Private Speech Therapy	3	
Private Occupational Therapy	3	
Physical Therapy*	1	
Speech Therapy*	1	
Occupational Therapy*	1	
Long Term Care	3	MCO responsibility begins once the member has been approved for, and admitted to the LTC facility. If the member stays in the facility for 30 consecutive days, the member will be disenrolled from the MCO at the earliest opportunity by SCDHHS. The MCO financial responsibility will not exceed 60 days total.
	1 = Required **2 = Optional** **3 = Attestation** **4 = Attest, if offered**	**Attestation** – The MCO attests that the service will be arranged and provided through any necessary means, including out-of-network providers. Use the **Attestation of Provider Network Submission** provided below.
Proximity Guidelines		
Primary Care Physicians should be within 30 miles		
Specialty Care Physicians should be within 50 miles		
SCDHHS considers all the facts and circumstances in reviewing sub-contracts and networks. SCDHHS may grant exceptions to its' stated criteria on 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. **Therapies are in-patient or out-patient based.		

(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 MCO 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 Medicaid 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,
- All contracts are in effect for at least for one year (12 months),
- 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

BENEFICIARY ENROLLMENT

Who is Eligible to Enter an MCO?

This program is limited to certain Medicaid eligibles who:

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

How Is Eligibility Determined

Individuals who meet financial and categorical requirements may qualify for Healthy Connections (Medicaid).

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

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

Persons who are approved for Healthy Connections receive a permanent, plastic Healthy Connections card. They are instructed to take the card with them when they receive a medical service.

Coverage Groups

A. Low Income Families (LIF)

- At least one child in the home is under age 18 (19 if in a secondary school) and lives in a family with low income. Countable resources must be at or below $30,000 per budget group. (A budget group is the case a person is in based on eligibility category).

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

- **Transitional Medicaid (TM)** - Up to twenty-four months of Medicaid benefits is available after the loss of LIF eligibility due to increased earnings/hours of employment of the caretaker or loss of the LIF 50% disregard by any member of the budget group.

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

- **Ribicoff Children** - These are children whose family income is below 50% of poverty. Countable resources must be at or below $30,000 per budget group. They can be eligible even if they live with both parents. South Carolina provides Partners for Health (Medicaid) to these children up to age 18.

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

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

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

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

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

- **Early Widows/Widowers** – These are individuals age 60 through 64 who would still be eligible for SSI “but for” early receipt of Social Security benefits.

C. Qualified Medicare Beneficiaries (QMB's) - These are individuals who have Medicare Part A hospital insurance and have a monthly income at or below 100% of the Federal Poverty Level. Their countable resources must be below $6,600

for an individual or $9,910 for a couple. A separate QMB determination is done for all Medicaid beneficiaries who have Medicare Part A, regardless of their coverage group.

D. Specified Low Income Medicare Beneficiaries (SLMBs) - These are individuals who have Medicare Part A hospital insurance and have a monthly income greater than 100% and less than 120% of the Federal Poverty Level for an individual. Their countable resources must be below $6,600 for an individual and $9,910 for a couple. For these individuals, Medicaid does not pay Medicare co-insurance and deductibles and any Medicaid covered services other than Part B Premium.

E. Optional Coverage for (Pregnant) Women and Infants (OCWI) – Medicaid coverage is provided to pregnant women and infants who have a monthly income at or below 185% of the Federal Poverty Level. Countable resources must be below $30,000 per Budget Group.

F. Healthy Connections Plans for Children Under Age 19 (HCPC) – Ages 1-19 – These are children who live in families with certain income limits. In South Carolina, this group is a mixture of mandatory and optional coverage and a separate State Children's Health Insurance Program (SCHIP).

The mandatory group is children between the ages of 1 and 6 whose family's monthly income is at or below 133% of the Federal Poverty Level and children older than age 6 that were born on or after September 1983 whose family's monthly income is at or below 100% of the Federal Poverty Level. Countable resources must be at or below $30,000 per Budget Group.

The optional group is children ages 1 to 19 whose family's monthly income is over the level of the mandatory groups but at or below 150% of the Federal Poverty Level. Countable resources must be at or below $30,000 per Budget Group.

Healthy Connections Kids, a separate SCHIP coverage group, is for uninsured children up to age 19 with family income greater than 150% but less than or equal to 200% of the Federal Poverty Level. Countable resources must be at or below $30,000 per Budget Group. Healthy Connections Kids provides a special benefits package administered by a Managed Care Organization. The coverage is based on the health insurance plan offered to South Carolina State employees, with the addition of vision and dental benefits. This coverage group is scheduled to transition into the HCPC program October 1, 2010. That program will expand to 200% of the FPL upon federal approval.

G. Institutionalized/Home and Community-Based Services - These are individuals who reside in a medical institution or receive home and community-based services and who would be eligible for LIF or SSI if they were not in an

institution. This group also includes individuals whose eligibility is determined using a special income level.

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

I. Children For Whom a State Adoption Assistance Agreement is in Effect - These are special needs children for whom there is a State Adoption Assistance Agreement in place and for whom the State Adoption Assistance Agency has determined a placement could not be made without medical assistance. Countable resources must be at or below $30,000 per budget group.

J. Children Under 21 With Special Living Arrangements - These are children under age 21 who reside in a foster home or a group home. Their board payment is fully or partially sponsored by public funds. If the child's income is below FI standards, they can qualify for Medicaid. Countable resources must be at or below $30,000 per budget group.

K. Aged, Blind and Disabled – These are individuals with countable income at or below 100% of poverty and who meet the resource requirements. Countable resources must be at or below $6,600 for an individual or $9,910 for a couple.

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

M. Working Disabled - These are individuals who meet the Social Security definition of disabled and are working, and who earn more than $800 per month. Eligibility is determined using a two-step process. In the first step, the family's income, after allowable deductions, must be less than 250% of the federal poverty guidelines. If the family income meets this test, the individual's own unearned income must be below the Supplemental Security Income limit for an individual and resources at or below $6,600.

N. Breast and Cervical Cancer Program (BCCP) – The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to provide full Medicaid benefits to uninsured women who are found in need of treatment for breast and/or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia).

Option 1: Best Chance Network (BCN) Patient

- She must meet SC state residency and identity requirements (refer to the Medicaid Policy and Procedures Manual – 102.03 and 102.02).
- She has been screened for breast or cervical cancer under the Best Chance Network program, diagnosed and found in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia).
- She is age 40- 64.
- She does not have other insurance coverage that would cover breast and/or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including Medicare Part A or B.
- Her family income is at or below 200% of the Federal Poverty Level.
- She is not eligible for another Medicaid eligibility group.

Option 2: Non-Best Chance Network (Non-BCN) Patient

Women diagnosed by a non-BCN provider and found in need of treatment for either breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia) can be eligible effective July 1, 2005, for Medicaid coverage if the following criteria are met:

- She must meet SC state residency and identity requirements (refer to the Medicaid Policy and Procedures Manual – 102.03 and 102.02).
- She is under age 65.
- She does not have other insurance coverage that would cover breast and/or cervical cancer or precancerous lesions (CIN 2/3 or atypical hyperplasia), including Medicare Part A or B.
- Her family income is at or below 200% of the Federal Poverty Level.
- She is not eligible for another Medicaid eligibility group.

Infants

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

“Non-deemed Infants” refers to infants who were not born to a Medicaid eligible pregnant woman. An application and eligibility determination must be completed for these infants. If an infant has siblings in the home who receive Medicaid under the Partners for Healthy Children or Low Income Families Program, the infant may be added to the case with the siblings. If the infant’s eligibility is determined under the Infants Program, the budget group

consists of the infant and parents in the home and may also include the siblings, but only the infant is eligible. Once the infant is determined eligible, Medicaid benefits continue for one year regardless of changes in circumstances and the infant continues to meet non-financial criteria.

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

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

Annual Review

Sixty (60) days prior to the annual review date, the beneficiary is sent a review form to complete. If the beneficiary does not return the review form, the case is closed and eligibility is terminated.

If the beneficiary returns an incomplete form, it is returned to the beneficiary with a checklist identifying the missing information and instructions on 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.

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.

If the beneficiary returns the form after the case has been closed, the date the form was received will be compared to the closure date. If the received date is less than 30 days after the closure date, the case is reopened and the review is processed as if it had been received on time.

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

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

Enrollment Process

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

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

Enrollment of Newborns

All newborns of Medicaid MCO program members, where the newborn resides in the same household as the mother, are the responsibility of the MCO. A newborn is defined as a Medicaid eligible beneficiary who is under 365 days of age.

To assure continuity of care in the crucial first months of the newborn's life, every effort shall be made by SCDHHS to expedite enrollment of newborns into the MCO's Plan.

SCDHHS eligibility staff will attempt to link all newborns to a Medicaid mother when appropriate information is available. In the absence of a linkage between the newborn and mother in the SCDHHS MEDS system, the newborn will be considered non-linked.

For the first year of life, non-linked newborns will 1) remain in fee-for-service Medicaid, or 2) be enrolled into a health plan by the person responsible for the newborn. If the newborn remains in FFS Medicaid after their first birthday, the enrollment rules that apply to the remainder of the population will be applied to this beneficiary.

Linked newborns that become Medicaid eligible within the first three months of life (as determined by the monthly cutoff date) will be enrolled as follows:

- If mother was enrolled in an MCO health plan in the birth month, the newborn will be retroactively assigned to that health plan. The newborn will remain in that health plan for the remainder of the year unless the mother changed MCO plans during the second or third month of the newborn’s life. In those cases, the newborn will be transferred to the next MCO health plan for the remainder of their first year in

managed care. If the mother transfers out of an MCO health plan (to an MHN or to fee-for-service Medicaid), the newborn will not be transferred from the MCO's Plan.

- If mother was enrolled in an MHN health plan in the birth month, the newborn will NOT be assigned to that plan. If the mother had transferred to an MCO health plan in month's two or three of the newborn's life, the newborn will be assigned to that plan for the remainder of their first year in managed care.
- If the mother was not enrolled in any health plan during the first three months of the newborn's life, the newborn will receive an Outreach enrollment packet and the mother will have the option of selecting a health plan for the newborn. This selection will begin on the first day of the next available assignment period after the choice is made.

Linked newborns that become Medicaid eligible after the first three months of life will not be considered for retroactive enrollment to the birth month. These members will be considered for enrollment in the next available assignment period. The available health plan will be determined by the health plan that the mother is in for that upcoming assignment period.

- If mother is, or will be, enrolled in an MCO health plan for the upcoming assignment period, the newborn will be auto-assigned to that plan.
- If mother will not be enrolled in any health plan for the upcoming assignment period, the newborn will receive an Outreach enrollment packet and the mother will have the option of selecting a health plan for the newborn. This selection will begin on the first day of the next available assignment period after the choice is made.

Atypical cases, whether identified by the enrollment counselor (MAXIMUS, Inc.), the SCDHHS or a MCO, will be researched and resolved by SCDHHS. A change made to the mother's Medicaid ID is one example of an atypical case.

MCOs receive a Daily Newborn Enrollee File, which must be processed daily. Using the Newborn Enrollment Error Form, MCOs must report any errors in newborn enrollment to SCDHHS within 72 business hours of identification. SCDHHS will review the newborn's record in an effort to validate the error. If the error can be validated and the newborn is within the first three months of life, SCDHHS will correct the enrollment error within 72 business hours of the notification. If the enrollment correction is dependent on a change being made to the newborn's eligibility record, SCDHHS staff cannot make the correction until the eligibility record has been updated.

Enrollment Period

MCO Program members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The member may request disenrollment once without cause at any time during the 90 days following the date of the member's initial enrollment or re-enrollment with the MCO. After the end of this 90 day period, a member shall remain in the MCO's plan unless the member:

- Submits an electronic, oral or written request to disenroll or change managed care plans for cause which is subsequently approved by SCDHHS,
- The member becomes ineligible for Medicaid, and/or
- The member becomes ineligible for MCO enrollment.

A member may request disenrollment from the MCO as follows:

- For cause, at any time.
- Without cause, at the following times:
  - During the 90 days following the members initial enrollment or re-enrollment with the MCO.
  - At least once every 12 months thereafter.

All member initiated disenrollment requests must be made to South Carolina Healthy Connections Choices (SCHCC), the SCDHHS's Enrollment Broker.

A member's request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request is automatically approved.

A member may request disenrollment from the MCO for cause at any time. For cause disenrollment requests must be submitted to SCHCC on the appropriate SCHCC form.

The following are considered cause for disenrollment by the member:

- The member moves out of the MCO's service area;
- The plan does not, because of moral or religious objections, cover the service the member seeks;
- The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time **and** not all related services are available within the network; **and** the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or,
- 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.

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 ten (10) calendar 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 is automatically approved. The recipient will be disenrolled from the first plan effective the last day of the month and enrolled in the new plan effective the first of the following month. A key

factor that determines the month of disenrollment is the date the request is received vis-à-vis the monthly cut-off date. The cutoff for all actions is generally around 10 days prior to the end of the month (and varies each month). For example, if cut-off is August 20th and the request is received on August 19th, the effective date of disenrollment will be October 1. If the request is received August 21st, the effective date of disenrollment will be November 1.

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

Disenrollment

Disenrollments may be initiated by (1) the member, (2) SCDHHS or (3) the MCO. Member-initiated disenrollment is addressed above in the section entitled **Enrollment Period.** 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 Medicaid MCO program member who becomes disenrolled due to loss of Medicaid eligibility but regains Medicaid eligibility within sixty (60) calendar days will be automatically enrolled in the MCO's plan. Depending on the date eligibility is regained, there may be a gap on the member's MCO coverage. If Medicaid eligibility is regained after 60 calendar days, the reinstatement of Medicaid eligibility will prompt the SCDHHS Enrollment Broker to mail an enrollment packet to the beneficiary. The beneficiary may also initiate the re-enrollment process without an enrollment packet.

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

- Loss of Medicaid eligibility or loss of Medicaid MCO program eligibility;
- Death of a member;
- Member's intentional submission of fraudulent information;
- Member becomes an inmate of a Public Institution (see Appendix A – Definition of Terms)
- Member moves out of state;
- Member elects Hospice;
- Member becomes Medicare eligible;
- Member becomes institutionalized in a Long Term Care Facility/Nursing Home for more than (30) days;
- Member elects Home and Community Based Waiver programs;
- Loss of MCO's participation;
- Member becomes age 65 or older;
- Enrollment in a commercial HMO.
- Member is placed out of home (i.e. Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF);

- ♦ Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MCO's ability to furnish services to the member or other enrolled members..

The MCO shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MCO program 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 Medicaid". This means that Medicaid eligibility has been terminated.

The MCO may request disenrollment of a Medicaid MCO Program member based upon the following reasons:

- MCO ceases participation in the Medicaid MCO program or in the Medicaid MCO Program member's service area;
- Member dies;
- Member becomes an inmate of a Public Institution;
- Member moves out of state or MCO's service area;
- Member elects Hospice;
- Member becomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Member elects Home and Community Based Waiver programs;
- MCO determines Medicaid MCO program member has Medicare coverage;
- Medicaid MCO program member becomes age 65 or older; and
- Medicaid MCO program member fails to follow the rules of the managed care plan.
- Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MCO's ability to furnish services to the member or other enrolled members..
- Member is placed out of home (i.e. Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF);

The MCO's request for member disenrollment must be made in writing to South Carolina Healthy Connections Choices (SCHCC). The request must state, in detail, the 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 and SCDHHS will give written notification to the MCO and the member of its decision. During this process, SCDHHS may request the MCO to provide additional information and documentation. The MCO and 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.)

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 no later than the last day of the month following

the month the disenrollment form is received. A Member's disenrollment is contingent upon their "lock-in" status (see **Enrollment Period** Section).

Payment Responsibility for Hospital Stays When Enrollment/Disenrollment Occurs

The MCO that covers a member on the day of admission to a hospital is responsible for the facility charges associated with the entire stay (through discharge), even if the MCO's member changes to another MCO or FFS during the hospital stay. The date of service will dictate the responsible MCO for physician charges. Similarly, if the member is FFS on the date of admission, FFS Medicaid is responsible for facility charges for the duration of the stay to discharge and the MCO is responsible for physician charges based on the date of service.

For example, an MCO (MCO1) member is admitted to a hospital on August 20th and discharged on September 15th. On September 1, the member changes to a new MCO (MCO2). MCO1 is responsible for the all facility charges from admission to discharge and all physician charges from August 20th to August 31st. MCO2 is not responsible for any facility charges but has responsible for all physician charges from September 1st to September 15th.

Guidelines for Voluntary/Involuntary Member Disenrollment *	
Reason for Voluntary/Involuntary Disenrollment	**Disenrollment Effective Date**
Loss of Medicaid eligibility	Member will be auto-disenrolled during next processing cycles.
Death of Member	Leave enrollment through the month of death. Member will be disenrolled at the end of the month of death. Any premiums for months following the month of death will be recouped.
Intentional submission of fraudulent information	Member will be disenrolled at the earliest effective date allowed.
Member becomes inmate** of public institution	Leave enrollment through the month of incarceration. Member will be disenrolled at the end of the month of incarceration. Any premiums for months following the month of incarceration will be recouped.
Member moves out of state	Leave enrollment through the first month the member moves out of state. Member will be disenrolled at the end of the month of the move. Any premiums for months following the month of the move will be recouped.
Member elects hospice	Member will be disenrolled at the end of the month immediately preceding hospice enrollment. Any premiums paid for months following the month of disenrollment will be recouped.
Member becomes Medicare eligible	Member will be auto-disenrolled during next processing cycles. (no retro-disenrollment)
Member in LTC/NH >30 days	MCO responsibility begins once the member has been approved for, and admitted to the LTC facility. If the member stays in the facility for 30 consecutive days, the member will be disenrolled from the MCO at the earliest opportunity by SCDHHS. The MCO financial responsibility will not exceed 60 days total.
Member elects CLTC/Waivers	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
Member becomes 65 or older	Member will be disenrolled in normal processing cycles.
Member enrolled in a Commercial HMO	Leave enrollment until the month of private HMO coverage. Member will be disenrolled at the end of the month of new enrollment. Any premiums for months following the month of enrollment in commercial HMO or other Medicaid managed care plan coverage will be recouped.
Recipient on Inconsistent County Report	Member will be disenrolled at the earliest effective date allowed by system edits following verification of new address.
Member fails to follow rules of managed care plan.	Member will be disenrolled at the earliest effective date allowed by system edits.
Member status changes to family planning only	If the status of the member changes while in the hospital to a category where the hospital and physician charges would not be paid under FFS, the patient would be responsible for both the facility and physician charges for the uncovered portion of the stay (from the date that their status changes to FP services only).
Member terminates with one MCO and joins another while in hospital (disenrollment/enrollment date occurs 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.
**SCDHHS policy allows special exceptions to the disenrollment provisions listed above when in the best interest of the member and/or the Medicaid program. These exceptions will be considered on a case by case basis.* ***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.*	

PCAT	PAYMENT CATEGORY	Major Group	MCO participation	MHN participation	PGM-TYPE	Auto	Outreach Only
	Regular Medicaid						
10	MAO (Nursing Home)	Elderly/Disabled			X - not MGC elig	N	N
11	MAO (Extended/Transitional)	Low Income Families	X	X	B - both MCO or MHN	Y	N
12	OCWI (Infants)	Pregnant Women and Infants	X	X	B - both MCO or MHN	N	Y
13	MAO (Fostercare/Adoption)	Low Income Families	X	X	B - both MCO or MHN	N	Y
14	MAO (General Hospital)	Elderly/Disabled			X - not MGC elig	N	N
15	MAO (Waivers - Home & Community)	Elderly/Disabled		X	P - MHN only	N	Y
16	Pass Along Eligibles	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
17	Early Widows/Widowers	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
18	Disabled Widows/Widowers	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
19	Disabled Adult Children	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
20	Pass Along Children	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
31	Title IV-E Foster Care	Low Income Families	X	X	B - both MCO or MHN	N	Y
32	Aged, Blind, Disabled (ABD)	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
33	ABD Nursing Home	Elderly/Disabled			X - not MGC elig	N	N
40	Working Disabled	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
48	Qualifying Individuals (QI)	Elderly/Disabled			X - not MGC elig	N	N
50	Qualified Disabled Working Individual	Elderly/Disabled			X - not MGC elig	N	N
51	Title IV-E Adoption Assistance	Low Income Families	X	X	B - both MCO or MHN	N	Y
52	SLMB	Elderly/Disabled			X - not MGC elig	N	N
54	SSI Nursing Home	Elderly/Disabled			X - not MGC elig	N	N
55	Family Planning Waiver	Low Income Families			X - not MGC elig	N	N
57	Katie Beckett/TEFRA	Elderly/Disabled	X	X	B - both MCO or MHN	N	Y
59	Low Income Families	Low Income Families	X	X	B - both MCO or MHN	Y	N
60	Regular Foster Care	Low Income Families	X	X	B - both MCO or MHN	N	Y
71	Breast and Cervical Cancer	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
80	SSI	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
81	SSI With Essential Spouse	Elderly/Disabled	X	X	B - both MCO or MHN	Y	N
85	Optional Supplement	Elderly/Disabled	X	X	B - both MCO or MHN	N	Y
86	Optional Supplement & SSI	Elderly/Disabled	X	X	B - both MCO or MHN	N	Y
87	OCWI Pregnant Women /Infants	Pregnant Women and Infants	X	X	B - both MCO or MHN	Y	N
88	OCWI Partners For Healthy Children	Children	X	X	B - both MCO or MHN	Y	N
90	Qualified Medicare Beneficiary	Elderly/Disabled			X - not MGC elig	N	N

91	Ribicoff Children	Low Income Families	X	X	B - both MCO or MHN	Y	N
E	Emergency Services				X - not MGC elig	N	N
I	Inmate Services				X - not MGC elig	N	N
C	Emergency/Inmate Services				X - not MGC elig	N	N
D	DJJ Inmate Services				X - not MGC elig	N	N
J	DJJ Emergency Inmate Services				X - not MGC elig	N	N
P	Other Inmate Services				X - not MGC elig	N	N
A	Other Emergency Inmate Services				X - not MGC elig	N	N
X	SCHIP Recipient in Paycat 88						
G	SCHIP Recipient Inmate						
	SCHIP						
99	Healthy Connections Kids		X		S - SCHIP MCO only	Y	N
	Others						
70	Refuge Entrant	Low Income Families			X - not MGC elig	N	N
92	GAPS (Medicare Part D Plan)	Elderly/Disabled			X - not MGC elig	N	N

Outreach only payment categories
Autoassign payment categories
Not MGC eligible payment categories

RSP Indicator	RSP Code	MHN	MCO	Potential File (Outreach)	New/Review File (Assignment Mailings)	Eligible for Dental Benefits
AUTW Autism Waiver	8	YES	NO	YES	NO	
CLTC Elderly Disabled Waiver	A	YES	NO	YES	NO	
DMRE DMR Waiver/Established	M	YES	NO	YES	NO	Adults in this RSP are granted the same benefits as any Medicaid recipient under the age of 21.
DMRN DMR Waiver/New	L	YES	NO	YES	NO	Adults in this RSP are granted the same benefits as any Medicaid recipient under the age of 21.
HIVA CLTC HIV AIDS	F	YES	NO	YES	NO	YES
HSCE Head & Spinal Cord Waiver Established	S	YES	NO	YES	NO	YES
HSCN Head & Spinal Cord Waiver New	T	YES	NO	YES	NO	YES
MCHS Hospice	K	YES	NO	YES	NO	YES
VENT CLTC Ventilator Dependent Waiver	V	YES	NO	YES	NO	YES
MCFC Medically Fragile Children's Program	U	NO	NO	NO	NO	YES
MCNF Medically Fragile Non-Foster Care	W	NO	NO	NO	NO	YES
NHTR Nursing Home Transition	4	NO	NO	NO	NO	YES
PSCA Palmetto Senior Care		NO	NO	NO	NO	YES
HOAD Healthy Opportunity Account; in deductible period	7	NO	NO	NO	NO	YES
HOAP Healthy Opportunity Account; no co-pay	6	NO	NO	NO	NO	YES
MFPG Money Follows the Person Grant		NO	NO	NO	NO	YES
ISED Interagency Sys. Of Care for Emotion. Disturbed Children	I	YES	YES	YES	NO	YES
CHPC CLTC Children's Personal Care Aide	H	YES	YES	YES	NO	YES
MCPC Integrated Personal Care Services	Z	YES	YES	YES	NO	YES
COSY Cosy Project Beaufort Co.	B	YES	YES	YES	NO	YES
WAHS Waiver Healthy Start	P	YES	YES	YES	NO	YES
PRTF Psychiatric Residential Treatment Facility Demonstration Waiver for SED Children	9	YES	NO	YES		YES
WMCC Medically Complex Children's Waiver	3	YES	NO	YES	NO	YES

Non-Pay Cat/RSP Eligiblity						
Dual Eligibles (Medicare/Medicaid)		YES	NO	YES	NO	YES
Aged 65 or over		YES	NO	YES	NO	YES

PAYMENTS/ADJUSTMENTS

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

SCDHHS uses a number of actuarially sound methodologies to develop its managed care rates These methodologies can be found in the Managed Care Data Book, found in the appendices of this Guide. 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. It is the MCO’s responsibility to reconcile the “Gross Level” adjustments that are sent to the MCO.
The following will be paid through Gross Level 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 via the SCDHHS Extranet. Based on the information in the payment request an adjustment will be prepared. This process is expected to become automated in August 2010.

Low Birth-Weight Kicker Payment Process

The Low Birth Weight Newborn kicker payment process has been established in order to 1) compensate managed care plans for the additional expenditures associated with the birth and care for a low birth weight infant, 2) ensure the equitable distribution of funds to MCOs based on the actual incidence of low birth weight newborns and 3) provide an incentive for MCOs to encourage behaviors and practices that reduce the occurrence of low birth weight infants. SCDHHS defines two categories of low birth weight newborns:

- Low Birth Weight Newborns – Infants born at a weight of 2499 grams to 1500 grams
- Very Low Birth Weight Newborns - Infants born at a weight of 1499 grams and below

It is important to ensure that all weight conversions from pounds and ounces to grams are accurate and concise. Birth Weight should not be rounded off i.e., when converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams (See chart below).

When an infant is born to a Plan member that falls within the parameters specified above, SCDHHS will make a fixed one-time kicker payment. This payment does not include the first month's pm/pm payment. The normal pm/pm payment begins for the month of birth and continues throughout membership period in the MCO. The amount of this payment is specified in the MCO contract, Capitation Rates, Appendix B. There are two specific payment amounts, one for low birth weight newborns and a one for very low birth weight newborns. This amount is calculated and adjusted as specified in the MCO contract. The payment itself is drawn from the Low Birth Weight Kicker funding pool. The operation of the pool's funding and distribution mechanism is discussed in the **Capitation Rate Development for Medicaid Managed Care Program**, which is included as an appendix to this Guide.

In order to obtain this payment, the MCO must submit demographic and identification information to the Department of Managed Care on a quarterly basis using the Low Birth Weight Kicker Payment Log contained in the Index of Required Files, Reports and Forms, "MCO Reports to SCDHHS" section of this Policy and Procedure Guide. The details of the submission information are contained on the Log. All sections of this log must be completed prior to submission, including the exact birth weight of the infant, in grams. Additionally, the MCO must maintain written official documentation of the identity and birth weight of the infant as supplied by the hospital or licensed health care professional. This official documentation can be in the form of surgical or operation notes, hospital notes, nursing records, nursing notes, delivery records, discharge documentation, birth certificate or other medical record. This official documentation will be reviewed by SCDHHS or it agents and must be made available upon request.

Regularly scheduled audits of low birth weight newborn kicker payments will be conducted and findings of payment errors may result in positive or negative adjustments. An annual reconciliation will also be performed to ensure the kicker payment process is cost neutral to SCDHHS.

BIRTHWEIGHT (Source: SCDHEC)

VERY LOW BIRTHWEIGHT: Very low birth weight is a weight at birth which is equal to or less than 1,499 grams (3 pounds, 4 ounces), regardless of the period of gestation.

LOW BIRTHWEIGHT: Low birth weight is a weight at birth which equal to 1500 but is less than or equal to 2,499 grams (5 pounds, 8 ounces), regardless of the period of gestation.

NORMAL BIRTHWEIGHT: Normal birth weight is a weight at birth which is equal to or greater than 2,500 grams (5 pounds, 8 ounces), regardless of the period of gestation.

GRAMS WEIGHT CONVERSION CHART

500 grams or less = 1lb. 1 oz. or less
501 - 1,000 grams = 1 lb. 2 oz. - 2 lb. 3 oz.
1,001 - 1,500 grams = 2 lb. 4 oz. - 3 lb. 4 oz.
1,501 - 2,000 grams = 3 lb. 5 oz. - 4 lb. 6 oz.
2,001 - 2,500 grams = 4 lb. 7 oz. - 5 lb. 8 oz.
2,501 - 3,000 grams = 5 lb. 9 oz. - 6 lb. 9 oz.
3,000 - 3,500 grams = 6 lb. 10 oz. - 7 lb. 11 oz.
3,501 - 4,000 grams = 7 lb. 12 oz. - 8 lb. 13 oz.
4,001 - 4,500 grams = 8 lb. 14 oz. - 9 lb. 14 oz.
4,501 - 5,000 grams = 9 lb. 15 oz. - 11 lb. 0 oz.
5,001 grams or more = 11 lb. 1 oz - or more

Dual Eligible Payment

Dual eligible individuals are not eligible to be placed in an MCO, however, some individuals may be in an MCO and receive retroactive Medicare eligibility. The Dual Eligible payment category is for the purpose of paying MCOs for those persons who receive retroactive Medicare eligibility and includes payment for both Medicaid and Medicare crossover claims.

Rate Change Adjustments

In the event that CMS approves a rate change and authorizes the new rate be implemented retroactively, the SCDHHS financial staff will calculate any appropriate credit/debit adjustments due to/from the MCO. If there are material changes, as determined by SCDHHS, to the Medicare fee schedule and subsequent changes to the Medicaid fee schedule during the Contract period, SCDHHS reserves the right to adjust the capitation rates accordingly.

Sanctions

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

Capitation/Premium Payment Adjustment

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

Interim Hospital Payments

In the event that hospital claims for an individual have met the limitation criteria as stated in the SCDHHS Hospital Services Provider Manual, an interim payment may be made. These limitations are: 1) charges have reached $400,000 and 2) discharge is not imminent.

FQHC/RHC Wrap Payment Process

Background Information

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires the determination of supplemental payments for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) contracting with Medicaid Managed Care Organizations (MCOs). These supplemental payments are calculated and paid to ensure that these providers receive reimbursement for their services to Medicaid MCO beneficiaries at least equal to the payment that would have been received under the traditional fee for service methodology. These determinations, generally referred to as Wrap-Around payments, are mandated by BIPA 2000 to be completed at least every four (4) months. SCDHHS is the state agency responsible for the Wrap-Around payment methodology. This reconciliation is incorporated into the agency's State Plan for Medical Assistance.

Specific requirements for FHQCs and RHCs contracting with Medicaid MCOs are contained in the MCO contract. The Medicaid MCO shall submit on a **quarterly basis**, **by date of service**, a report of all paid and denied encounter/claim data for all contracting FQHCs and RHCs for State Plan required reconciliation purposes. This encounter/claims data will be submitted no later than **sixty (60)** days following the quarter's end date.

FQHC/RHC Wrap Data Files (Spreadsheets)

Encounter/claims detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one file. These spreadsheets/file shall be in Microsoft Excel file format. General instructions are provided in this section. **Exhibits 1 – 4** contain specific

instructions regarding the field name, size, location, type and description for these two data spreadsheets.

A. Encounter/Claims Detail Data File (spreadsheet 1)

Data shall be provided in a separate file using MS Excel file format. All paid and denied records for a member by FQHC/RHC will be submitted to SCDHHS, excluding records where place of services equals 21,22 or 23 (i.e. hospital inpatient, outpatient or ER services). These records will be sorted by FQHC/RHC (ascending legacy number order), then by dates of service (ascending order). **Specific instructions are provided in Exhibits 1 and 2.**

B. Summary Data File (spreadsheet 2)

Data shall be provided in a second file using Microsoft Excel file format. There is only one record for each month of service for each FQHC/RHC. These records will be sorted by FQHC/RHC (ascending legacy number order), then by month/year of service (ascending order). Capitation payments (fields 8 & 9) must be provided. Fields 8 and 9 are also to be used for any additional or enhanced MCO per member per month payments (i.e. non fee for service) if applicable. These elements are critical and are not provided in the encounter/claims detail file. Specific instructions are provided in Exhibits 3 and 4.

Regarding services to children insured by the SCHIP stand alone program, these records should not be submitted in the files described above. FQHC and RHC encounter rates have been used in the determination of the SCHIP per member per month payments made to the MCOs; therefore, these services are not included in the quarterly wrap-around calculations.

FQHC/RHC Data Transmission Requirements

The Extranet shall be used for transmitting data to SCDHHS. Presently, each MCO has access to the Extranet through an existing data sharing agreement with SCDHHS. This service is preferred, as it was specifically designed for the purpose of transferring data electronically in a secure environment.

All capitation payments and all other payments specified in the summary data file by the Medicaid MCO to the FQHC/RHC for the specified quarter must be provided. This payment information is not shown in the claims detail and is critical to the Wrap-Around settlement process.

Each MCO must adhere to the following requirements:

A. Submit each quarter (January – March; April – June; July – September; and October – December) by dates of service, all paid and denied encounter/claims for each FQHC/RHC contracting with the MCO. The first quarter of encounter/claims data for the MCO contract will be for dates of service between July 1 and September 30, 2009.

This encounter/claims data will be submitted no later than sixty (60) days following the quarter's end date.

B. Each quarter, the MCO is required to notify the Division of Ancillary Reimbursements by e-mail when the files have been uploaded to the SCDHHS Extranet. Attached to this e-mail, an updated and comprehensive list of FQHCs/RHCs contracting with the MCO must be provided. The MCO should list for each FQHC/RHC, the provider name, legacy number and the effective (and terminating, if applicable) date(s) of the contract.

   The Division of Ancillary Reimbursements, Bureau of Reimbursement Methodology and Policy, will provide the appropriate e-mail addresses and key contact persons to the MCOs to facilitate data submission and to provide technical assistance.

C. Based on the FQHC/RHCs fiscal year end, an annual reconciliation of MCO payments and services to allowable reimbursement based on the FQHC/RHCs encounter rate will be determined. To complete this process, the following will be required:

   Within 180 days of a FQHC/RHCs fiscal year end, all quarterly wrap around files for the applicable FQHC/RHC fiscal year should be re-run (i.e. updated) in order to capture additional encounter and payment data not available or processed when the applicable quarter was originally run.

   Transmission requirements remain the same as the quarterly submissions. That is, the updated files should be transmitted through the SCDHHS Extranet with notification to the appropriate staff member of the Division of Ancillary Reimbursements.

MCO Deadlines for Data Transmission

Submit the quarterly data to the Division of Ancillary Reimbursements using the SCDHHS Extranet network, no later than sixty (60) days from the quarter's end date. Using the example given in Data Transmission Requirement A (above), the 3nd quarter 2009 encounter/claims data should be received no later than November 29, 2009.

Submit the quarterly re-runs (see Requirement C – above) to the Division of Ancillary Reimbursements using the SCDHHS Extranet network, no later than 180 days from the FQHC/RHC provider's year-end date.

SCDHHS Reporting Requirements

An interim wrap calculation will be generated on a quarterly basis for each FQHC and RHC contracting with a participating MCO. The Division of Ancillary Reimbursements utilizes a series of macros in MS Excel to determine the allowable encounters and the appropriate fee-for-service CPT codes. These macros adhere to the requirements provided in the Medicaid Provider Manual: Physicians, Laboratories and Other Medical Professionals, State Plan and MCO contract. An example of the report generated is provided as Exhibit 5. Page 1 of this report will be provided to each FQHC/RHC with a letter from the Division of Ancillary

Reimbursements notifying them of the interim wrap calculation and settlement, if appropriate. Exhibit 6 shows the report using the data elements (encounter/claims detail and summary data) from Exhibits 1 and 3.

Contact Information

Division Director
Division of Ancillary Reimbursements
SCDHHS
Post Office Box 8206
Columbia, SC 29202-8206
(803) 898-1040 Telephone
(803) 255-8228 Fax

Exhibits 1-4 are to be produced by MCOs and sent to SCDHHS

Exhibit 1
ENCOUNTER/CLAIMS DETAIL DATA FILE - FIELD DESCRIPTIONS

Encounter/Claims Detail Data are provided in a separate file in MS Excel file format. All paid and denied claims for each FQHC/RHC contracting with the MCO during a specified quarter, by **dates of service,** are provided to SCDHHS via the Extranet, 60 days from the quarter's end date. This file is sorted by ascending legacy number order, then by ascending date of service order. **Exhibit 1** shows in field number order, the field name, description, length of field and field type. Actual MS Excel file format is shown as **Exhibit 2.** The fields from **Exhibit 1** are presented in a horizontal file format.

Field	Data Element Name	Example Length/Field Type	Field Description
1	**Unique Claim Number**	ABC999999999999 (Text-15)	Unique number assigned by the MCO to identify the entire claim record.
2	**Legacy Number**	RHC000 or FQC000 (Text-6)	A 6-digit Number assigned by the Medicaid Program Office to uniquely identify the practice/facility as an RHC or FQHC.
3	**NPI Number**	9999999999 (Number-10)	The National Provider Identification number assigned to the FQHC or RHC.
4	**Name**	ABC Health Care (Text-50)	FQHC or RHC Provider legal name.
5	**Tax ID**	99-9999999 (Text-10)	The federal tax identification number assigned to the FQHC or RHC.
6	**Member Last Name**	Smith (Text-20)	The member's last name.
7	**Member First Name**	John (Text-20)	The member's first name.
8	**Medicaid ID**	99999999999 (Number-10)	The 10-digit Medicaid number assigned to the member.
9	**Member Plan Type**	9 (Number-1)	Indicate whether the record is: **1**-Fee-for-Service; or **2**-CAP Encounter.
10	**Date of Service**	00/00/0000 (Date-10)	Date of service.

11	**CPT Code**	99999 (Text-5)	CPT Code.
12	**CPT Code Modifier**	99 (Text-2)	2-digit modifier for CPT Code.
Field	**Data Element Name**	**Example Length/Field Type**	**Field Description**
13	**Net Paid Amount**	$9,999.99 (Currency-6)	MCO amount paid for service rendered.
14	**Other Insurance Amount**	$9,999.99 (Currency-6)	Other insurance amount paid for this service (i.e., Third Party Liability).
15	**Claim Type**	E (Text-1)	Indicate whether the CPT code is: **E**-Evaluation & Management; **M**-Medicine; or **S**-Surgery.
16	**Status**	P (Text-1)	Indicate whether the record is: **P**-Paid or **D**-Denied.
17	**Claim Explanation 1**	Duplicate Encounter (Text-50)	**If the claim was not paid the contracted rate for any reason**, provide an explanation (primary). Explanation to be provided may include one of the following: Authorization or referral not obtained; Missing CPT code or other critical information; Diagnosis invalid or missing; individual provider ID must be submitted; member not enrolled on date of service; duplicate encounter; or this procedure is considered redundant to the primary procedure. Other explanations may be used if not included on this list.
18	**Claim Explanation 2**	(Text-50)	If the claim was not paid the contracted rate for any reason, provide an explanation (secondary). See description for Field 16.
19	**Attending Physician Name**	Doolittle, William (Text-30)	The attending physician's legal name.
20	**Attending Physician Number**	999999 (Text-6)	The Medicaid number assigned to the attending physician.
21	**MCO Name**	ABC MCO (Text-20)	MCO name.
22	**MCO Provider Number**	HM9999 (Text-6)	MCO provider number assigned by the Medicaid Program Office.

Exhibit 2
Encounter/Claims Detail Data File – Actual Layout

Exhibit 2 is the actual horizontal file format of the 22 Data Fields provided in Exhibit 1.

1	2	3	4	5	6	7	8	9	10	11
Unique Claim Number	Legacy Number	NPI Number	Name	Tax ID	Member Last Name	Member First Name	Medicaid ID	Member Plan Type	Date of Service	CPT Code
ABC999999999999	RHC999	9999999999	ABC Health Care	99-9999999	Smith	John	99999999999	2	00/00/0000	99213

12	13	14	15	16	17	18	19	20	21	22
Mod	Paid Amount	Other Ins. Amount	Claim Type	Status	Claim Explanation 1	Claim Explanation 2	Attending Physician Name	Attending Physician Number	MCO Name	MCO Number
0	$9,999.99	$9,999.99	E	P	Duplicate Encounter		Doolittle, William	999999	ABC MCO	**HM9999**

Exhibit 3

SUMMARY DATA - FIELD DESCRIPTIONS

Summary data is provided in a separate file in MS Excel file format. The field names, descriptions, length of field and field types are presented in field number order. Fee-for-service (FFS) and capitation (CAP) encounter/claims detail data are summarized by month and year of service for specified dates of service in the quarter. Capitation payments (fields 8 & 9) to include any additional or enhanced MCO per member per month payments (i.e. non fee for service) must be provided by the MCO. Fields 10-14 are calculated using information obtained from the encounter/claims detail data (Attachments 1 & 2).

Field	Data Element Number/Name	Example Length/Field Type	Description
1	**MCO Name**	ABC MCO (Text-30)	MCO name.
2	**MCO Provider Number**	HM9999 (Text-6)	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the MCO.
3	**Legacy Number**	RHC000 or FQC000 (Text-6)	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the FQHC or RHC.
4	**NPI Number**	9999999999 (Number-10)	The National Provider Identification number assigned to the FQHC or RHC.
5	**Name**	ABC Health Care (Text-50)	FQHC or RHC provider legal name.
6	**Tax ID**	99-99999999 (Text-10)	The federal tax identification number assigned to the FQHC or RHC.
7	**Month/Year of Service**	01/2008 (Date-7)	Enter the month and year of service in the appropriate format.
8	**Monthly CAP Number of Members**	99,999 (Number-5)	Enter the total number of members for month of service with capitation payments .
9	**Monthly CAP Amount Paid**	$99,999,999.99 (Number-10)	Enter the total amount paid for field 8. Field 9 is also to be used for any additional or enhanced MCO per member per month payments (i.e. non fee for service) if applicable.
10	**Monthly FFS Number Members**	99,999 (Number-5)	Enter the **unduplicated** number of members for month of service with fee-for-service payments .

11	**Monthly FFS Number Encounters**	99,999 (Number-5)	Enter the total number of fee-for-service encounters for month of service. **One encounter is a member's visit to the FQHC or RHC for each date of service regardless of the cpt4 code or status of the claim.** SCDHHS calculates the actual number of allowed fee-for-service encounters per member.
12	**Monthly FFS Amount Paid**	$99,999,999.99 (Number-10)	Enter the total amount paid for fee-for-service payments per month of service.
13	**Monthly CAP Encounters Number Members**	99,999 (Number-5)	Enter the unduplicated number of members for month of service with CAP encounter data only.
14	**Monthly CAP Encounters Number of Encounters**	999,999 (Number-6)	Enter the total number of CAP encounters for month of service. **One encounter is a member's visit to the FQHC or RHC for each date of service regardless of the cpt4 code or status of the claim.** SCDHHS calculates the actual number of allowed CAP encounters per member.

Exhibit 4

SUMMARY DATA - ACTUAL LAYOUT

Summary data is provided in a separate file in MS Excel file format. Each FQHC or RHC will have **one record per month/year of service**. Fields 8 - 9 must be provided by the MCO; the encounter/claims detail data does not contain this information. Fields 10 - 14 are summarized using encounter/claims detail data (Attachments 1 & 2).

1	2	3	4	5	6	7	8	9	10	11	12	13	14
							Summarize by Month/Year						
MCO Name	MCO Provider Number	Legacy Number	NPI Number	Name	Tax ID	Month/Year of Service	CAP No. Members	CAP Amount Paid	FFS No. of Clients	FFS No. Encounters	FFS Amount Paid	CAP Encounters - No. Clients	CAP Encounters - No. Encounters
ABC MCO	HM9999	RHC000	9999999999	ABC Health Care	99-9999999	01/2008	99,999	$99,999,999.99	99,999	99,999	$99,999,999.99	99,999	999,999

Exhibits 5-6 are produced by SCDHHS*

*These reports are available to MCOs upon request

Exhibit 5		
NEW MCO Health Plan Provider Quarterly Review		
Provider Name: ABC Heath Care, Inc.		
Provider Number: RHC999/NPI #: 1999999999		
Quarter: January 1 - March 31, 2008		
Quarter Ended	**March**	
	2008	
Encounters per NEW MCO	16	
RHC/FQHC Rate	$ 99.23	
Total Due at RHC/FQHC Rate	$ 1,588	
Less: Paid per NEW MCO	$ 1,115	
Total Due (From)/To Provider	**$ 473**	

NEW MCO Health Plan					
RHC/FQHC Summary Report for the Quarter Ended:				**3/31/2008**	
ABC Health Care, Inc.			Tax ID: 57-9999999		
Capitation payments					
Month	# of members			Amount Paid	
January	85			$0.00	
February	80			$0.00	
March	92			$0.00	
Total	257			$0.00	**2a**
Encounters by month					
Month	# of clients seen	# of encounters		Payments	
January	8	8	①	$580.95	**A**
February	6	7	①	$371.53	**B**
March	2	3	①	$213.13	**C**
Total	16	18	Σ①	$1,165.61	**2b = (A+B+C)**
Encounters CAP by month					
Month	# of clients seen	# of encounters			
January					
February					
March					
Total					
Σ①	Total number of encounters claimed by NEW MCO				
2a	Total capitation payments per NEW MCO				
2b	Total fee-for-service encounter payments per NEW MCO				
Σ③	Total number of allowed encounters (Reference subsequent pages) =				**16**
A - C	Traces to intermediary's calculation. Reference subsequent pages for determination.				
	$ -	(Ref. **2a**)			
	1,165.61	(Ref. **2b**)			
	$ -	(Ref. **2c**)			
	22.95	(Other insurance paid)			
	(73.23)	(Less fee for service)			
	$ 1,115.33	(Total quarterly payments per NEW MCO)			

NEW MCO Health Member Visits Made to RHC/FQHC Clinics										
ABC Health Care, Inc.										
Tax ID: 57-9999999										
MEMBER	**MEDICAID**	**DATE OF**		**AMOUNT**		**ALLOWED**	**FEE FOR**	**OTHER**		
NAME	**NUMBER**	**SERVICE**	**CPT4**	**PAID**		**ENCOUNTER**	**SERVICE**	**INS. PAID**		
DOE, JOHN	*****2901	1/3/2008	99213	$48.12		③				
DOE, JOHN	*****2901	1/3/2008	99213	$0.00	DE				**Duplicate Encounter**	
DOE, JOHN	*****2901	1/3/2008	99214	$72.95	SE				**Second Encounter**	
COTTON, LIZ	*****5284	1/3/2008	81002	$3.07			$3.07			
COTTON, LIZ	*****5284	1/3/2008	99214	$0.00	DC				**Authorization not Obtained**	
SMITH, BILL	*****5601	1/8/2008	90471	$12.00						
SMITH, BILL	*****5601	1/8/2008	90658	$15.98			$15.98			
SMITH, BILL	*****5601	1/8/2008	99214	$72.95		③				
PALMER, MO	*****7102	1/8/2008	99214	$72.95		③				
KELLY, MISSY	*****6201	1/11/2008	36415	$2.58						
KELLY, MISSY	*****6201	1/11/2008	99213	$48.12		③				
KENNEDY, JOE	*****3101	1/14/2008	36415	$2.58						
KENNEDY, JOE	*****3101	1/14/2008	99214	$72.95		③				
STRICK, TY	*****4604	1/15/2008	81002	$3.07			$3.07			
STRICK, TY	*****4604	1/15/2008	99213	$48.12		③				
KELLY, MISSY	*****6201	1/15/2008	90471	$12.00						
KELLY, MISSY	*****6201	1/15/2008	90658	$15.98			$15.98			
KELLY, MISSY	*****6201	1/15/2008	90732	$27.53			$27.53			
KELLY, MISSY	*****6201	1/15/2008	99214	$50.00		③		$22.95		
		January Total		**$580.95**	**A**	**7**	**$65.63**	**$22.95**		
A - Cross reference sub-total on Quarterly Summary page.										
CHIP, KATHY	*****4102	2/6/2008	99213	$48.12		③				
CHIP, KIKI	*****4103	2/6/2008	99213	$48.12		③				
MEDICAID, LOU	*****8994	2/6/2008	99213	$48.12		③				
FLORENCE, KAI	*****8996	2/6/2008	99213	$48.12		③				
FLORENCE, KAI	*****8996	2/26/2008	11200	$55.40						
PARKER, BEBE	*****9501	2/26/2008	99214	$72.95		③				

HALL, LEWIS	*****8372	2/27/2008	99213	$48.12		③				
HALL, LEWIS	*****8372	2/27/2008	36415	$2.58						
		February Total		**$371.53**	**B**	**6**	**$0.00**	**$0.00**		
B - Cross reference sub-total on Quarterly Summary page.										
ANT, CATHY	*****3701	3/5/2008	69210	$36.34						
ANT, CATHY	*****3701	3/5/2008	99213	$48.12		③				
ANGEL, BOB	*****8203	3/6/2008	81025	$7.60			$7.60			
ANGEL, BOB	*****8203	3/6/2008	99213	$48.12		③				
ANT, CATHY	*****3701	3/26/2008	99214	$72.95		③				
		March Total		**$213.13**	**C**	**3**	**$7.60**	**$0.00**		
C - Cross reference sub-total on Quarterly Summary page.										
		Grand Total		**$1,165.61**	**Σ③**	**16**	**$73.23**	**$22.95**		
Σ③ - Total number of encounters allowed. Reference Quarterly Summary page for further review.										
DC - Denied claim can not be considered as an allowed encounter.										
DE - Duplicate encounter not allowed.										
SE - Second encounter not allowed.										

Exhibit 6

SCDHHS REPORT - EXAMPLE USING CLAIMS/SUMMARY FIELDS

ABC MCO Review — Field 20 - Claims — Plan Provider Quarterly			
Provider Name: ABC Health Care	Field 4 - Claims		
Provider Number: FQHC or RHC # / NPI #:	Field 2 - Claims	Field 3 - Claims	
Quarter: January 1 - March 31, 2008			
Quarter Ended	March		
	2008		
Encounters per ABC MCO	-		
RHC/FQHC Rate			
Total Due at RHC/FQHC Rate	#VALUE!		
Less: Paid per ABC MCO	$ -		
Total Due (From)/To Provider	**#VALUE!**		

TOTAL NUMBER OF FEE-FOR-SERVICE AND CAP ENCOUNTERS. SEE 'PROVIDER' WORKSHEET (PAGE 2).

MEDICAID CALCULATED FIELDS

MEDICAID RATE FOR TIME PERIOD

ABC MCO Plan	Field 20 - Claims					
RHC/FQHC Summary Report for the Quarter Ended:				**3/31/2008**	Field 10 - Claims	
ABC Health Care	Field 4 - Claims		Tax ID:	Field 5 - Claims		
Capitation Payments						
Month	# of members			Amount Paid		
January	Field 8 - Summary			Field 9 - Summary		
February						
March						
Total					**2a**	
FFS Encounters by Month						
Month	# of clients seen	# of encounters		Payments		
January	Field 10 - Summary	Field 11 - Summary	①	Field 12 - Summary	**A**	
February			①		**B**	
March			①		**C**	
Total			Σ①		**2b = (A+B+C)**	
CAP Encounters by Month						
Month	# of clients seen	# of encounters				
January	Field 13 - Summary	Field 14 - Summary	②			
February			②			
March			②			
Total			Σ②			

Σ①	Total number of FFS encounters claimed by ABC MCO				
Σ②	Total number of CAP encounters claimed by ABC MCO				
2a	Total capitation payments per ABC MCO				
2b	Total FFS encounter payments per ABC MCO				
Σ③	Total number of allowed FFS encounters (Reference subsequent pages) =				**0**
Σ④	Total number of allowed CAP encounters (Reference subsequent pages) =				**0**
A - C	Traces to intermediary's calculation. Reference subsequent pages for determination.				
	$ -	(Ref. **2a**)			
	-	(Ref. **2b**)			
	-	(Add other insurance paid)			
	-	(Less fee for service - services not covered under encounter rate)			
	$ -	(Total quarterly payments per ABC MCO)			

Additional FFS Payments by Month			
Month		Payments	
January			
February			
March			
Total			**2c**

Field 15 - Summary

ABC MCO Member Visits Made to RHC/FQHC Clinics		Field 4 - Claims							
ABC Health Care									
Tax ID:		Field 5 - Claims							
MEMBER LAST NAME	**MEMBER FIRST NAME**	**MEDICAID NUMBER**	**DATE OF SERVICE**	**CPT4**	**AMOUNT PAID**		**ALLOWED ENCOUNTER**	**FEE FOR SERVICE**	**OTHER INS. PAID**
Field 6 - Claims	Field 7 - Claims	Field 8 - Claims	Field 10 - Claims	Field 11 - Claims	Field 13 - Claims		MEDICAID CALCULATED FIELDS	Field 14 - Claims	
			January Total		**$0.00**	**A**	**0**	**$0.00**	**$0.00**
A - Cross reference sub-total on Quarterly Summary page.									
			February Total		**$0.00**	**B**	**0**	**$0.00**	**$0.00**
B - Cross reference sub-total on Quarterly Summary page.									
			March Total		**$0.00**	**C**	**0**	**$0.00**	**$0.00**
C - Cross reference sub-total on Quarterly Summary page.									
			Grand Total		**$0.00**	**Σ③**	**0**	**$0.00**	**$0.00**

Σ③ - Total number of encounters allowed. Reference Quarterly Summary page for further review.									

ABC MCO Member Visits Made to RHC/FQHC Clinics									
ABC Health Care	Field 4 - Claims								
Tax ID:	Field 5 - Claims								
MEMBER	MEMBER	MEDICAID	DATE OF			ALLOWED CAP			
LAST NAME	FIRST NAME	NUMBER	SERVICE	CPT4		ENCOUNTER			
Field 6 - Claims	Field 7 - Claims	Field 8 - Claims	Field 10 - Claims	Field 11 - Claims		MEDICAID CALCULATED FIELD			
			January Total			A	0	$0.00	$0.00
			February Total			□			
			March Total			□			
			Grand Total		Σ④	□			
Σ④ - Total number of CAP encounters allowed. Reference Quarterly Summary page for further review.									

CORE BENEFITS

☑ The "check" symbol is used to denote services that are in the MCO rate.

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

MCO plans may offer expanded services to Medicaid MCO Program members. Additions, deletions or modifications to the expanded services made during the contract year must be submitted to SCDHHS for approval. These expanded services may include medical services which are currently non-covered and/or which are above current Medicaid limitations. If the 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 Medicaid contract or whenever it adopts the policy during the term of the contract.
- The information must be provided to potential enrollees before and during enrollment.
- The information must be provided to enrollees within ninety (90) days after adopting the policy.

SCDHHS, on a regular basis, may expand, limit, modify or eliminate specific services, procedures and diagnosis codes offered by the SC Medicaid program. These changes may also affect maximum reimbursement rates and service limitations , These changes are documented and distributed via Medicaid 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.

In the event the amount , duration and/or scope of services is modified under the Medicaid fee-for-service program, SCDHHS, in its discretion, may exempt the Medicaid MCO Program from the modification.

Prior Authorization, Decision Timeframes and PA Special Instructions

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 fourteen (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 three (3) business 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.

As stated in the MCO contract, when a Medicaid member entering a MCO is receiving Medicaid covered pharmacy and/or durable medical equipment services the day before enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the MCO is responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. That MCO shall provide continuation of such services for up to thirty (30) calendar days or until the member may be transferred without disruption, . The MCO must also honor any prior authorization for pharmacy and/or durable medical equipment services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of thirty (30) calendar days after the member's enrollment. In addition, for members with the following conditions, the MCO must provide continuation of pharmaceutical services and/or honor prior authorization and additionally thirty (30) days for a total of up to sixty (60) calendar days or until the member may be transferred without disruption, whichever is less: major depression, schizophrenia, bipolar disorder, major anxiety disorder and attention-deficit/hyperactivity disorder.

☑ Inpatient Hospital Services

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

Responsibility for Hospital Stays When Enrollment/Disenrollment Occurs" located in the Beneficiary Enrollment section of this Guide.

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

☑ Ancillary Medical Services

Ancillary medical services, including, but not limited to pathology, radiology, emergency medicine and anesthesiology are part of in the managed care rate and covered under hospital inpatient and outpatient services. When the MCO's member is provided these services the MCO shall reimburse the professional component of these services at the Medicaid fee-for-service rate, unless another reimbursement rate has been previously negotiated. Prior authorization for these services shall not be required of either network or non-participating providers. All anesthesia services, even those associated with behavioral health and dental procedures, are the responsibility of the MCO.

☑ Transplant and Transplant-Related Services

Group I – Kidney and Corneal

Kidney: The MCO is responsible for all services prior to 72 hour pre-admission, post transplant services upon discharge by MUHA and post transplant pharmacy services.
All potential kidney transplants, cadaver or living donor, must be authorized by The Division of Physician Services before the services are performed. The Division of Physician Services will review all Medicaid referrals for organ transplants and issue an approval or a denial.

Corneal: MCO is responsible for this service.

Transportation arrangement for Group I transplants are coordinated through the Division of Medical Support Services. For information on the transportation program, call or write:

SCDHHS
Division of Medical Support Services
Post Office Box 8206
Columbia, SC 29202
(803) 898-2655

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

Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung and Heart/Lung, Multivisceral, Small Bowel:

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

All potential Group II transplants, cadaver or living donor, must be authorized by SCDHHS, Department of Physician Services before the services are performed. The Department will review all Medicaid referrals for organ transplants and issue an approval or a denial.

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

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

Transplant Coordinator
Department of Physician Services: 803-898-2660

☑ Newborn Hearing Screenings

Newborn Hearing Screenings are included in the core benefits when they are rendered to newborns in an inpatient hospital setting. This procedure is **not** included in the DRG. Therefore the MCO should work with providers to insure payment. The MCO is responsible for payment for this screening. The MCO rate includes payment for this service.

☑ Outpatient Services

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

therapy, occupational therapy, and speech therapy rendered in an outpatient hospital setting. Services performed in an outpatient hospital setting are considered to be Family Planning services only when the primary diagnosis is "Family Planning."

☑ Outpatient Pediatric Aids Clinic Services (OPAC)

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

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

- All exposed children will be followed with frequent clinical and laboratory evaluations to allow early identification of those children who are infected.
- Provide proper care for infected infants and children, i.e., pneumocystis carinii prophylaxis or specific treatment for HIV infection.
- Coordinate primary care services with the family's primary care provider (when one is available and identified).
- Coordinate required laboratory evaluations that occur when clinical evaluations are not needed. These should be arranged at local facilities if this is more convenient and the tests are available locally. May be coordinated with the primary care provider and often with the assistance of local health department personnel.
- Provide management decisions and regularly see the children and parents when HIV infected children are hospitalized at the Level III Hospitals. When HIV infected children are hospitalized at regional or local hospitals with less severe illnesses, provide consultation to assist in the management of their care.
- Provide case coordination and social work services to the families to assure specialty and primary care follow-up and to assist in obtaining needed services for the child and family.

☑ Psychiatric Assessment and Psychiatric Emergency Services

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

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

For these services, Nurse Practitioners are included as allowed provider types (19/86).

Should a member receive outpatient services in an emergency room setting for which the primary diagnosis is behavioral health (class code C), the emergency room visit (both professional and facility fees) shall be paid by the MCO.

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

☑ Physician Services

Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics, skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service. Medical services (physician services that are not mental health treatment services) provided by a psychiatrist or child psychiatrist are in the MCO rate and should be paid by the MCO.

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

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

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

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

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

☑ Maternity Services

Maternity services include high levels of quality care for pregnant members. Maternity care service benefits include prenatal, delivery, postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. All pregnant members and their infants should receive risk appropriate medical and referral services.

Hospital claims with both a cesarean section and sterilization are not reimbursed through Family Planning funding sources. Therefore, all MCOs are responsible for these inpatient hospital claims. MCOs that have been approved to operate under the section of the SCDHHSMCO contract titled "Moral or Religious Objections to .Providing Certain Covered Services". are not responsible for any associated sterilization professional fees. This will be reimbursed by the fee-for-service system.

☑ Communicable Disease Services

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

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

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

☑ Family Planning

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

considered to be Family Planning services only when the primary diagnosis is "Family Planning."

Eligible recipients should be encouraged to receive family planning services through an in network provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. However, eligible recipients have the freedom to receive family planning services from any appropriate Medicaid providers without any restrictions.
If the member receives these services through the MCO primary care provider, the MCO is responsible for reimbursement for the services . If the member receives these services outside the MCO network, providers will be reimbursed through the Fee-For-Service system. If an MCO has been approved to operate under the section of the MCO SCDHHS contract titled "Moral or Religious Objections to .Providing Certain Covered Services," the Fee-For-Service system is responsible for payment for members who receive this services through their primary care provider or outside of the MCO network.

☑ Independent Laboratory And X-Ray Services

Benefits cover laboratory and x-ray services ordered by a physician and provided by independent laboratories and portable x-ray facilities. An independent laboratory and x-ray facility is defined as a facility licensed by the appropriate State authority and not part of a hospital, clinic, or physician's office. In cases where the Department of Alcohol & Other Drug Abuse Services or the Department of Mental Health submit laboratory claims under Provider Type "80" (Independent Lab), MCOs are responsible for reimbursement. When these two agencies submit laboratory claims under Provider Type "10" (Mental Health/Rehabilitation), they are the responsibility of the Fee-for-Service reimbursement system.

☑ Durable Medical Equipment

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

☑ Hearing Aids and Hearing Aid Accessories

The MCO is responsible for providing hearing aids and accessories to members under age 21. The specific products and limitations are listed in the DME provider manual and updated via Medicaid bulletin. Pricing is available from the monthly fee schedule and/or contract schedule provided to MCOs.

☑ Prescription Drugs

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

Routinely covered pharmaceutical services include most rebated legend (i.e. prescription) and most rebated over-the-counter (OTC) products. Medicaid sponsors reimbursement for unlimited prescriptions or refills for eligibles to the date of their 21st birthday. Eligibles age 21 and above are allowed up to four (4) Medicaid-covered prescriptions per month. However, certain items are routinely exempt from the monthly prescription limit. The exemptions to the monthly prescription limit are the following: insulin syringes used in the administration of home injectable therapies; home-administered injectables (insulin products, however, count toward the monthly limit); aerosolized pentamidine; clozapine therapy; and family planning pharmaceuticals and devices. A prescription limit override process allows for adult beneficiaries' monthly prescription limit to be exceeded if the prescription limit has already been reached *and* the prescription meets stipulated override criteria. SCDHHS provides prescription coverage for a maximum 31-day supply of medication per prescription (31 days' supply for Schedule II drugs) or refill. At least 75% of the current non-controlled substance prescription must be used (as directed on the prescription) before Medicaid pays for a refill of the prescription. Medicaid reimburses for most rebated generic products; many brand name products for which generics are available require prior authorization (PA). Prior authorization is also required for certain other products as well as for quantities exceeding established per month limitations. Approval for Medicaid coverage of products requiring prior authorization is patient-specific and is determined according to certain established medical criteria and conditions.

If the beneficiary is responsible for co-payments, the current prescription co-payment for Medicaid beneficiaries is $3.00 per prescription or refill. In those cases where an MCO plan utilizes a formulary, the formulary and any updates/changes must be provided to Medicaid members and providers in a timely manner. The formulary must allow for coverage of any non-formulary products currently reimbursable as fee-for-service by South Carolina Medicaid. Information regarding coverage allowance for a non-formulary product must be disseminated to Medicaid members and providers.

MCOs are required to have a policy which allows provision of no less than a five (5) day emergency supply of prescription drugs by October 1, 2010. SCDHHS will review such policies to ensure members are provided adequate access.

☑ Ambulance Transportation

All transportation services provided via ambulance (provider code 82) are the responsibility of the MCO. MCO's are responsible for all member ambulance transports for Advanced Life Support (ALS) or Basic Life Support (BLS) either emergency or non-emergency transports billable by an Ambulance provider. These trips may be routine or non-routine transports to a Medicaid covered service. The MCO will provide stretcher trips, as well as, air ambulance or medivac transportation.

In the event that an ambulance is called to a location but not used for transport (i.e. the member is not taken to a medical services provider), the MCO is still responsible for payment to the provider.

The MCO may review ambulance services, however, the contractual definition of medical necessity must be used as guidance in making determinations. MCOs may require the same level of documentation from the provider as required by the fee-for-services system.

Transportation for Out-of-State Medical Services

MCO members are eligible for prior authorized transportation as described below:

- If the MCO authorizes out-of-state referral services and the referral service is available in-state, the MCO is responsible for all Medicaid covered services related to the referral to include all modes of transportation, escorts, meals and lodging.

- If the MCO authorizes out-of-state services and the service is not available in-state the MCO will be responsible for the cost of referral services and any ambulance or medivac transportation.

☑ Home Health Services

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

☑ Institutional Long Term Care Facilities/Nursing Homes

MCO plans are required to pay for up to the first 30 days of continuous confinement in a long term care facility/nursing home/hospital who provides swing bed or administrative days. Additionally, the MCO is responsible for long term care until the member can be disenrolled at the earliest effective date allowed by system edits, at which time payment for institutional long-term care services will be reimbursed fee-for-service by the Medicaid program. The maximum MCO liability is a total of 60 days. Specifically, administrative days are counted as part of the hospital stay and **do not** count towards fulfilling the MCO long term care responsibility. Swing beds are counted in the same way as nursing home days and **do** count

towards fulfilling the MCO responsibility for long term care. SCDHHS will work in conjunction with MCO care management staff to ensure timely identification of persons certified to enter long term care facilities/nursing homes.

Admission of a MCO beneficiary, must follow the Medicaid requirements of participation for nursing facilities, including level of care certification, preadmission screening and resident review (PASARR), resident assessment, notification of patient's rights, and other requirements. The MCO must obtain a level of care certification from CLTC for a Medicaid MCO program member prior to admission to the facility. The Certification Letter will have an effective period of **45 calendar days**.

The SCDHHS CLTC nurse consultant, in addition to the above, must complete the following tasks:

- Review the completed assessment and follow policy for assessment.
- Follow policy for level of care determination.
- If referral for Medicare for skilled applicant is appropriate, complete CLTC Notification and instructs support staff to send to applicant and agency, if appropriate.
- Follow policy for retroactive certification, if appropriate.
- Follow policy for time-limited certification, if appropriate.
- Follow policy 0 for completing Level of Care Certification Letter, DHHS Form 185, and instruct support staff to mail copies to agencies and person designated on form.
- Follow policy for nursing facility under denial of payment sanctions.
- Complete Nursing Home Certification.

☑ Hysterectomies, Sterilizations, And Abortions

The MCO shall cover sterilizations, abortions, and hysterectomies pursuant to applicable Federal and State laws and regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the instructions with the original form maintained in the member's medical file and a copy submitted to the MCO for retention in the event of audit. In the event a physician does not complete and submit the required specific forms referenced above, it is permissible for the MCO to delay or reject payment until such time as the forms are properly completed and submitted. It is **not** permissible for the MCO to deny or delay payment to the hospital or other ancillary providers should the physician not complete of submit the required forms. Each claim must stand on its own merit, not upon a physician's failure to submit the required documentation.

The following are applicable current policies:

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

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

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

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

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

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

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

(d) Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

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

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

(b) The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

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

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

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

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

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

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

2. **Abortions*:** Abortions and services associated with the abortion procedure shall be covered only when the physician has found, and certified in writing that on the basis of his professional judgment, the pregnancy is a result of rape or incest or the women suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the women in danger of death unless an abortion is performed and must be documented in the medical record by the attending physician stating why the abortion is necessary; or if the pregnancy is the result of an act of rape or incest. Abortions must be documented with a completed Abortion Statement Form (see Forms section) which will satisfy federal and state regulations.

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

   The abortion statement must contain the name and address of the patient, the reason for the abortion and the physician's signature and date. The patient's certification statement is only required in cases of rape or incest.

   Information regarding the appropriate CPT, ICD-9 and Diagnosis codes for therapeutic abortions can be found in the Hospital Services Provider Manual. Please consult the monthly fee schedule for accurate payment information.

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

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

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

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

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

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

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

☑ Developmental Evaluation Services

Developmental Evaluation Services are defined as medically necessary comprehensive neurodevelopmental and psychological developmental, evaluation and treatment services for recipients between the ages of 0 – 21. These individuals have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. These services are for the purpose of facilitating correction or amelioration of physical, emotional and/or mental illnesses and other conditions which if left untreated, would negatively impact the health and quality of life of the recipient. Developmental Evaluation Services may be provided through referral to MCO network providers which

may include but shall not be limited to one of the three tertiary level Developmental Evaluation Centers (DEC) located within the Departments of Pediatrics at the Greenville Hospital System, Greenville, The University School of Medicine, USC, Columbia, or the Medical University of South Carolina at Charleston. Pediatric Day Treatment, when rendered by the DECs, is considered as one of the DEC treatment services. The MCO is responsible for the following:

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

Current Medicaid Service Limitations: 12 units per year

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

Current Medicaid Service Limitations: 4 units per visit

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

Current Medicaid Service Limitations: 12 units per year

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

Current Medicaid Service Limitations: 4 units per visit

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

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

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

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

S5105 – Pediatric Day Treatment

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

☑ Disease Management

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

☑ Audiological Services

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

The MCO is responsible for providing a range of examinations, fittings and related audiological services. The specific procedures and limitations are listed in the Private Rehabilitative Therapy and Audiological Services provider manual and updated via Medicaid bulletin. Pricing is available from the monthly fee schedule and/or contract schedule provided to MCOs.

☑ Chiropractic Services

Chiropractic services are available to all recipients. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit.

☑ Rehabilitative Therapies For Children -- Non-Hospital Based

The Title XIX SC State Medicaid Plan provides for a wide range or therapeutic services available to individuals under the age of twenty-one (21) who have sensory impairments, mental retardation, physical disabilities, and/or developmental disabilities or delays.

Rehabilitative therapy services include: speech-language pathology, audiology, physical and occupational therapies, and Nursing Services for Children under 21 years of age. These services are provided through the Local Education Authorities (LEA) or the Private Rehabilitation Services programs. MCOs are only responsible for Private providers that are not providing services under contract with LEA.

The specific services and fee-for-service limitations can be found in the Private Rehabilitative Therapy and Audiological Services Provider Manual.

☑ Vision Care Services

All vision services, with the exception of corrective appliances (glasses and frames, contact lenses) and associated fees (fitting and dispensing fees) are the responsibility of the MCO. MCOs are responsible for one vision test during any 12 month period, as well as the other vision services outlined in the SCDHHS Physician's manual. Vision associated enhanced benefits provided solely by the MCO (not part of the Medicaid benefit) are the responsibility of the MCO.

SERVICES OUTSIDE THE CORE BENEFITS

☒ The "X" symbol is used to denote services that are NOT in the MCO rate.

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

☒ Institutional Long Term Care Facilities/Nursing Homes - Limitations

MCO plans are not responsible for continuous confinement in a long term care facility/nursing home/hospital which extends beyond 30 days or the earliest disenrollment effective date past the 30 days allowed by system edits, **whichever is greater.** In no case is the MCOs' financial responsibility to exceed 60 calendar days. . Services include nursing facility and rehabilitative services at the intermediary or sub-acute intermediate levels of care. Administrative days are counted as part of the hospital stay and **do not** count towards fulfilling MCO responsibility for long term care. Swing beds are counted in the same way as nursing home days and **do** count towards fulfilling MCO responsibility for long term care. As stated in the "Core Benefits" section of this Guide, the MCO **is** responsible for long term care until the member can be disenrolled at the earliest effective date allowed by system edits, at which time payment for institutional long-term care services will be reimbursed fee-for-service by the Medicaid program.

☒ Mental Health And Alcohol And Other Drug Abuse Treatment Services

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

Hospital Services (UB-04 claims)

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

Physician/Clinic (CMS 1500 claims)

- Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS) **;**
- Services provided by the Department of Mental Health (DMH) ;
- Psychiatric services as outlined in the Physician Services Provider Manual, Section 2, Psychiatric and Counseling Services, except the assessment codes detailed in the Psychiatric Assessment and Psychiatric Emergency Services section.

If a member presents at the emergency room with a behavioral health primary diagnosis and is admitted to the hospital, (DRG's 424-433 and 521-523) SCDHHS would be the responsible

party and would not make a payment for an emergency room visit but would reimburse the hospital for an inpatient stay using a DRG payment. For services billed by a psychiatrist, SCDHHS will pay for procedure codes 90804 – 90899 as fee-for -service. For services billed by a medical doctor (including a psychiatrist) or a para –professional, SCDHHS will pay for the following procedure codes as fee-for-service: 90804, 90806, 90847, 90853, 90882 and 99441. Both assessment codes listed in the Psychiatric Assessment Services section are the responsibility of the MCO.

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

☒ Medical (Non-Ambulance) Transportation

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

Broker-Based Transportation (Routine Non-Emergency Medicaid Transportation)

These are transports of MCO members to covered services as follows:

- Urgent transportation for member trips and urgent transportation for follow-up medical care when directed by a medical professional.

- Unplanned or unscheduled requests for immediate transportation to a medical service when directed by a medical professional (i.e., pharmacy, hospital discharge).

- Routine non-emergency transportation to medical appointments for eligible members. Any planned and/or scheduled transportation needs for Medicaid beneficiaries must be pre-arranged via direct contact with the regional Brokers.

- Non-emergency transports requiring BLS that are planned/scheduled transports to a scheduled medical appointment (i.e. transport from nursing home to physician's office, nursing home to dialysis center or hospital to residence).

- Non-emergency wheelchair transports that require use of a lift vehicle and do not require the assistance of medical personnel on board at the time of transport to

medical appointments for eligible beneficiaries. These transports do not require the use of an ambulance vehicle.

MCO staff should communicate directly with the Brokers to ensure services are arranged, scheduled and fulfilled as required for a member's access to covered-Medicaid services. These services are paid Fee-for–Service.

☒ Vision Care Services

Glasses, contact lenses, fitting and dispensing fees are the responsibility of the Fee-For-Service Medicaid program. Recipients under age 21are eligible to receive one pair of glasses per year. Recipients age 21 and older may only receive glasses following certain eye surgeries detailed in the Medicaid Physician's manual. Replacement glasses or contacts due to breakage or loss are the responsibility of the member, unless replacement is offered by the MCO under an enhanced benefits program provided by the MCO.

☒ Dental Services

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

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

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

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

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

☒ Targeted Case Management Services

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

- Department of Mental Health: services for chronically mentally ill adults and children with serious emotional disturbances.
- Department of Alcohol and Other Drug Abuse Services: services for substance abusers/dependents.
- Department of Juvenile Justice: services for children 0-21 receiving community services (non-institutional level) in association with the juvenile justice system.
- Department of Social Services: a) services to emotionally disturbed children 0-21 in the custody of DSS and placed in foster care, and adults 18 and over in need of protective services and b) vulnerable adults in need of protective custody.
- Continuum of Care for Emotionally Disturbed Children: children ages 0-21 who are severely emotionally disturbed.
- Department of Disabilities and Special Needs: services to individuals with mental retardation, developmental disabilities, and head and spinal cord injuries. Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training.
- South Carolina School for the Deaf and the Blind: services to persons with sensory impairments. Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training for children up to age six.
- Sickle Cell Foundations and other authorized providers: services for children and adults with sickle cell disease and/or trait that enable recipients to have timely access to a full array of needed community services and programs that can best meet their needs.

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

☒ Home And Community Based Waiver Services

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

☒ Pregnancy Prevention Services - Targeted Populations

The Medicaid program provides reimbursement for pregnancy prevention services for targeted populations through state and community providers. The Medicaid program will reimburse fee-for-service directly to enrolled Medicaid providers for these services. The MCO should ensure that Medicaid MCO program members continue to have access to these programs.

☒ MAPPS Family Planning Services

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

THIRD PARTY LIABILITY

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

Specific Areas for TPL Activity

A. Comprehensive Insurance Verification Activities

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

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

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

Only verified TPL coverage data will be passed to MCOs.

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

B. Cost Avoidance

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

C. Aggressive Benefit Recovery Activities

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

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

The following types of recoveries are initiated by SCDHHS:

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

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

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

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

PROVIDER CERTIFICATION AND LICENSING

Medical service providers must meet certification and licensing requirements for the State of South Carolina. A provider cannot be enrolled if their name appears on the Centers for Medicare and Medicaid Services (CMS) Sanction Report, or is not in good standing with their licensing board (i.e., license has been suspended or revoked). Enrolled providers are terminated upon notification of a suspension, disbarment, or termination by USHHS, Office of Inspector General. A 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.

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

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

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

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

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

Laboratory Certification - In accordance with Federal regulations, all laboratory testing facilities providing services must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver or a Certificate of Registration with a CLIA

identification number. Laboratories can only provide services that are consistent with their type of CLIA certification.

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

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

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

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

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

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

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

Rural Health Clinics (RHC) - Clinics must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by the Centers for Medicare and Medicaid Services (CMS). Providers billing laboratory procedures must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate.

Laboratories can only provide services that are consistent with their type of CLIA certification.

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

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

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

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

Mobile Ultrasound - No license or certification required.

Physiology Labs - Providers must be enrolled with Medicare.

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

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

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

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

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

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

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

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

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.

Initial Credentialing and Re-Credentialing Policy

The MCO will develop and maintain policies and procedures regarding the initial credentialing and re-credentialing processes of all physician. Any changes to the MCO's credentialing or re-credentialing policies and procedures must be submitted to SCDHHS for approval prior to implementing the changes.

An initial onsite review is required of all Primary Care Physicians, as defined in this Guide , prior to the completion of the initial credentialing process. The MCO must assess the quality, safety, and accessibility of all office sites(including part-time or satellite offices) where care is delivered. The following, at a minimum, must be included in the assessment:

- accessibility, safety, sanitation and appearance
- Handicapped accessibility and compliance with federal/state/local requirements
- Adequacy of waiting/public rooms
- Adequacy of examination rooms
- Posting of office hours
- Adequate patient record-keeping system which is compliant with state and federal requirements
- Adequate system of maintaining patient appointments

Additional onsite review, is required within 45 calendar days when a complaint has been lodged against a specific provider which relates to the assessment issues listed above. Should the complaint be verified, the MCO and provider must institute actions to correct the deficiency(ies). The MCO must evaluate the effectiveness of corrective actions and certify the deficiency(ies) has been rectified.

MCO Credentialing Committee and the Credentialing Process

Each MCO will maintain a Credentialing Committee. The MCO's Medical Director shall have overall responsibility for the committee's activities. The Committee shall have a broad representation from all disciplines (including Mid-Level Practitioners) and reflect a peer review process.

Credentialing must be completed and approved by the MCO Credentialing Committee for all Medicaid provider(s) who participate with the MCO prior to serving MCO members. If an MCO provider has been credentialed using the MCO's commercial credentialing process the MCO Medical Director must sign an attestation stating the commercial credentialing meets SCDHHS Medicaid MCO credentialing criteria.

For existing Medicaid-only providers, MCOs must conduct the re-credentialing process in accordance with SCDHHS criteria. For providers who serve both the commercial and Medicaid populations, the credentialing committee must acknowledge in separate minutes that the provider(s) have met SCDHHS criteria. These minutes must be attached to the provider(s) Medicaid credentialing file. An identifiable separate page/section (also included in the file) of the minutes that addresses Medicaid providers is also acceptable.

The initial credentialing and re-credentialing process will include, at a minimum the following:

- 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 re-credentialing adverse results (for results other than quality of care), but not at initial credentialing.

The MCO may delegate the credentialing / re-credentialing process, with SCDHHS' prior written approval. All delegated agreement must be a written contract that has been approved by SCDHHS prior to execution by either party. SCDHHS does not accept MOU, LOA or any other type of agreement other than a written contract. The MCO is responsible for ensuring that the delegated entity follows the requirements as set forth by SCDHHS. The MCO must conduct an initial on-site review of the delegated entity and perform an audit to ensure the entity is in compliance with SCDHHS credentialing requirements. This review must include, at a minimum, a sample detailed analysis of 5% or 50 files (whichever is greater). The MCO must repeat this process annually. Re-credentialing for delegated entities will be completed no less than every three (3) years.

Whether the MCO does the initial credentialing/re-credentialing, or it has delegated this function to another approved delegated entity, the MCO is responsible to have an ongoing monitoring program of the provider(s) who participate (s) in Medicaid through a contract with the MCO. The monitoring program must have policies and procedures in place to monitor provider(s) sanctions, complaints and quality issues between re-credentialing cycles, and must take the appropriate action against providers when it identifies any of the above listed occurrences.

The MCO may use its own credentialing application or the most current SCMA application until the SCMA finalize it format. When the SCMA has finalized its credentialing format, the MCO shall use the new South Carolina Medical Association Credentialing Application in their initial credentialing and recredentialing of physicians. However, a**ll MCOs shall use the updated SCMA credentialing format exclusively, no later than April 1, 2011**. The application may be downloaded at the following website: http://www.scmanet.org.

QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

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

1. Have a quality assessment system that:

    a) Is consistent with applicable federal regulations;
    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) Quality Assessment Program Description – A description of the QA program which outlines the MCO's mechanisms to monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The QA efforts should be health outcome oriented and rely upon data generated by the MCO as well as that developed by outside sources. The description must be organized and written so that staff members and practitioners can understand the program's goals, objective, 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 operations of the QA program. Such person shall be a health care professional (i.e. registered nurse, physician, CPHQ), who has the necessary knowledge and skills to design, implement, and maintain ongoing healthcare quality, patient safety, utilization, and clinical risk management strategies, systems, processes, and associated activities. This person shall spend an adequate percentage of his/her time dedicated to QA activities to ensure the effectiveness of the QA program and be accountable for QA in all MCO providers and subcontractors. In addition, the medical director must have substantial regular involvement in QA activities..

    c) Annual Quality Assessment Work Plan – The work plan should include but not limited to the planned activities, objectives, timeframe or milestones for each activity and the responsible staff member. This document should be update frequently to reflect the progress on all activities.

    d) Program Integrity Plan – (SCDHHS Contract Section 11.1)

e) 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.)
- ♦ participating network providers in a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.). with emphasis on primary care including obstetric and pediatric representation; and
- ♦ MCO management or Board of Directors.

f) The QA Committee shall be located within the MCO such that it can be responsible for all aspects of the QA program.

g) The QA Committee shall meet at least quarterly, produce dated and signed written documentation of all meetings and committee activities and. submit this information, on a quarterly basis, to the MCO Board of Directors, SCDHHS and its authorized agents.

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

i) The MCO shall have written procedures which addresses the MCO's approach to measurement, analysis, and interventions for QA activity findings. This procedure should include monitoring activities following intervention implementation. The measurement, analysis and interventions shall be documented in writing and submitted to the MCO Board of Directors and SCDHHS.

j) 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.

k) 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. In future contracts, pay-for-performance will be used to access the quality improvements measured in HEDIS and CAHPS surveys. At a minimum, the MCO shall:

- ➢ Conduct performance improvement projects as described in this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement. This improvement should be sustained over time and have favorable effects on both health outcomes and enrollee satisfaction.,
- ➢ Submit performance measurement data as described in 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.

    - Performance Measurements: Annually the MCO shall measure and report to SCDHHS its performance using ALL NCQA defined HEDIS measures applicable to Medicaid by June 15th of the following calendar year. MCO's must use the correct HEDIS Technical Specifications for data collection and reporting for each year (i.e. 2009 data would use HEDIS 2010 Technical Specifications).

    - Performance Improvement Projects (PIP): Annually, the MCO shall have an ongoing program of performance improvement projects (a minimum of two 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.
- Each project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregated to produce new information on quality of care each year [42 CFR 438.240 (d) (2)].

l) Annual Written Evaluation of the QA Program – An annual evaluation of the overall effectiveness of the QA and performance improvement program. [42 CFR 438.240 (e) (2)].

m) Report the MCO's QA program performance information to network providers and members at least annually.

3. Assist the SCDHHS in its quality assurance activities.

a) The MCO will assist SCDHHS and SCDHHS's External Quality Review Organization (EQRO) in the identification of provider and recipient data required to carry out on-site medical chart reviews.

b) The MCO will arrange orientation meetings for physician office staff concerning on-site medical chart reviews..

c) 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.

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

e) Whether announced or unannounced MCO shall allow duly authorized agents or representatives of the State or Federal government, , 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.

f) 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.

4. Assure that all persons, whether they are 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. MCO shall and also require the subcontractor to check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or contracts with another subcontractor, to ensure that it does not employ individuals or use subcontractors who are debarred, suspended, or otherwise excluded from participating in Federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are significant to the subcontractor's contractual obligation. The subcontractor shall also report to the MCO any employees or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

   a) The MCO must have written policies and procedures for credentialing and re-credentialing. The MCO may use its own credentialing and re-credentialing forms or may use the South Carolina Uniform Managed care Provider credentialing application or Credentials Update form.

   b) The MCO shall maintain a copy of all plan providers current valid license to practice or be able to access a copy within 72 hours, if requested.

   c) The MCO shall have policies and procedures for approval of new subcontractors and termination or suspension of a subcontractor.

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

5. 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) A referral system for medically necessary, specialty, secondary and tertiary care.

d) Assurance of the provision of emergency care, 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. MCOs shall clearly specify referral requirements to providers and subcontractors and keep copies of referrals (approved and denied) in a central file or in the member's medical record.

f) Assignment of an MCO qualified representative to interface with the case manager for those members receiving out of plan continuity of care and case management services. The MCO representative shall work with the case manager to identify what Medicaid covered services, in conjunction with the other identified social services, are to be provided to the member.

6. Have systems for maintaining medical records for all Medicaid members in the plan, to ensure the medical record:

a) Is accurate, legible and safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all individuals evaluated or treated, and is accessible for review and audit. Also, the MCO shall maintain, or require its network providers and subcontractors to maintain, individual medical records for each Medicaid member. Such records shall be readily available to the SCDHHS and/or its designee and contain all information necessary for the medical management of each enrolled member. Procedures shall also exist to facilitate the prompt transfer of patient care records to other in - or out-of-plan providers.

b) Is readily available for MCO-wide QA and UM activities and provides adequate medical and 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) Contain, at a minimum, the following items:

- ✓ Patient name, Medicaid identification number, age, sex, and places of residence and employment and responsible party (parent/guardian).
- ✓ Services provided through the MCO, date of service, service site, and name of service provider.

- ✓ Medical history, diagnoses, prescribed treatment and/or therapy and drug(s) administered or dispensed. The medical record shall commence on the date of 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 12 and under)** record of immunization status. Documentation of advance directives, if completed.
- ✓ The documentation for each visit must include:
  - Date
  - 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.

7. Submit Encounter Data as required on a monthly basis a format 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

8. Have written utilization management policies and procedures which include, at a minimum :

   1. Protocols for 1) denial of services, 2) prior approval, 3) hospital discharge planning and 4) retrospective review of claims.
   2. Processes to identify utilization problems and undertake corrective action.
   3. An emergency room log, or equivalent method, specifically to track emergency room utilization and prior authorization (to include denials).
   4. 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.

9. Furnish members with approved written information regarding the nature and extent of their rights and responsibilities as a member of the MCO. The minimum information shall include:

    a) A description of the managed care plan,
    b) A current listing of practitioners providing health care,
    c) Information about benefits and how to obtain them,
    d) Information on the confidentiality of patient information,
    e) Grievance and appeal rights,
    f) Advance directive information as described in 42 CFR 417.436 and 489 subpart I,
    g) Eligibility and enrollment information

10. Maintain a grievance and appeal system which:

    a) Has written policies and procedures that are distributed to members. These policies and procedures must comply with the provisions of the MCO Contract.
    b) Informs members they must exhaust the MCO grievance and appeal process prior to filing for a state fair hearing, and informs the member of the state fair hearing process and its procedures.
    c) Attempts to resolve grievances through internal mechanisms whenever possible.
    d) Maintains a record keeping system for oral and written grievances and appeals and records of disposition.
    e) Provides 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 any resulting corrective action

        The MCO shall forward any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the MCO Program member.

    g) In the event a Member or provider requests a State Fair Hearing, the MCO must transmit copies of all communication (written and electronic) to the program manager concurrent with communication to the Member/provider/SCDHHS hearing officer.

11. Allow for SCDHHS to evaluate each MCOs compliance with SCDHHS program policies and procedures, identify problem areas and monitor the MCO's progress in this effort. At a minimum this must include, but is not limited to, :

    (a) SCDHHS review and approval of the MCO's written Quality Assurance and Improvement Plan. The MCO must submit any subsequent changes and/or revisions to its Plan to SCDHHS for approval on or before April 30th annually.

(b) SCDHHS review and approval of 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) SCDHHS review of 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) SCDHHS review of quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.

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

(f) SCDHHS staff approves all of the MCO's Plan of Correction (POC) and monitoring of disposition of identified items developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective actions.

12. Annually, SCDHHS will evaluate the MCO's compliance with QA standards through an annual comprehensive QA evaluation. 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:

a) Conducting an annual review of the MCO. The CMS protocol, Monitoring Medicaid Managed Care Organizations and SCDHHS approved review standards will serve as a guide for the review. SCDHHS will receive a written report within 30 days following the onsite visit and will convey the final report findings to the MCO with a request for a POC, if warranted.

b) Effective January 1, 2013, verifying 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 an MCO. Prior to this date, verification of the most recent NCQA or URAC Accreditation survey and status with those organizations is required.

c) With SCDHHS staff, conducting workshops and trainings for MCO staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.

NCQA HEDIS Reporting Measures

MCOs must use guidelines for HEDIS measures defined by NCQA for that respective measurement year (i.e. 2009 measurement year and reported in 2010 would use HEDIS 2010 Technical Specifications). Measures must be submitted to SCDHHS by June 15th 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 NCQA.

June 15th 2011:

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

It is highly recommended that HEDIS and CAHPS reports are generated and reported in 2010 for data and quality improvement purposes.

MARKETING/ADVERTISING AND MEMBER EDUCATION

The MCO shall be responsible for developing and implementing a written marketing/advertising plan designed to provide the Medicaid beneficiary with information about the MCO's managed care plan. All marketing/advertising and member education materials must contain the Health Connections logo, the 1-877-552-4642 telephone number of the statewide Healthy Connections 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**. All written member correspondence and marketing materials must contain the Healthy Connections logo.** The logo requirement applies to all new marketing materials submitted for approval on or after July 1, 2010. It also applies to previously approved materials that have a new production run that occurs on or after July 1, 2010. SCDHHS is not requiring MCOs to change or discard existing marketing materials that have been produced or purchased.

Definitions

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

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

Marketing/advertising means any communication, from an MCO to a Medicaid beneficiary who is not enrolled in that entity, which can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's Medicaid product or either to not enroll in, or to disenroll from, another MCO's Medicaid 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 Medicaid 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 Medicaid 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 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 know 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 Medicaid beneficiary, marketing representatives may provide him/her with information (excluding an enrollment form) about the MCO to give to other interested Medicaid beneficiaries (i.e. business card, marketing brochure).

Activities Which Are Not Permitted

- The MCO is prohibited from distributing enrollment forms or aiding a Medicaid 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 Medicaid beneficiary will lose his/her benefits under the Medicaid program or any other health or welfare benefits to which he/she is legally entitled, if he/she does not enroll with the MCO.

- The MCO cannot make offers of material or financial gain (such as gifts, gift certificates, insurance policies) to Medicaid 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 Medicaid beneficiaries, providers or the public. The MCO shall not misrepresent or provide fraudulent misleading information about the Medicaid 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 XIX.

- The MCO's marketing representatives may not solicit or accept names of Medicaid beneficiaries from Medicaid 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 Medicaid 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.

Medicaid 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 Medicaid beneficiaries for purposes of soliciting enrollment in their plan.

- The MCO may not market directly to Medicaid applicants/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 Medicaid 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 Medicaid beneficiary.

Beneficiary Marketing and Member Education Materials/Media

Marketing may include providing informational materials to enhance the ability of Medicaid beneficiary to make an informed choice of Medicaid 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 Medicaid 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 Medicaid 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 Contractor shall also include a written statement to inform beneficiaries and members that enrollment is voluntary. Should the voluntary nature of the program be changed, this requirement will be modified/deleted.

SCDHHS has established the following requirements for the MCO's Medicaid 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 Help Line, Health Connection logo and the plan's toll free number. Promotional materials (items designed as "give-aways") are excluded from this requirement. 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. Exceptions to this requirement will be considered on a case-by-case basis.

- MCOs can **passively** distribute approved marketing/advertising and educational materials, with written authorization from the entity responsible for the distribution site, to Medicaid 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 Medicaid beneficiaries are prohibited

- MCOs' network providers can correspond with beneficiaries concerning their participation status in the Medicaid 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. An affidavit of reading level compliance must accompany each submission request for approval.

The MCO shall ensure that appropriate foreign language versions of all marketing/advertising and education materials are developed and available to Medicaid 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. 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 (Fee-for-Service) 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

A description of the WIC program	Information on member disenrollment and termination
A description of the plan's well-child 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
Information reminding pregnant members that their newborn will be automatically enrolled in the plan for the first ninety (90) calendar days from birth unless the mother indicates otherwise prior to delivery	

- When the MCO identifies its MCO Medicaid beneficiaries 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, 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 family planning services and services for communicable diseases such as TB, STD, and HIV/AIDS. Included must be a statement of the member's right to obtain family planning services from the plan or from any approved Medicaid enrolled provider. 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) full 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 15th of the month, the notification to SCDHHS must be received by 5:00pm on Monday, the 11th. Using this same example, if Wednesday the 13th is a holiday, the notification must be received by Friday the 8th). 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

Medicaid MCO 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 MCO 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 Medicaid 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 Medicaid 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 Medicaid 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
- Healthy Connections logo

Enrollment

All enrollment activities are to be exclusively conducted by the enrollment broker. This includes distribution of forms, assistance to Medicaid 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 Medicaid 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: reduced or no copayments, medications, additional services and visits, vision and dental benefits to adults, increases over Medicaid limitations or membership in clubs and activities.

NETWORK TERMINATION/TRANSITION PROCESS

The loss of an essential medical provider(s) in a network could seriously impact the MCO's ability to deliver medical services to its Medicaid beneficiaries in compliance with federal regulations and contractual obligations to SCDHHS. This could ultimately result in 1) the SCDHHS-supervised transition to acceptable alternate providers or 2) the termination of the MCOs authority to serve the residents of one or more counties.

There are three ways in which the) Network Termination /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 from the essential provider(s). 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 All termination must occur at the end of the month of termination, since the MCO has been compensated for a full month of services for each member.

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 in writing (by letter or email) within 24 hours of receipt of the essential provider's intent to terminate.

3. During the annual review of the Provider Network Listing Spreadsheet or during a review conducted at the discretion of SCDHHS, should SCDHHS determine the MCO does not meet the network adequacy standards contained in the MCO contract and/or this Guide.

Should SCDHHS initiate the Network Termination/Transition Process, the MCO will be notified within twenty-four (24) hours of the decision in writing (letter or email).

Upon initiation of the Network Termination or Transition Process, SCDHHS will schedule the initial Network Termination or Transition Plan meeting between SCDHHS staff and the MCO. The MCO must identify the members of it's transition/termination response team to SCDHHS. At the initial meeting, the SCDHHS Care Management Staff will determine the specific and critical dates the MCO will be required to submit reports, letters, and other requirements. The MCO is responsible for creating, maintaining and updating the Termination/Transition Form (see attached document). The MCO will be required to submit new networks, using the standard county network submission format and standards found in the P&P Guide. SCDHHS reserves the right to obtain copies of original contracts (including rates, lists of services provided, credentialing applications and approvals and other requested information.. SCDHHS may, at its discretion, halt (and reinstitute) the assignment of MCO members to the affected county(ies) at anytime. SCDHHS also reserves the right to allow MCO members to leave the affected plan in order to maintain continuity of care . Any additional cost incurred by the enrollment broker or SCDHHS during of this process will be reimbursed by the MCO.

Project Plan

Project Name	Network Terminationand/or Transition Plan Form
Project Description	South Carolina Provider Task Force
Team	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**					
					Not Started		
4		**Provider Notification Plan**					
					Not Started		
5		**Website**					

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. Their purpose is 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. SCDHHS receives complaints via three main mechanisms: The fraud hotline toll free number, 1-888-364-3224, the fraud reporting fax line 803-255-8224 or the Program Integrity Extranet portal address.

Coordination Involving DHHS Fraud Hotline Complaints:

- If the SCDHHS Fraud Hotline receives a complaint about an MCO beneficiary/member's eligibility for Medicaid, the complaint is referred within three business days to the Division of Program Integrity.
- If DHHS 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 SCDHHS secure portal to share information.
- If DHHS 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 Medicaid, the complaint is referred to Program Integrity. The referral is made within three business days using the DHHS 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 Medicaid 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 subcontractor . The MCO should submit all relevant information about the case, including its findings and the details of its investigation.

- Upon suspicion of Medicaid 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. SCDHHS 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 Medicaid fraud on the part of a health care provider paid to provide services to SC Medicaid 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 Medicaid 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

INCENTIVE PLANS

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

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

The 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 DHHS, 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 Medicaid recipients upon request)

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

The 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 Medicaid recipients. The disclosure must include the required information and be made at the times specified.

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

- Conduct enrollee surveys

A 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 Medicaid recipients must comply with requirements above.

Recipient Survey

42 CFR 417.479(g)(1) requires that organizations that operate incentive plans that place physicians or physician groups at Substantial Financial Risk (SFR) must conduct surveys of enrollees. Surveys must include either all current Medicaid enrollees in the 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 120 days 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 to Medicaid 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(I) requirements related to subcontractors. These regulations cover: 1) the prohibition of physician payments as an inducement to reduce or limit covered medically necessary services furnished to an individual enrollee, 2) proper computation of substantial financial risk, 3) physician stop-loss protection, 4) enrollee survey requirements, and 5) disclosure requirements.

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

Intermediate Sanctions and/or Civil Money Penalties

42 CFR 438.700(a) states that intermediate sanctions (42 CFR 438.702, types of intermediate sanctions) may be imposed on a 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 Medicaid recipients 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 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.

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.

PAY FOR REPORTING PROCESS

MCO performance is monitored, in part, through the review and analysis of reports that detail encounter data, payment information and services utilization. In order to 1) provide an incentive for complete and accurate reporting and 2) reconcile encounter submissions with MCO experience, commencing 10/1/09, MCOs are required to submit quarterly Capitation Rate Calculation Sheet (CRCS) reports to SCDHHS. This is to be done in a timely, complete and accurate manner. The data elements and other requirements for the report format are set forth as specified in the report. CRCS reports are due within one hundred and five (105) days of the end of each calendar quarter. The following reporting schedule will be used:

For the period January 1 to March 31, the CRCS report is due no later than July 14:
For the period April 1 to June 30, the CRCS report is due no later than October 12;
For the period July 1 to September 30, the CRCS report is due no later than January 12;
For the period October 1 to December 31, the CRCS report is due no later than April 15 (or 16th in a leap year).

Should the due date specified above fall on a weekend or state holiday, the CRCS report is due on the next business day. For instance, if the final day to submit a report falls on a Saturday, the report is due on the following Monday. If that Monday is a state holiday, the report is due the next day (Tuesday).

CRCS Report Spreadsheets and Definitions Sheets

In order to fulfill this requirement, the MCO will utilize the CRCS Report and Definitions located in the "MCO Reports to SCDHHS" section of the **INDEX OF REQUIRED FILES, REPORTS AND FORMS** of this Guide. Each MCO will be supplied with an Excel template which contains locked formulas and will automatically calculate for the appropriate cells. The CRCS Report must contain the name of the MCO, the appropriate reporting period (quarter) and total number of member months. The CRCS Report consists of two spreadsheets: Composite (all services except maternity) and Maternity. Each of these spreadsheets has a defined listing of categories of service, definition of units, and cells for placement of number of units and payment information. The locked formulas will calculate the utilization, unit cost and service cost information.

The Definitions sheets contain the specific DRGs, Revenue Codes, CPT 4/HCPCS codes, SCDHHS provider manual references and appropriate provider type listings to be used for both the Composite and Maternity spreadsheets.

Each quarterly CRCS report submission by the MCO will be compared to their submitted encounter data by SCDHHS. This analysis will be the basis for determining if an MCO has met a 95% completeness requirements for all claims .

SCDHHS and it's actuary will conduct this analysis and report the CRCS report findings to each MCO on a quarterly basis. In the event the above-referenced requirement is not met, the MCO will be assessed a penalty of one quarter of one percent (0.25%) of the capitation payment for each month of the reporting quarter. These penalty funds will be withheld from future capitation payments or other payable accounts to the MCO.

SCDDHS will retain all penalty funds and may make such funds (including funds forfeited by other MCOs) available to fund all or a portion of quality improvement initiatives proposed by MCOs.

INDEX OF REQUIRED FILES, REPORTS AND FORMS

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

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

Submission of all reports, (monthly, quarterly, annual, etc) are due no later than twelve (12) PM (Noon) Eastern Time (ET) on the due date,

General Instructions			
Data Transmission Requirements		Page 118	
Security Requirements For Users of SCDHHS Computer Systems		Page 119	
Use of Control Files for EDI Transfers		Page 120	
Void Instructions for HIC, HOSP or DRUG Encounters		Page 125	
MCO Files to SCDHHS	**Frequency**	**Format Specifications**	**Recipient**
Encounter Data Submission Process	NA	Page 127	NA
MCO HCFA 1500 Encounter Rec (ambulatory encounters) File	Monthly*	Page 131	SCDHHS MMIS
MCO Hospital Encounter Rec (hospital encounters) File	Monthly*	Page 150	SCDHHS MMIS
MCO Drug Encounter Rec INP – 3 (drug encounters) File	Monthly*	Page 161	SCDHHS MMIS
Capitated Payment Summary Layout	Monthly*	Page 167	SCDHHS MMIS
Third Party Liability File Layout	Monthly	Page 170	SCDHHS MMIS
MCO Provider Identification Record File Layout (Non-Medicaid Providers	Monthly	Page 172	SCDHHS MMIS

MCO Reports to SCDHHS	Frequency	Format Specifications	Recipient
Model Attestation	To be Attached to all Reports	Page 175	Recipient of Report
Network Providers and Subcontractors Listing Spreadsheet Requirements	Monthly	Page 176	Department of Managed Care, Quality Programs
Grievance Log with Summary Information	Collected Monthly and Reported Quarterly	Page 178	Department of Managed Care, Quality Programs
Appeals Log with Summary Information	Collected Monthly and Reported Quarterly	Page 179	Department of Managed Care, Quality Programs
Maternity Kicker Payment Notification Log	Monthly	Page 180	Department of Managed Care, Quality Programs
Newborn Enrollment Error Form	Monthly	Page 182	Department of Managed Care, Quality Programs
Low Birth Weight Kicker Payment Log	Quarterly	Page 183	Department of Managed Care, Quality Programs
CRCS Report (Composite & Maternity)	Quarterly	Page 184, 187	Department of Managed Care, Quality Programs
Claims Payment Report	Monthly	Page 195	Department of Managed Care, Quality Programs
FQHC/RHC Data Files	Quarterly	Page 35	Division of Ancillary Reimbursements
Quality Assurance (QA) a. QA Plan b. QA Plan of Correction c. Performance Improvement Projects d. HEDIS Reporting Measures	 As required As required As required Annually	 See Contract See Contract	Department of Managed Care, Quality Programs
Member Satisfaction Survey	Annually	Instrument and Survey Results	Department of Managed Care, Quality Programs
GME Report	Quarterly	Page 198	Division of Acute Care Reimbursement
WRAP Summary Encounter Layout	Quarterly	Page 202	Division of Ancillary Reimbursements
SCDHHS Files to MCOs	**Frequency**	**Format Specifications**	**Recipient**
Managed Care MLE Record Description – MCO Member Listing Record	Monthly	Page 205	MCO
Output Record for Provider Identification File	Monthly	Page 208	MCO
Output Encounter Data Layout for Pharmacy Services	One business day after processing	Page 209	MCO
Output Encounter Data Layout for Ambulatory Services	Once business day after processing	Page 218	MCO
Output Encounter Data Layout for Hospital Services	Once business day after processing	Page 226	MCO

Record for EPSDT Visits and Immunizations	Monthly	Page 233	MCO
Claims Record Description	Monthly	Page 234	MCO
MCO/MHN Recipient Review Recertification File	Monthly	Page 238	SCDHHS MMIS
Daily Newborn Enrollee File	Daily	Page 241	SCDHHS MMIS
Other Files to be received (no examples in this Guide) - Carrier Codes File - Contact Rates File - Fee Schedule File - Recertification File - 820 File	Monthly	NA	MCO
MCO/MHN/MASIMUS Sync File Layout	At least Monthly	Page 247	MCO/SCDHHS
Form Listing			
Sample WIC Referral Form			
Hysterectomy Acknowledgement Form (Acknowledgement of Receipt of Hysterectomy Information)			
Instructions for Completion of Hysterectomy Acknowledgement Form			
Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients Form (DHHS 1723)			
Instructions for Completion of Sterilization Consent Form			
Abortion Statement			
Instructions for Completion of Abortion Statement			
Request for Medicaid ID Number Form			

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

GENERAL INSTRUCTIONS

Data Transmission Requirements

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

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

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

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

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

SECURITY REQUIREMENTS FOR USERS OF SCDHHS COMPUTER SYSTEMS

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

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

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

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

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

Organization Contact Signature: _____Date: _____

HHS Approver Signature: _____Date: _____

Use of Control Files for EDI

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

DEFINITION:

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

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

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

Consider: if the Sender is wanting to create a new file he will check to see if a control 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 totaling. A suggestion is to use MMSS (minutes and seconds) as the value of the additional bytes.

Refer to control file description of records below.

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

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

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

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

EXAMPLE of file contents:

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

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

COMMENTS LRECL= 340

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

RECORD ONE 80 bytes:

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

RECORD TWO 80 bytes:

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

RECORD THREE 80 bytes:

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

RECORD FOUR 80 bytes:

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
	PHONE:				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.
3) 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 8th of the month. This file must be submitted even if you have no input. In the case of no input, a blank file must be submitted to SCDHHS.

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

FILES UPLOADED:

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

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

ACTUAL FILES AND FILE NAMES SENT TO MCO FROM SCDHHS

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

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

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

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

Example:

During the cutoff run of August some recipients are auto closed. This means that the MCO will not get paid for them. During DHHS review, they are reinstated. They will be included in the MLE produced on the 1st of September. When the MGC cutoff run is completed for September (approximately the 3rd week), the MCO will receive two premium payments. One will be retro for the payment missed in August and the second payment will be for the current month of September. The MCO will be able to identify the retro payment. "If the member regains eligibility within 60 days of the disenrollment date, the member will be automatically re-enrolled with the 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.EPSDT
A special EPSDT system was developed, by DHHS, when the Federal EPSDT system was shut down. There are two files created with visit codes. One set for office visits

and one set for injections. These files are created after the last payment run of the month. There is only 1 file that is sent on the last day of the month.

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

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

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

NOTIFICATION:

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

HIPAA FILE NAMING CONVENTION:

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

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

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MCO HCFA-1500-ENCOUNTER-REC (Ambulatory)

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	JULIAN-SUBMISSION-DATE	7	1	7	N	This is the last date of the period for which you are reporting Mask: CCYYDDD
2.	CLAIM-TYPE	1	8	8	C	HCFA-7500-DATA VALUE 'A'
3.	FILLER	1	9	9	C	
4.	FILLER	1	10	10	C	
5.	HMO-PAYMENT-DENIED-INDICATOR	1	11	11	C	**FOR FUTURE USE** 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. 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 Mask: YYMM
9.	RECIPIENT-MEDICAID-NUM	10	18	27	N	Client Medicaid number
10.	INSURED-POLICY-NUMBER	15	28	42	C	HMO Client ID number
11.	HMO-NUMBER	6	43	48	C	Managed Care plan number
12.	TPL-INFO-1	71				THIRD PARTY INSURANCE INFORMATION
13.	CARRIER-CODE-1	5	49	53	C	
14.	CARRIER-POLICY-NUM-1	25	54	78	C	
15.	INSURED-NAME-1.	32			C	
16.	INSURED-LAST-NAME-1	17	79	95	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
17.	INSURED-FIRST-NAME-1	14	96	109	C	
18.	INSURED-MIDDLE-INIT-1	1	110	110	C	
19.	TPL-AMOUNT-PAID-1	9	111	119	N	999999999 Assumed 2 decimal places
20.	TPL-INFO-2	71				THIRD PARTY INSURANCE INFORMATION
21.	CARRIER-CODE-2	5	120	124	C	
22.	CARRIER-POLICY-NUM-2	25	125	149	C	
23.	INSURED-NAME-2	32			C	
24.	INSURED-LAST-NAME-2	17	150	166	C	
25.	INSURED-FIRST-NAME-2	14	197	180	C	
26.	INSURED-MIDDLE-INIT-2	1	181	181	C	
27.	TPL-AMOUNT-PAID-2	9	182	190	N	Mask: 9999999V99
28.	TPL-INFO-3	71				THIRD PARTY INSURANCE INFORMATION
29.	CARRIER-CODE-3	5	191	195	C	
30.	CARRIER-POLICY-NUM-3	25	196	220	C	
31.	INSURED-NAME-3	32			C	
32.	INSURED-LAST-NAME-3	17	221	237	C	
33.	INSURED-FIRST-NAME-3	14	238	251	C	
34.	INSURED-MIDDLE-INIT-3	1	252	252	C	
35.	TPL-AMOUNT-PAID-3	9	253	261	N	Mask: 9999999V99
36.	REFERRING-PROVIDER	6	262	267	C	Provider who referred patient for service
37.	PRINCIPAL-DIAGNOSIS	6	268	273	C	Diagnosis code for principal condition

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
38.	OTHER-DIAGNOSIS-1	6	274	279	C	Diagnosis other than principal
39.	OTHER-DIAGNOSIS-2	6	280	285	C	Diagnosis other than principal
40.	OTHER-DIAGNOSIS-3	6	286	291	C	Diagnosis other than principal
41.	LINE-ENCOUNTER-DATA-1		292	348		Data line for up to eight procedures
42.	PROCEDURE-CODE-1	5	292	296	C	
43.	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).
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	
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 Medicaid number if enrolled in Medicaid

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
60.	AMOUNT-BILLED-1	7	335	341	N	Amount billed by provider of service Mask: 99999V99
61.	AMOUNT-PAID-1	7	342	348	N	Amount paid by HMO plan for service Mask: 99999V99
62.	LINE-ENCOUNTER-DATA-2		349	405		
63.	PROCEDURE-CODE-2	5	349	353	C	
64.	MODIFIER-2	3	354	356	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).
65.	UNITS-MILES-2	3	357	359	N	
66.	FIRST-DATE-OF-SERV-2		360	367		
67.	FIRST-DATE-CENTURY-2	2	360	361	N	
68.	FIRST-DATE-YEAR-2	2	362	363	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
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 Medicaid number if enrolled in Medicaid 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'
80.	REIMBURSE-IND-2	1	391	391	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
81.	AMOUNT-BILLED-2	7	392	398	N	Amount billed by provider of service Mask: 99999V99
82.	AMOUNT-PAID-2	7	399	405	N	Amount paid by HMO plan for service Mask: 99999V99
83.	LINE-ENCOUNTER-DATA-3		406	462		
84.	PROCEDURE-CODE-3	5	406	410	C	
85.	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).
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	
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						Medicaid number if enrolled in Medicaid 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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
102.	AMOUNT-BILLED-3	7	449	455	N	Amount billed by provider of service Mask: 99999V99
103.	AMOUNT-PAID-3	7	456	462	N	Amount paid by HMO plan for service 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 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-	2	476	477	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
	YEAR-4					
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
119.	SERV-PROVIDER-NUM-4	6	492	497	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
120.	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 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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service 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
123.	AMOUNT-BILLED-4	7	506	512	N	Amount billed by provider of service Mask: 99999V99
124.	AMOUNT-PAID-4	7	513	519	N	Amount paid by HMO plan for service 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		
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
140.	SERV-PROVIDER-NUM-5	6	549	554	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
141.	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.
142.	EPSDT-INDICATOR-5	1	561	561	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
143.	REIMBURSE-IND-5	1	562	562	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
144.	AMOUNT-BILLED-5	7	563	569	N	Amount billed by provider of service Mask: 99999V99
145.	AMOUNT-PAID-5	7	570	576	N	Amount paid by HMO plan for service Mask: 99999V99
146.	LINE-ENCOUNTER-DATA-6		577	563		
147.	PROCEDURE-CODE-6	5	577	581	C	
148.	MODIFIER-6	3	582	584	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).
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	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
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	2	604	605	C	See PLACE OF SERVICE table for values
161.	SERV-PROVIDER-NUM-6	6	606	611	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
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 assigned by HMO (if not enrolled in Medicaid) of the provider to whom payment was made.
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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
165.	AMOUNT-BILLED-6	7	620	626	N	Amount billed by provider of service Mask: 99999V99

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
166.	AMOUNT-PAID-6	7	627	633	N	Amount paid by HMO plan for service 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		
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
182.	SERV-PROVIDER-NUM-7	6	663	668	C	Number assigned to provider of service Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						in Medicaid
183.	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.
184.	EPSDT-INDICATOR-7	1	675	675	C	Indicates this is a well child visit that needs follow up or referral. VALUE 'Y'
185.	REIMBURSE-IND-7	1	676	676	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
186.	AMOUNT-BILLED-7	7	677	683	N	Amount billed by provider of service Mask: 99999V99
187.	AMOUNT-PAID-7	7	684	690	N	Amount paid by HMO plan for service Mask: 99999V99
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-	2	706	707	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
	MONTH-8					
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 Medicaid number if enrolled in Medicaid Unique number assigned by HMO if not enrolled in Medicaid
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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
207.	AMOUNT-BILLED-8	7	734	740	N	Amount billed by provider of service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						Mask: 99999V99
208.	AMOUNT-PAID-8	7	741	747	N	Amount paid by HMO plan for service 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	
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						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-IND-5	1	932	932	C	Indicates the procedure code is not recognized by 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.	LINE-NDC-IND-1	1	936	936	C	This is only populated if line 1 of the encounter contains a JCODE.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						Value 'Y'
244.	LINE-NDC-1	11	937	947	C	If the procedure code in line 1 is a JCODE, you would put the NDC of the drug in this field.
245.	LINE-NDC-IND-2	1	948	948	C	This is only populated if line 2 of the encounter contains a JCODE. Value 'Y'
246.	LINE-NDC-2	11	949	959	C	If the procedure code in line 2 is a JCODE, you would put the NDC of the drug in this field.
247.	LINE-NDC-IND-3	1	960	960	C	This is only populated if line 3 of the encounter contains a JCODE. Value 'Y'
248.	LINE-NDC-3	11	961	971	C	If the procedure code in line 3 is a JCODE, you would put the NDC of the drug in this field.
249.	LINE-NDC-IND-4	1	972	972	C	This is only populated if line 4 of the encounter contains a JCODE. Value 'Y'
250.	LINE-NDC-4	11	973	983	C	If the procedure code in line 4 is a JCODE, you would put the NDC of the drug in this field.
251.	LINE-NDC-IND-5	1	984	984	C	This is only populated if line 5 of the encounter contains a JCODE. Value 'Y'
252.	LINE-NDC-5	11	985	995	C	If the procedure code in line 5 is a JCODE, you would put the NDC of the drug in this field.
253.	LINE-NDC-IND-6	1	996	996	C	This is only populated if line 6 of the encounter contains a JCODE. Value 'Y'
254.	LINE-NDC-6	11	997	1007	C	If the procedure code in line 6 is a JCODE, you would put the NDC of the drug in this field.
255.	LINE-NDC-IND-7	1	1008	1008	C	This is only populated if line 7 of the encounter contains a JCODE. Value 'Y'

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
256.	LINE-NDC-7	11	1009	1019	C	If the procedure code in line 7 is a JCODE, you would put the NDC of the drug in this field.
257.	LINE-NDC-IND-8	1	1020	1020	C	This is only populated if line 8 of the encounter contains a JCODE. Value 'Y'
258.	LINE-NDC-8	11	1021	1031	C	If the procedure code in line 8 is a JCODE, you would put the NDC of the drug in this field.
259.	FILLER	236	1032	1267		
260.	HMO-OWN-REF-NUMBER	16	1268	1283	C	HMO own reference number
261.	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. Mask: CCYYDDD
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	**FOR FUTURE USE** 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. 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 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-	25	54	78	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
	NUM-1					
15.	INSURED-NAME-1.	32			C	
16.	INSURED-LAST-NAME-1	17	79	95	C	
17.	INSURED-FIRST-NAME-1	14	96	109	C	
18.	INSURED-MIDDLE-INIT-1	1	110	110	C	
19.	TPL-AMOUNT-PAID-1	9	111	119	N	999999999 Assumed 2 decimal places
20.	TPL-INFO-2	71				THIRD PARTY INSURANCE INFORMATION
21.	CARRIER-CODE-2	5	120	124	C	
22.	CARRIER-POLICY-NUM-2	25	125	149	C	
23.	INSURED-NAME-2	32			C	
24.	INSURED-LAST-NAME-2	17	150	166	C	
25.	INSURED-FIRST-NAME-2	14	197	180	C	
26.	INSURED-MIDDLE-INIT-2	1	181	181	C	
27.	TPL-AMOUNT-PAID-2	9	182	190	N	Mask: 9999999V99
28.	TPL-INFO-3	71				THIRD PARTY INSURANCE INFORMATION
29.	CARRIER-CODE-3	5	191	195	C	
30.	CARRIER-POLICY-NUM-3	25	196	220	C	
31.	INSURED-NAME-3	32			C	
32.	INSURED-LAST-NAME-3	17	221	237	C	
33.	INSURED-	14	238	251	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
	FIRST-NAME-3					
34.	INSURED-MIDDLE-INIT-3	1	252	252	C	
35.	TPL-AMOUNT-PAID-3	9	253	261	N	Mask: 9999999V99
36.	ATTENDING-PHYSICIAN	6	262	267	C	Attending physician
37.	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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL 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	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
50.	LAST-DATE-DAY-1	2	307	308	N	
51.	ADMISSION-DATE	8	309	316		Admission date
52.	ADMIT-DATE-CENTURY-1	2	309	310	N	
53.	ADMIT-DATE-YEAR-1	2	311	312	N	
54.	ADMIT-DATE-MONTH-1	2	313	314	N	
55.	ADMIT-DATE-DAY-1	2	315	316	N	
56.	DISCHARGE-DATE	8	317	324		Discharge date
57.	DISCH-DATE-CENTURY-1	2	317	318	N	
58.	DISCH-DATE-YEAR-1	2	319	320	N	
59.	DISCH-DATE-MONTH-1	2	321	322	N	
60.	DISCH-DATE-DAY-1	2	323	324	N	
61.	PATIENT-STATUS	2	325	326	C	See PATIENT STATUS table for values
62.	ADMISSION-DIAGNOSIS	6	327	332	C	
63.	PRINCIPAL-DIAGNOSIS	6	333	338	C	ICD-9 code for principal condition
64.	OTHER-DIAGNOSIS-1	6	339	344	C	ICD-9 diagnoses other than principal
65.	OTHER-DIAGNOSIS-2	6	345	350	C	ICD-9 diagnoses other than principal
66.	OTHER-DIAGNOSIS-3	6	351	356	C	ICD-9 diagnoses other than principal
67.	OTHER-DIAGNOSIS-4	6	357	362	C	ICD-9 diagnoses other than principal
68.	OTHER-DIAGNOSIS-5	6	363	368	C	ICD-9 diagnoses other than principal
69.	OTHER-DIAGNOSIS-6	6	369	374	C	ICD-9 diagnoses other than principal

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
70.	OTHER-DIAGNOSIS-7	6	375	380	C	ICD-9 diagnoses other than principal
71.	OTHER-DIAGNOSIS-8	6	381	386	C	ICD-9 diagnoses other than principal
72.	PRINCIPAL-SURGERY	14	387	400		
73.	PRIM-SURG-PROC	6	387	392	C	ICD-9 Performed
74.	PRIM-SURG-DATE	8	393	400	N	CCYYMMDD
75.	OTHER-SURGERY-1	14	401	414		
76.	OTHER-SURG-PROC-1	6	401	406	C	ICD-9 Performed
77.	OTHER-SURG-DATE-1	8	407	414	N	CCYYMMDD
78.	OTHER-SURGERY-2	14	415	428		
79.	OTHER-SURG-PROC-2	6	415	420	C	ICD-9 Performed
80.	OTHER-SURG-DATE-2	8	421	428	N	CCYYMMDD
81.	OTHER-SURGERY-3	14	429	442		
82.	OTHER-SURG-PROC-3	6	429	434	C	ICD-9 Performed
83.	OTHER-SURG-DATE-3	8	435	442	N	CCYYMMDD
84.	OTHER-SURGERY-4	14	443	456		
85.	OTHER-SURG-PROC-4	6	443	448	C	ICD-9 Performed
86.	OTHER-SURG-DATE4	8	449	456	N	CCYYMMDD
87.	OTHER-SURGERY-5	14	457	470		
88.	OTHER-SURG-PROC-5	6	457	462	C	ICD-9 Performed
89.	OTHER-SURG-DATE-5	8	463	470	N	CCYYMMDD
90.	DRG	3	471	473	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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
99.	UNITS-3	4	509	512	N	
100.	REVENUE-CODE-4	4	513	516	N	Code for specific hospital service
101.	PROCEDURE-CODE-4	5	517	521	C	HCPCS Code applicable to revenue code
102.	UNITS-4	4	522	525	N	
103.	REVENUE-CODE-5	4	526	529	N	Code for specific hospital service
104.	PROCEDURE-CODE-5	5	530	534	C	HCPCS Code applicable to revenue code
105.	UNITS-5	4	535	538	N	
106.	REVENUE-CODE-6	4	539	542	N	Code for specific hospital service
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
128.	PROCEDURE-CODE-13	5	634	638	C	HCPCS Code applicable to revenue code
129.	UNITS-13	4	639	642	N	
130.	REVENUE-CODE-14	4	643	646	N	Code for specific hospital service
131.	PROCEDURE-CODE-14	5	647	651	C	HCPCS Code applicable to revenue code
132.	UNITS-14	4	652	655	N	
133.	REVENUE-CODE-15	4	656	659	N	Code for specific hospital service
134.	PROCEDURE-CODE-15	5	660	664	C	HCPCS Code applicable to revenue code
135.	UNITS-15	4	665	668	N	
136.	REVENUE-CODE-16	4	669	672	N	Code for specific hospital service
137.	PROCEDURE-CODE-16	5	673	677	C	HCPCS Code applicable to revenue code
138.	UNITS-16	4	678	681	N	
139.	REVENUE-CODE-17	4	682	685	N	Code for specific hospital service
140.	PROCEDURE-CODE-17	5	686	690	C	HCPCS Code applicable to revenue code
141.	UNITS-17	4	691	694	N	
142.	REVENUE-CODE-18	4	695	698	N	Code for specific hospital service
143.	PROCEDURE-CODE-18	5	699	703	C	HCPCS Code applicable to revenue code
144.	UNITS-18	4	704	707	N	
145.	REVENUE-CODE-19	4	708	711	N	Code for specific hospital service
146.	PROCEDURE-CODE-19	5	712	716	C	HCPCS Code applicable to revenue code
147.	UNITS-19	4	717	720	N	
148.	REVENUE-CODE-20	4	721	724	N	Code for specific hospital service
149.	PROCEDURE-CODE-20	5	725	729	C	HCPCS Code applicable to revenue code
150.	UNITS-20	4	730	733	N	
151.	REVENUE-CODE-21	4	734	737	N	Code for specific hospital service
152.	PROCEDURE-CODE-21	5	738	742	C	HCPCS Code applicable to revenue code
153.	UNITS-21	4	743	746	N	
154.	REVENUE-CODE-22	4	747	750	N	Code for specific hospital service
155.	PROCEDURE-CODE-22	5	751	755	C	HCPCS Code applicable to revenue code
156.	UNITS-22	4	756	759	N	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
157.	REVENUE-CODE-23	4	760	763	N	Code for specific hospital service
158.	PROCEDURE-CODE-23	5	764	768	C	HCPCS Code applicable to revenue code
159.	UNITS-23	4	769	772	N	
160.	REVENUE-CODE-24	4	773	776	N	Code for specific hospital service
161.	PROCEDURE-CODE-24	5	777	781	C	HCPCS Code applicable to revenue code
162.	UNITS-24	4	782	785	N	
163.	REVENUE-CODE-25	4	786	789	N	Code for specific hospital service
164.	PROCEDURE-CODE-25	5	790	794	C	HCPCS Code applicable to revenue code
165.	UNITS-25	4	795	798	N	
166.	REVENUE-CODE-26	4	799	802	N	Code for specific hospital service
167.	PROCEDURE-CODE-26	5	803	807	C	HCPCS Code applicable to revenue code
168.	UNITS-26	4	808	811	N	
169.	REVENUE-CODE-27	4	812	815	N	Code for specific hospital service
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
186.	UNITS-32	4	886	889	N	
187.	REVENUE-CODE-33	4	890	893	N	Code for specific hospital service
188.	PROCEDURE-CODE-33	5	894	898	C	HCPCS Code applicable to revenue code
189.	UNITS-33	4	899	902	N	
190.	REVENUE-CODE-34	4	903	906	N	Code for specific hospital service
191.	PROCEDURE-CODE-34	5	907	911	C	HCPCS Code applicable to revenue code
192.	UNITS-34	4	912	915	N	
193.	REVENUE-CODE-35	4	916	919	N	Code for specific hospital service
194.	PROCEDURE-CODE-35	5	920	924	C	HCPCS Code applicable to revenue code
195.	UNITS-35	4	925	928	N	
196.	REVENUE-CODE-36	4	929	932	N	Code for specific hospital service
197.	PROCEDURE-CODE-36	5	933	937	C	HCPCS Code applicable to revenue code
198.	UNITS-36	4	938	941	N	
199.	REVENUE-CODE-37	4	942	945	N	Code for specific hospital service
200.	PROCEDURE-CODE-37	5	946	950	C	HCPCS Code applicable to revenue code
201.	UNITS-37	4	951	954	N	
202.	REVENUE-CODE-38	4	955	958	N	Code for specific hospital service
203.	PROCEDURE-CODE-38	5	959	963	C	HCPCS Code applicable to revenue code
204.	UNITS-38	4	964	967	N	
205.	REVENUE-CODE-39	4	968	971	N	Code for specific hospital service
206.	PROCEDURE-CODE-39	5	972	976	C	HCPCS Code applicable to revenue code
207.	UNITS-39	4	977	980	N	
208.	REVENUE-CODE-40	4	981	984	N	Code for specific hospital service
209.	PROCEDURE-CODE-40	5	985	989	C	HCPCS Code applicable to revenue code
210.	UNITS-40	4	990	993	N	
211.	REVENUE-CODE-41	4	994	997	N	Code for specific hospital service
212.	PROCEDURE-CODE-41	5	998	1002	C	HCPCS Code applicable to revenue code
213.	UNITS-41	4	1003	1006	N	
214.	REVENUE-CODE-42	4	1007	1010	N	Code for specific hospital service

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
215.	PROCEDURE-CODE-42	5	1011	1015	C	HCPCS Code applicable to revenue code
216.	UNITS-42	4	1016	1019	N	
217.	REVENUE-CODE-43	4	1020	1023	N	Code for specific hospital service
218.	PROCEDURE-CODE-43	5	1024	1028	C	HCPCS Code applicable to revenue code
219.	UNITS-43	4	1029	1032	N	
220.	REVENUE-CODE-44	4	1033	1036	N	Code for specific hospital service
221.	PROCEDURE-CODE-44	5	1037	1041	C	HCPCS Code applicable to revenue code
222.	UNITS-44	4	1042	1045	N	
223.	REVENUE-CODE-45	4	1046	1049	N	Code for specific hospital service
224.	PROCEDURE-CODE-45	5	1050	1054	C	HCPCS Code applicable to revenue code
225.	UNITS-45	4	1055	1058	N	
226.	REVENUE-CODE-46	4	1059	1062	N	Code for specific hospital service
227.	PROCEDURE-CODE-46	5	1063	1067	C	HCPCS Code applicable to revenue code
228.	UNITS-46	4	1068	1071	N	
229.	REVENUE-CODE-47	4	1072	1075	N	Code for specific hospital service
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

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

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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
DRUG-ENCOUNTER-REC-INP-3 (1300 BYTES)

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	*DEI-CC*	2	1	2	N	ENCOUNTER SUBMIT DATE CENTURY
2.		2	3	4	N	ENCOUNTER SUBMIT DATE YEAR
3.	DEI-DDD	3	5	7	N	ENCOUNTER SUBMIT DATE DAYS (JULIAN)
4.	DEI-ENC-DOC-TYPE	1	8	8	C	RECORD TYPE, DRUG='D'
5.	FILLER	3	9	11	C	FILLER
6.	DEI-ADJUSTMENT-IND	1	12	12		THIS FIELD IS ONLY POPULATED WHEN YOU ARE VOIDING A PREVIOUSLY ACCEPTED ENCOUNTER. 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 Mask: YYMM
9.	DEI-INDIV-NO	10	18	27	N	RECIPIENT MEDICAID NUMBER
10.	DEI-HMO-RECIP-ID	15	28	42	C	HMO RECIPIENT NUMBER
11.	DEI-PROV-NUMBER	6	43	48		SC ASSIGNED PROVIDER NUMBER (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 TO THE MCO (AMT BEING BILLED BY THE PROVIDER TO THE MCO) MASK 9999999V99 ZERO FILLED, NO SIGN
15.	DEI-TOT-AMT-HMO-PAID	9	289	297	N	AMOUNT PAID BY THE MCO 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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL 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 IF A COMPOUND DRUG IS BEING REPORTED, THIS FIELD SHOULD BE ALL ZEROS.
21.	DEI-UNIT-TYPE	3	318	320	C	AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES IF A COMPOUND DRUG IS BEING REPORTED, THIS FIELD SHOULD BE ALL ZEROS.
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	PHYSICAN PROVIDER NUMBER
26.	FILLER	2	351	352	C	
27.	DEI-REFILL-INP	2	353	354	C	Indicates new RX (blank) or number of refills used
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.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
30.	DEI-PHYSICIAN-NPI	10	375	384		PHYSICIAN NPI
31.	DEI-COMPOUND-NDC-1	11	385	395		IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE FIRST COMPONENT OF THE COMPOUND DRUG.
32.	DEI-COMPOUND-UNIT-TYPE-1	3	396	398		AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
33.	DEI-COMPOUND-QUANTITY-1	10	399	408		AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
34.	DEI-COMPOUND-NDC-2	11	409	419		IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE SECOND COMPONENT OF THE COMPOUND DRUG.
35.	DEI-COMPOUND-UNIT-TYPE-2	3	420	422		AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
36.	DEI-COMPOUND-QUANTITY-2	10	423	432		AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
37.	DEI-COMPOUND-NDC-3	11	433	443		IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE THIRD COMPONENT OF THE COMPOUND DRUG.
38.	DEI-COMPOUND-UNIT-TYPE-3	3	444	446		AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
						EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
39.	DEI-COMPOUND-QUANTITY-3	10	447	456		AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
40.	DEI-COMPOUND-NDC-4	11	457	467		IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE FOURTH COMPONENT OF THE COMPOUND DRUG.
41.	DEI-COMPOUND-UNIT-TYPE-4	3	468	470		AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
42.	DEI-COMPOUND-QUANTITY-4	10	471	480		AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
43.	DEI-COMPOUND-NDC-5	11	481	491		IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE FIFTH COMPONENT OF THE COMPOUND DRUG.
44.	DEI-COMPOUND-UNIT-TYPE-5	3	492	494		AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
45.	DEI-COMPOUND-QUANTITY-5	10	495	504		AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
46.	DEI-COMPOUND-DRUG-IND	1	505	505		THIS FIELD IS ONLY POPULATED IF THIS ENCOUNTER IS A COMPOUND DRUG ENCOUNTER. VALUE: 'Y'
47.	FILLER	762	506	1267		
48.	DEI-HMO-OWN-REF-NUMBER	16	1268	1283		PROVIDER'S OWN REFERENCE NUMBER
49.	DEI-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

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 14: 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 25: DEI-PHYSICIAN-NO is the SCDHHS physician assigned number.

Field number 48: 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.

All of the DEI-COMPOUND-QUANTITY fields are going to have a Mask = 9999999v999 zero filled to the left. These fields are all assumed three decimal fields.

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MCO CAPITATED PAYMENT SUMMARY LAYOUT

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	MCO Provider Number	6	1	6	C	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the MCO
2.	Facility or Practice Legacy Number	6	7	12	C	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the facility/practice
3.	Facility or Practice NPI Number	10	13	22	N	The National Provider Identification number assigned to the practice/facility
4.	Month/Year of Service	6	23	28	N	Enter the month and year of service in the appropriate format - MASK: MMCCYY
5.	FILLER	1	29	29	C	For possible future use.
6.	Monthly Capitated Number of Members	5	30	34	N	Enter the total number of members for month of service with capitation payments – MASK: 99999
7.	Monthly Capitated Amount Paid	10	35	44	N	Enter the total amount paid for field 6 - MASK: 99999999V99
8.	Number of Members with Rate Cell = AH3	3	45	47	N	Enter the total number of members with rate cell = AH3
9.	Amount Paid for Rate Cell = AH3	10	48	57	N	Enter the amount paid for field 8 - MASK: 99999999V99
10.	Number of Members with Rate Cell = AI3	3	58	60	N	Enter the total number of members with rate cell = AI3
11.	Amount Paid for Rate Cell = AI3	10	61	70	N	Enter the amount paid for field 10 - MASK: 99999999V99
12.	Number of Members with Rate Cell =AB3	3	71	73	N	Enter the total number of members with rate cell = AB3
13.	Amount Paid for Rate Cell = AB3	10	74	83	N	Enter the amount paid for field 12 - MASK: 99999999V99
14.	Number of Members with Rate Cell = AC3	3	84	86	N	Enter the total number of members with rate cell = AC3
15.	Amount Paid for Rate Cell = AC3	10	87	96	N	Enter the amount paid for field 14- MASK: 99999999V99

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
16.	Number of Members with Rate Cell = AD1	3	97	99	N	Enter the total number of members with rate cell = AD1
17.	Amount Paid for Rate Cell = AD1	10	100	109	N	Enter the amount paid for field 16 - MASK: 99999999V99
18.	Number of Members with Rate Cell = AD2	3	110	112	N	Enter the total number of members with rate cell = AD2
19.	Amount Paid for Rate Cell = AD2	10	113	122	N	Enter the amount paid for field 18- MASK: 99999999V99
20.	Number of Members with Rate Cell = AE1	3	123	125	N	Enter the total number of members with rate cell = AE1
21.	Amount Paid for Rate Cell = AE1	10	126	135	N	Enter the amount paid for field 20 - MASK: 99999999V99
22.	Number of Members with Rate Cell = AE2	3	136	138	N	Enter the total number of members with rate cell = AE2
23.	Amount Paid for Rate Cell = AE2	10	139	148	N	Enter the amount paid for field 22 - MASK: 99999999V99
24.	Number of Members with Rate Cell = AF3	3	149	151	N	Enter the total number of members with rate cell = AF3
25.	Amount Paid for Rate Cell = AF3	10	152	161	N	Enter the amount paid for field 24 - MASK: 99999999V99
26.	Number of Members with Rate Cell = SG3	3	162	164	N	Enter the total number of members with rate cell = SG3
27.	Amount Paid for Rate Cell = SG3	10	165	174	N	Enter the amount paid for field 26 - MASK: 99999999V99
28.	Number of Members with Rate Cell = WG2	3	175	177	N	Enter the total number of members with rate cell = WG2
29.	Amount Paid for Rate Cell = WG2	10	178	187	N	Enter the amount paid for field 28- MASK: 99999999V99
30.	Date of File Submission	6	188	193	N	This is the date the file was submitted. MASK: MMCCYY
31.	FILLER	7	194	200	N	Possible future use

Special instruction:
All records must be fixed length:

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

EX: 5 bytes 123 will appear as 00123

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

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0044297. The decimal is 'implied' and will not be included.

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

Rate Cells are defined as the following:

AH3 = 1 - 3 months old
AI3 = 4 - 12 months old
AB3 = Age 1 - 6
AC3 = Age 7 - 13
AD1 = Age 14 - 18 Male
AD2 = Age 14 - 18 Female
AE1 = Age 19 - 44 Male
AE2 = Age 19 - 44 Female
AF3 = Age 45+
SG3 =SSI
WG2 =OCWI

Unless otherwise specified there will be no signed fields

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

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

Special instruction:
All records must be fixed length:
Column N/C;
EX: 5 bytes 123 will appear as 00123

N = Numeric – All numeric fields are right justified and zero filled to left

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)

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
	LICENSE-NUMBER					
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 MCO LISTING SPREADSHEET REQUIREMENTS

Provide the following information regarding all network providers:

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

4. Office hours- the hours the physician is actually available to see the MCO Member (i.e. 8-5)

5. Days of Operation-state what day the physician is actually in the office. (i.e. Monday through –Friday or Tuesday and Thursday , or any variations etc)

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

7. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number, if they are a Medicaid provider.

8. Specialty Code - Indicate the practitioner's specialty using the Medicaid Specialty Codes .

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

10. Practice Limitation - Indicate any restrictions or limitations of a provider's scope of service.. For instance, for a physician who only sees patients up to age 18, indicate < 18; Should an OB/GYN not accept high risk patients, indicate this clearly in a short descriptive narrative.

11. 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.

12. Contract Begin Date – Indicate the date the contract became effective.

13. Contract Termination Date – Indicate the date the contract ended.

14. 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 1-14 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 (Medicaid 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 (Medicaid 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

<<MCO Name>>

Maternity Kicker Payment Notification Log

<< Month>>

Count	DOB	Mother's Information Last Name	First Name	Medicaid ID #	Newborn's Information Last Name	First Name	Sex	Multiple Birth	Y/N*	$ amt*

Maternity Kicker Notification Payment 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

<<MCO Name>>

Newborn Enrollment Error Form

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

*The following reason codes should be used in this column:
1 = Newborn not enrolled
2 = Incorrect enrollment date
3 = Mom not in plan

Low Birth Weight Kicker Payment Log

Mother's	Information			Newborn	Information						
										**	**
Last Name	First Name	Medicaid ID #	SSN	Last Name	First Name	Medicaid #	Weight *	LBW	VLBW	Y/N	$ amt
Smith	Ann	1231231234	1231231234	Smith	James	1231231235	2255	X			
Jones	Mary	3213213215	1231231239	Jones	Frank	3213213216	1465		X		

*Weight must be in grams. For metric conversion standards, please see the Low Birth Weight Kicker Process section of this Policy and Procedure Guide.

** These columns reserved for SCDHHS use.

State of South Carolina						
Department of Health and Human Services						
MCO Reporting Manual						
Capitation Rate Calculation Sheet (CRCS)						
MCO Name: MCO						
Quarterly Reporting Period: MM/DD/YYYY-MM/DD/YYYY						
Region: Statewide						
Rate Category: Composite						
Member Months In The Reporting Quarter: XXXX	**0**					
		A	**B**	**C**	**D**	**E**
Category of Service	**Units**	**# of Units**	**Amount Paid**	**Annual Utilization per 1,000**	**Cost per Unit**	**Service Cost PMPM**
Inpatient Hospital						
I/P Medical/Surgical/Non-Delivery Maternity	Days	-	$ -	-	$ -	$ -

I/P Well Newborn	Days	-	$ -	-	$ -	$ -
Mental Health / Substance Abuse	Days	-	$ -	-	$ -	$ -
Other Inpatient	Days	-	$ -	-	$ -	$ -
Outpatient Hospital						
Surgical (Type 1)	Encounters	-	$ -	-	$ -	$ -
Non-Surgical Emergency Room (Type 5)	Encounters	-	$ -	-	$ -	$ -
Non-Surgical-All Other (Type 5)	Encounters	-	$ -	-	$ -	$ -
Observation Room (Type 1 and Type 5)	Encounters	-	$ -	-	$ -	$ -
Treatment/Therapy/Testing (Type 4)	Encounters	-	$ -	-	$ -	$ -
All Other Outpatient	Encounters	-	$ -	-	$ -	$ -
Pharmacy						
Prescription Drugs	Scripts	-	$ -	-	$ -	$ -
Ancillaries						
Ambulance	Runs	-	$ -	-	$ -	$ -
Prosthetic/DME	Units	-	$ -	-	$ -	$ -
Other Ancillaries	Units	-	$ -	-	$ -	$ -
Physician						
Surgery - I/P and O/P	Procedures	-	$ -	-	$ -	$ -

Surgery - I/P and O/P - Anesthesia	Procedures	-	$ -	-	$ -	$ -
Maternity – Non-Delivery	Cases	-	$ -	-	$ -	$ -
Hospital Visits	Visits	-	$ -	-	$ -	$ -
Office Visits	Visits	-	$ -	-	$ -	$ -
Hospital Inpatient Visits	Visits	-	$ -	-	$ -	$ -
Immunizations	Services	-	$ -	-	$ -	$ -
Radiology	Procedures	-	$ -	-	$ -	$ -
Pathology	Procedures	-	$ -	-	$ -	$ -
Mental Health / Substance Abuse	Visits	-	$ -	-	$ -	$ -
Other Professional	Procedures	-	$ -	-	$ -	$ -
SUM OF COVERED SERVICES		-	$ -	-	$ -	$ -

State of South Carolina						
Department of Health and Human Services						
Maternity						
Capitation Rate Calculation Sheet (CRCS)						
MCO Name: MCO						
Quarterly Reporting Period: MM/DD/YYYY - MM/DD/YYYY						
Region: Statewide						
Rate Category: Maternity						
Number of Deliveries for the Reporting Quarter:	**0**					
		A	**B**	**C**	**D**	**E**
Category of Service	**Units**	**# of Units**	**Amount Paid**	**Annual Utilization per Delivery**	**Cost per Unit**	**Service Cost per Delivery**
Inpatient Hospital						
Inpatient Maternity Delivery	Days	-	$ -	-	$ -	$ -
Outpatient Hospital						

Outpatient Hospital - Maternity	Cases	-	$ -	-	$ -	$ -
Physician						
Maternity – Delivery	Cases	-	$ -	-	$ -	$ -
Maternity – Delivery - Anesthesia	Procedures	-	$ -	-	$ -	$ -
SUM OF COVERED SERVICES		-	$ -	-	$ -	$ -

Capitation Rate Calculation Sheet
Data Element Summary

MCO Name: Plan Name

Quarterly Reporting Period: Identify the beginning and ending period for the submitted report. The reporting period is on an incurred date of service basis without adjustment for completion factors.

Region: Statewide

Rate Category: Separate Reports for each Capitation Rate Category

Member Months or Deliveries: This field represents the number of member months or deliveries for the reporting period.

# of Units (Column A): This field represents the total number of units allowed from the health plan paid claim experience. The definition of units has been defined in the "Units" Column.

Amount Paid (Column B): This field represents the net amount paid for the service.

Annual Utilization per 1,000 (Column C): This is a calculated field using the following formula:

(Column A ÷ Member Months) x 12 x 1,000

Utilization per Delivery (Column C): This is a calculated field using the following formula:

(Column A ÷ Deliveries) x 1,000

Cost per Unit (Column D): This is a calculated field using the formula: (Column B ÷ Column A)

Service Cost PMPM or Per Delivery (Column E): This is a calculated field using one of the following formulas:

If Non-Maternity = Column B ÷ Member Months, or,
If Maternity = Column B ÷ Number of Deliveries

CRCS Capitation Rate Calculation Sheet

Category of Service	Medicare DRGs	Other Information	Unit Measure
Inpatient Hospital			
IP Medical/Surgical/Non‐Delivery Maternity	0001-0003, 0006-0019, 0021-0023, 0026-0106, 0108, 0110-0111, 0113-0114, 0117-0147, 0149-0153, 0155-0208, 0210-0213, 0216-0220, 0223-0230, 0232-0369, 0376-0377, 0385-0390, 0392-0399, 0401-0414, 0417-0424, 0439-0455, 0461-0468, 0471, 0473, 0476-0477, 0479-0482, 0484-0513, 0515, 0518-0520, 0524-0525, 0528-0579		Days
IP Well Newborn	0391		Days
Mental Health / Substance Abuse	0425 – 0433, 0521-0523		Days
Other Inpatient	0004-0005, 0020, 0024-0025, 0107, 0109, 0112, 0115-0116, 0148, 0154, 0209, 0214-0215, 0221-0222, 0231, 0400, 0415-0416, 0434-0438, 0456-0460, 0469-0470, 0472, 0474-0475, 0478, 0483, 0514, 0516-0517, 0526-0527	Any services provided by Inpatient Hospital Providers and not assigned by DRG methodology.	Days

			Unit Measure
Outpatient Hospital			
			Claims
			Claims
			Units
			Units
			Units

Type of Service	FFS Methodology and Revenue Codes		Unit Measure

Outpatient Hospital			
-Surgical (Type 1) -Non-Surgical Emergency Room (Type 5) -Non-Surgical – All Other (Type 5) -Observation Room (Type 1 and Type 5) -Treatment/Therapy/Testing (Type 4) -All Other Outpatient	The Fee for Service methodology and revenue codes for the types of service can be found in the SCDHHS Hospital Provider Manual, Section 4, Billing Codes- http://www.scdhhs.gov/internet/pdf/manuals/Hospital/SECTION%204.pdf Pages 4-1 to 4-18. For this section, Encounter = Visit		Encounters Encounters Encounters Encounters Encounters Encounters

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Pharmacy			
Prescription Drugs	All Prescription Drugs Dispensed		Line Items
Ancillaries			
Ambulance	A0001-A0999, Q3019-Q3020, S0207-S0215	*Note: Removed provider logic	Line Items
Prosthetic/DME	A4206-A4265, A4270-A4640, A4648-A8004, A9155, A9274-A9284, A9900-A9999, B4000-B9999, D5985-D5988, E0100-E9999, J7602-J7799, K0000-K0899, L0100-L9999, Q0480-Q0505, Q1001-Q1005, Q4001-Q4051, Q4093-Q4094, S0142-S0143, S0515, S1015-S1016, S1030-S1031, S1040, S5560-S5571, S8095-S8101, S8120-S8490, S8999-S9007, S9061, V2600-V2632, V2788, V5335-V5336 *Note: moved S8004 to Other Professional	*Note: Removed provider logic	Units
Other Ancillaries	92325-92326, 92340-92342, 92370, 92390-92392, 92396, 99500-99602, G0151-G0156, Q5001, S0270-S0274, S0345-S0347, S0500-S0514, S0516-S0590, S0595, S5035-S5036, S5108-S5116, S5180-S5181, S5497-S5523, S9097-S9098, S9122-S9131, S9208-S9590, S9810, V2020-V2599, V2700-V2787, V5011-V5298	*Note: Removed provider logic	Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Surgery - I/P and O/P	10000-36410, 36420-58999, 59525, 60000-69999, 92973-92974, 92980-92998, 93501-93533, 93561-93581	Excludes anesthesiologist services.	Units
Surgery - I/P and O/P - Anesthesia	00100-00849, 00851-00856, 00858-00945, 00947-00954, 00956-01959, 01962-01966, 01969-01999, 99100, 99116, 99135, 99140, 99143-99145, 99148-99150	Or surgery services provided by an anesthesiologist as identified by a modifier. *Note: Removed provider logic	Line Items
ER Visits	99281-99288		Units
Hospital Visits	90816-90829, 99217-99239, 99289-99316, 99356-99357, 99431, 99433-99440, 99460, 99462-99480, G0263-G0264, G0390, S0310		Units
Office Visits	98966-98969, 99050-99060, 99201-99215, 99321-99355, 99358-99359, 99361-99380, 99441-99444, 99499, G0179-G0182, G0337, S0220-S0260, S9083, S9088 *Note: moved 99024 to Other Professional, 99281-99288 to ER		Units
Immunizations	90465-90749, G0008-G0010, J3530, S0195		Units
Radiology	70000-79999, R0070-R0076		Units
Pathology	80000-89999, P2028-P2038, P3000-P3001, P7001		Units
Mental Health/ Substance Abuse	90801-90815, 90845-90899		Units
Other Professional Services		Any services provided by Professional Providers and not assigned by CPT-4 HCPCS methodology. *Note: Removed provider logic	Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Non-Delivery	59000-59399, 59425-59426, 59428, 59430, 59812-59899 *Note: moved 59412, 59414 to delivery		Units

Category of Service	Medicare DRGs	Other Information	Unit Measure
Inpatient Hospital			
Inpatient Maternity Delivery	0370-0375, 0378-0384		Days

Type of Service	Revenue Code	Other Information	Unit Measure
Outpatient Hospital			
Outpatient Hospital Maternity	Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2)		Claims

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Delivery	59400, 59409-59410, 59412, 59414, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	*Note: Removed provider logic	Claims
Maternity – Delivery - Anesthesia	00850, 00857, 00946, 00955, 01960-01961, 01967-01968	Or delivery services provided by an anesthesiologist as identified by a modifier. *Note: Removed provider logic	Line Items

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		
Describe		
Describe		
Describe		

Describe		
Describe		
Describe		
Describe		
Describe		
Describe		
Describe		
Describe		
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 2).
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.

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.

Graduate Medical Education Report

GME stands for Graduate Medical Education and consists of two components: IME (indirect medical education) and DME (direct medical education). Indirect education means the hospital has a teaching program without residents. If a hospital does have residents, then they have both indirect & direct medical education add-ons. CMS does not allow the MCO's to make the medical education payments to the providers so SCDHHS calculates and make these payments. These add-ons apply only to inpatient hospital claims.

In order for SCDHHS accurately calculate payments, a list of paid inpatient claims for all teaching hospitals is required from MCOs. The necessary fields are designated on the sample file below. This file includes discharge status and a listing of discharge status categories. The report format also includes a column for information regarding adjusted claims. All adjusted claims should be submitted quarterly, along with newly paid claims, and an explanation of the adjustment should provided in this column. This should also include claims that were paid and then later denied. Please use the same claim number for the adjusted claim that was used in the initial submission. By following this methodology, SCDHHS will be able to make any necessary adjustments to the GME calculations. This information be submitted quarterly. The due date is the last day of the month following the end of the quarter.

Sample File Layout

Patient control #*	HMO claim #	Admission Date	Discharge Date	LOS	Discharge Status	Total Charges	DRG	Provider name	Provider Medicaid #	Reason for Adjustment**
123456789	08888A888888	11/10/2006	11/12/2006	2	1	6,531.85	026	ABC Hospital	111111	

Effective April 1st, 2010

*** Patient control# -** This was added at the request of the hospitals so that they can easily identify the claim to post the GME add on.

****Reason for Adjustment** - This is a new required field for any adjusted claims. Please provide a description as to why this claim, which has been paid in a previous quarter, is now being recouped. The claim number of the adjusted claim should match a claim that has been previous paid. This should NOT included any claims that have been reprocessed for rate changes. This should ONLY be for claims that have been paid and should not have been for whatever reason or if the total charges or length of stay has changed.

Discharge Status

Status	Description
01	Discharged to home or self care (routine discharge)
02	Transferred to another short-term general hospital
03	Transferred to a SNF
04	Transferred to an ICF
05	Transferred to another type of institution
06	Discharged to home under care of an organized home health service organization
07	Left against medical advice

08	Discharge to home care under the care of a home IV therapy provider						
20	Expired						
30	Still patient or expected to return for outpatient services						
31	Still patient - SNF administrative days program						
32	Still patient - ICF administrative days program						
62	Discharged/transferred to an inpatient rehabilitation facility including rehabilitation distinct part unit of a hospital						
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital						

List of Teaching Hospitals (effective 6/1/10 – List is subject to modification)

TEACHING HOSPITALS

Hospital Name	IP Provider
Aiken Regional Medical Center	226374
AnMed Health	450780
Carolinas Medical Center	460403
Greenville Hospital System	111717
Lexington Medical Center	313118
McLeod Regional Medical Center	459938
Medical College of Georgia	315846
Medical University Hospital	178277
Memorial Health University Medical Center	117736
Oconee Memorial Hospital	354027
Palmetto Health Baptist Columbia	418962
Palmetto Health Richland	387175
Roper Hospital	400872
Self Regional Healthcare	417160
Spartanburg Regional Medical Center	369963
St Francis Hospital	412885
Trident Medical Center	269338
Union Regional Medical Center	222150
University Hospital Augusta	150241

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WRAP SUMMARY ENCOUNTER LAYOUT

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	MCO Provider Number	6	1	6	C	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the MCO
2.	Facility or Practice Legacy Number	6	7	12	C	A 6-digit number assigned by the Medicaid Program Office to uniquely identify the facility/practice. This must be the FQHC or RHC ID.
3.	Facility or Practice NPI Number	10	13	22	N	The National Provider Identification number assigned to the practice/facility
4.	Month/Year of Service	7	23	29	C	Enter the month and year of service in the appropriate format -MASK: MMYYYY
5.	Monthly Capitated Number of Members	5	30	34	N	Enter the total number of members for month of service with capitation payments – MASK: 99999
6.	Monthly Capitated Amount Paid	10	35	44	N	Enter the total amount paid for field 5 - MASK: 99999999V99
7.	Monthly Fee-For-Service Number of Clients	5	45	49	N	Enter the total number of members for month of service with fee-for-service payments – MASK: 99999 (Unduplicated)
8.	Monthly Fee-For-Service Number of Encounters	5	50	54	N	Enter the total number of encounters for field 7 – MASK: 99999
9.	Monthly Fee-For-Service Amount Paid	10	55	64	N	Enter the total amount paid for field 7 - MASK: 99999999V99
10.	Monthly CAP Encounters Number of Clients	5	65	69	N	Enter the total number of members for month of service with CAP encounter data only – MASK: 99999 (Unduplicated)
11.	Monthly CAP Encounters Number of Encounters	10	70	79	N	Enter the total number of CAP encounters for field 10 - MASK: 99999999V99
12.						

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 0044297. 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

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						06 - MANAGED CARE PROVIDER TERMINATED 07 - OCWI (PEP AND PAYMENT CATEGORY 87) 08 - RECIPIENT HAS TPL HMO POLICY
30.	MLE-PR-KEY	3	285	287		Premium Rate Category
31.	MLE-PREMIUM-RATE	9	288	296		Amount of Premium paid
32.	MLE-PREM-DATE.	6	297	302		CCYYMM – Month for which the premium is paid.
33.	MLE-MENTAL-HEALTH-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
53.	*POL-GRP-CITY*	39	634	672		Policy group city
54.	*POL-GRP-STATE*	2	673	674		Policy group state
55.	*POL-GRP-ZIP*	9	675	683		Policy group zip code + 4
56.	*POL-POST-PAYREC-IND*	1	684	684		0-cost avoid, 1-no cost avoid
57.	*POLICY-INSURED-LAST NAME*	17	685	701		Insured last name
58.	*POLICY-INSURED-FIRST NAME*	14	702	715		Insured first name
59.	*POLICY-INSURED-MI-NAME*	1	716	716		Insured middle Initial
60.	*POLICY--SOURCE-CODE*	1	717	717		Source of info about policy (ie. champus, highway)
61.	*POLICY--LETTER-IND*	1	718	718		If present, pass group address info

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
62.	*POL-EFFECTIVE-DATE*	8	719	726		Effective date of policy CCYYMMDD
63.	*POL-OPEN-DATE*	8	727	734		First stored date
64.	*POL-COVER- IND-ARRAY*	30	735	764		1 BYTE FIELDS X 30 What policy will cover
65.	*RECIPIENT-RACE*	2	4491	4492		Race code - Reference Table 13
66.	*RECIPIENT-LANGUAGE*	1	4493	4493		Language code -Reference Table 21
67.	*RECIPIENT-FAMILY--NUM*	8	4494	4501		Family Number
68.	*FILLER*	99	4502	4600		Filler

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

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

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

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

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OUTPUT ENCOUNTER LAYOUT FOR PHARMACY SERVICES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	DEC-ENC-KEY	23	1	23		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 'D' = Drug 'Z' = Hospital UB
9.	DEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
10.	DEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
11.	DEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
12.	DEC-ENC-SUBMIT-	7	53	59	C	Julian date

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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
27.	DEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
28.	DEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
29.	DEC-QMB-IND	1	149	149	C	Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level
30.	DEC-RSP-PGM-IND (occurs 6 times)	1	150	155	C	Indicates enrollment in special programs This is an array field and occurs 6 times in this space.
31.	FILLER	4	156	159	C	
32.	DEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
33.	DEC-CARRIER-CODE	5	160	164	C	Carrier Code
34.	DEC-POLICY-NUMBER	25	165	189	C	Policy number
35.	DEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
36.	DEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
37.	DEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
38.	DEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
39.	FILLER	1	373	373	C	
40.	FILLER	1	374	374	C	
41.	DEC-PAYMENT-DENIED-IND	1	375	375	C	**FOR FUTURE USE** 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 Value 'V' = void/cancel

43	DEC-ENC-IND-1	1	377	377	C	Possible future use
44	DEC-CLAIM-PAID-DATE	4	378	381	C	Date claim paid Mask: YYMM
45	DEC-ENCOUNTER-STATUS	1	382	382	C	Indicates if the encounter was accepted Value 'A' = accepted 'R' = replacement needed 'D' = duplicate 'T' = TPL 'V' = voided 'X' = deleted
46	DEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
47	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 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 Value 'C' = critical 'N' = non critical '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-	15	811	825	C	Prescription number

	NO					
63	DEC-DISPENSE-DATE-8	8	826	833	C	Date which prescription was dispensed 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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did not charge
69	DEC-TOT-AMT-HMO-BILLED	9	853	861	N	Amount billed for service Mask: S9999999V99 (this is zone signed)
70	DEC-TOT-AMT-HMO-PAID	9	862	870	N	Amount paid for service rendered 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 of 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	DEI-COMPOUND-NDC-1	11	899	909	C	IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE FIRST COMPONENT OF THE COMPOUND DRUG.
76	DEI-COMPOUND-UNIT-TYPE-1	3	910	912	C	AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY

						ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
77	DEI-COMPOUND-QUANTITY-1	10	913	922	N	AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
78	DEI-COMPOUND-NDC-2	11	923	933	C	IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE SECOND COMPONENT OF THE COMPOUND DRUG.
79	DEI-COMPOUND-UNIT-TYPE-2	3	934	936	C	AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
80	DEI-COMPOUND-QUANTITY-2	10	937	946	N	AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
81	DEI-COMPOUND-NDC-3	11	947	957	C	IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE THIRD COMPONENT OF THE COMPOUND DRUG.
82	DEI-COMPOUND-UNIT-TYPE-3	3	958	960	C	AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS

						ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
83	DEI-COMPOUND-QUANTITY-3	10	961	970	N	AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
84	DEI-COMPOUND-NDC-4	11	971	981	C	IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE FOURTH COMPONENT OF THE COMPOUND DRUG.
85	DEI-COMPOUND-UNIT-TYPE-4	3	982	984	C	AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES TAB – TABLETS TDP – TRANSDERMAL PATCHES
86	DEI-COMPOUND-QUANTITY-4	10	985	994	N	AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
87	DEI-COMPOUND-NDC-5	11	995	1005	C	IF A COMPOUND DRUG IS BEING REPORTED, THIS IS THE NDC OF THE FIFTH COMPONENT OF THE COMPOUND DRUG.
88	DEI-COMPOUND-UNIT-TYPE-5	3	1006	1008	C	AHF – ANTI-HEMOPHILIC FACTOR INJECTABLES CAP – CAPSULES EA - NOT IDENTIFIABLE BY ANOTHER UNIT TYPE GM - GRAMS ML - MILLILITERS SUP – SUPPOSITORIES

						TAB – TABLETS TDP – TRANSDERMAL PATCHES
89	DEI-COMPOUND-QUANTITY-5	10	1009	1018	N	AMOUNT EXPRESSED IN METRIC DECIMAL UNITS OF THE PRODUCT INCLUDED IN THE COMPOUND MIXTURE. MASK 9(7)V999 ZERO FILLED NO SIGN
90	DEI-COMPOUND-DRUG-IND	1	1019	1019	C	THIS FIELD IS ONLY POPULATED IF THIS ENCOUNTER IS A COMPOUND DRUG ENCOUNTER. VALUE: 'Y'
91	FILLER	1245	1020	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

OUTPUT ENCOUNTER LAYOUT FOR AMBULATORY SERVICES

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
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 'D' = Drug 'Z' = Hospital UB
9.	HEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
10.	HEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
11.	HEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
12.	HEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter submitted CCYYDDD
13.	HEC-PROCESS-DATE-8	8	60	67	N	Date encounter processed in MMIS Mask: CCYYMMDD
14.	HEC-ENC-DATA-STATUS	1	68	68	C	Status of encounter after edit Value 'G' = good data

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						'F' = flawed data 'I' = ignore data 'T' = TPL data
15.	HEC-HMO-PROV-INFO	28	69	96	C	Provider information
16.	HEC-PROVIDER-TYPE	2	69	70	C	Managed Care provider type
17.	HEC-PROVIDER-NAME	26	71	96	C	Managed Care provider name
18.	HEC-ENC-RECIP-INFO	63	97	159		Recipient information
19.	HEC-RECIP-LAST-NM	17	97	113	C	Recipient Last Name
20.	HEC-RECIP-FIRST-NM	14	114	127	C	Recipient First Name
21.	HEC-RECIP-MIDDLE-INIT	1	128	128	D	Recipient Middle Initial
22.	HEC-DOB-8	8	129	136	C	Recipient date of birth CCYYMMDD
23.	HEC-SEX	1	137	137	C	Sex
24.	HEC-AGE	3	138	140	N	Age in years
25.	HEC-RACE	2	141	142	C	Race code
26.	HEC-COUNTY	2	143	144	C	County Code
27.	HEC-ASSIST-PAYMENT-CATEGORY	2	145	146	C	Recipient category of payment assigned by DSS
28.	HEC-QUALIFYING-CATEGORY	2	147	148	C	Status that qualifies recipient for benefits
29.	HEC-QMB-IND	1	149	149	C	Indicate if recipient is a qualified Medicare beneficiary for catastrophic health care and/or the recipient is above or below poverty level
30.	HEC-RSP-PGM-IND (occurs 6 times)	1	150	155	C	Indicates enrollment in special programs This is an array field and occurs 6 times in this space.
31.	FILLER	4	156	159	C	
32.	HEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
33.	HEC-CARRIER-	5	160	164	C	Carrier Code

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	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	**FOR FUTURE USE** 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 Value 'V' = void/cancel
43.	HEC-ENC-IND-1	1	377	377	C	Possible future use
44.	HEC-CLAIM-PAID-DATE	4	378	381	C	Date claim paid Mask: YYMM
45.	HEC-ENCOUNTER-STATUS	1	382	382	C	Indicates if the encounter was accepted Value 'A' = accepted 'R' = replacement needed 'D' = duplicate 'T' = TPL 'V' = voided 'X' = deleted
46.	HEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
47.	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.	HEC-ERROR-COUNT	2	450	451		Number of errors on the encounter

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						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 Value 'C' = critical 'N' = non critical '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 CCYY
65.	HEC-FDOS-mm	2	788	789	C	First date of service month MM
66.	HEC-FDOS-DD	2	790	791	C	First date of service day DD
67.	HEC-LDOS-CCYY	4	792	795	C	Last date of service full year CCYY
68.	HEC-LDOS-mm	2	796	797	C	Last date of service month MM
69.	HEC-LDOS-DD	2	798	799	C	Last date of service day DD
70.	HEC-PROC-CODE-6	6	800	805		Full 6 byte code
71.	HEC-PROC-BYTE-1	1	800	800	C	For future use
72.	HEC-	5	801	805	C	HCPCS code

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	PROCEDURE-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 Mask: S999 (field is zone signed)
75.	HEC-TWO-BYTE-POS	2	812	813	C	Location at which service was rendered 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 Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						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
113	HEC-PROC-CODE-EDIT-IND	8	1562	1569	C	**OCCURS 8 TIMES (ONE FOR EACH LINE)** Indicates the procedure code is not recognized by SCDHHS but the MCO covered the service/procedure. Value 'Y'
114	HEC-LINE-NDC-IND-1	1	1570	1570	C	This is only populated if line 1 of the encounter contains a JCODE. Value 'Y'
115	HEC-LINE-NDC-1	11	1571	1581	C	If the procedure code in line 1 is a JCODE, you would put the NDC of the drug in this field.
116	HEC-INE-NDC-IND-2	1	1582	1582	C	This is only populated if line 2 of the encounter contains a JCODE. Value 'Y'
117	HEC-LINE-NDC-2	11	1583	1593	C	If the procedure code in line 2 is a JCODE, you would put the NDC of the drug in this field.
118	HEC-LINE-NDC-IND-3	1	1594	1594	C	This is only populated if line 3 of the encounter contains a JCODE. Value 'Y'
119	HEC-LINE-NDC-3	11	1595	1605	C	If the procedure code in line 3 is a JCODE, you would put the NDC of the drug in this field.
120	HEC-LINE-NDC-IND-4	1	1606	1606	C	This is only populated if line 4 of the encounter contains a JCODE. Value 'Y'
121	HEC-LINE-NDC-4	11	1607	1617	C	If the procedure code in line 4 is a JCODE, you would put the NDC of the drug in this field.
122	HEC-LINE-NDC-IND-5	1	1618	1618	C	This is only populated if line 5 of the encounter contains a JCODE. Value 'Y'
123	HEC-LINE-NDC-5	11	1619	1629	C	If the procedure code in line 5 is a JCODE, you would put the NDC of the drug in this field.
124	HEC-LINE-NDC-IND-6	1	1630	1630	C	This is only populated if line 6 of the encounter contains a JCODE. Value 'Y'
125	HEC-LINE-NDC-6	11	1631	1641	C	If the procedure code in line 6 is a JCODE, you would put the NDC of the drug in this field.

126	HEC-LINE-NDC-IND-7	1	1642	1642	C	This is only populated if line 7 of the encounter contains a JCODE. Value 'Y'
127	HEC-LINE-NDC-7	11	1643	1653	C	If the procedure code in line 7 is a JCODE, you would put the NDC of the drug in this field.
128	HEC-LINE-NDC-IND-8	1	1654	1654	C	This is only populated if line 8 of the encounter contains a JCODE. Value 'Y'
129	HEC-LINE-NDC-8	11	1655	1665	C	If the procedure code in line 8 is a JCODE, you would put the NDC of the drug in this field.
130	FILLER	599	1666	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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
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 'D' = Drug 'Z' = Hospital UB
9.	ZEC-HMO-RECIP-ID	15	35	49	C	HMO recipient number assigned by HMO
10.	ZEC-PEP-HMO-IND	1	50	50	C	Designates type of PEP/HMO Value 'P' = PEP 'H' = HMO
11.	ZEC-FORMAT	2	51	52	C	FOR INTERNAL USE ONLY Designates format of input encounter Value '01 – 06'
12.	ZEC-ENC-SUBMIT-DATE	7	53	59	C	Julian date encounter

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

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 (occurs 6 times)	6	150	155	C	Indicates enrollment in special programs This is an array field and occurs 6 times in this space.
31.	FILLER	4	156	159	C	
32.	ZEC-ENC-TPL-INFO (occurs 3 times)	71	160	372		Third party insurance information Occurs 3 times
33.	ZEC-CARRIER-CODE	5	160	164	C	Carrier Code
34.	ZEC-POLICY-NUMBER	25	165	189	C	Policy number
35.	ZEC-INS-LAST-NAME	17	190	206	C	Insured's Last Name
36.	ZEC-INS-FIRST-NAME	14	207	220	C	Insured's First Name
37.	ZEC-INS-MIDDLE-INITIAL	1	221	221	C	Insured's Middle Initial
38.	ZEC-CARRIER-PAID-INP	9	222	230	C	Mask: 9999999V99
39.	FILLER	1	373	373	C	
40.	FILLER	1	374	374	C	
41.	ZEC-PAYMENT-DENIED-IND	1	375	375	C	**FOR FUTURE USE** THIS FIELD IS

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						NOT CURRENTLY BEING USED, PLEASE LEAVE THIS FIELD BLANK.
42.	ZEC-ADJUSTMENT-IND	1	376	376	C	Identifies as being voided or canceled Value 'V' = void/cancel
43.	ZEC-ENC-IND-1	1	377	377	C	Possible future use
44.	ZEC-CLAIM-PAID-DATE	4	378	381	C	Date claim paid Mask: YYMM
45.	ZEC-ENCOUNTER-STATUS	1	382	382	C	Indicates if the encounter was accepted Value 'A' = accepted 'R' = replacement needed 'D' = duplicate 'T' = TPL 'V' = voided 'X' = deleted
46.	ZEC-REPLACED-ECN	17	383	399	C	Claim number of a replacement encounter
47.	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 Mask: S9999 COMP (signed packed EBCDIC)
54.	ZEC-ERROR-CODE-	300	452	751		This array allows

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	ARRAY					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 Value 'C' = critical 'N' = non critical '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 Mask: 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 began Mask:

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						CCYYMMDD
70.	ZEC-TO-DATE-8	8	856	863	C	Last date of service Mask: 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 Mask: 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 Mask S9999999v99 (zone signed)
78.	ZEC-TOT-AMT-HMO-PAID	9	960	968	N	Amount billed for hospital services Mask S9999999v99 (zone signed)
79.	ZEC-REIMBURSE-METHOD	1	969	969	C	Indicates HMO method of reimbursement Value 'C' = Capitated Value 'F' = Fee For Service Value 'T' = Procedure/Service paid by TPL Value 'Z' = Zero Billed/Provider did

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						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 Mask: X – not used at this time 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 VISITS AND IMMUNIZATIONS

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

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

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

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CLAIMS RECORD DESCRIPTION

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

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

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

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

Special instruction:
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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.
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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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
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:
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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 1: Payment Categories for Field 29.
10 MAO (NURSING HOMES)
11 MAO (EXTENDED TRANSITIONAL)
12 OCWI (INFANTS UP TO AGE 1)
13 MAO (FOSTER CARE/SUBSIDIZED ADOPTION)
14 MAO (GENERAL HOSPITAL)
15 MAO (CLTC)
16 PASS-ALONG ELIGIBLES
17 EARLY WIDOWS/WIDOWERS
18 DISABLED WIDOWS/WIDOWERS
19 DISABLED ADULT CHILD
20 PASS ALONG CHILDREN
30 AFDC (FAMILY INDEPENDENCE)
31 TITLE IV-E FOSTER CARE
32 AGED, BLIND, DISABLED
33 ABD NURSING HOME
40 WORKING DISABLED
41 MEDICAID REINSTATEMENT
48 S2 SLMB
49 S3 SLMB
50 QUALIFIED WORKING DISABLED (QWDI)
51 TITLE IV-E ADOPTION ASSISTANCE
52 SLMB (SPF LOW INC MEDCARE BENEFICIAR)
53 NOT CURRENTLY BEING USED
54 SSI NURSING HOMES
55 FAMILY PLANNING
56 COSY/ISCEDC
57 KATIE BECKETT CHILDREN - TEFRA
58 FI-MAO (TEMP ASSIST FOR NEEDY)
59 LOW INCOME FAMILIES
60 REGULAR FOSTER CARE
68 FI-MAO WORK SUPPLEMENTATION
70 REFUGEE ENTRANT
71 BREAST AND CERVICAL CANCER
80 SSI
81 SSI WITH ESSENTIAL SPOUSE
85 OPTIONAL SUPPLMENT
86 SUPPLEMENT & SSI
87 OCWI (PREGNANT)
88 OCWI (CHILD UP TO 19)
90 MEDICARE BENE(QMB)
91 RIBICOFF CHILDREN
92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
RSS2170-834-RECORD
DAILY NEWBORN ENROLLEE FILE

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
1.	R834-EDI-REC-TYPE	1	1	1	C	
2.	R834-PROVIDER-NAME	26	2	27	C	
3.	R834-PROV-EMP-ID	9	28	36	C	
4.	R834-MAINT-TYPE-CODE	3	37	39	C	
5.	R834-INDIV-NO-CHECK-DIGIT	1	40	40	C	
6.	R834-INDIV-NO	9	41	49	N	
7.	R834-MCARE-PLAN-CODE	1	50	50	C	VALUE 'A' = MEDICARE-PART-A VALUE 'B' = MEDICARE-PART-B VALUE 'C' = MEDICARE-PART-A and B VALUE 'D' = MEDICARE-UNKNOWN VALUE 'E' = NO MEDICARE
8.	R834-HANDICAP-IND	1	51	51	C	
9.	R834-ELIG-DATES.	16	52	67	N	
10.	R834-MKD-CN-EL	2	52	53	N	
11.	R834-MKD-YR-EL	2	54	55	N	
12.	R834-MKD-MO-EL	2	56	57	N	
13.	R834-MKD-DA-EL	2	58	59	N	
14.	R834-MKD-CN-INL	2	60	61	N	
15.	R834-MKD-YR-INL	2	62	63	N	
16.	R834-MKD-MO-INL	2	63	65	N	
17.	R834-MKD-DA-INL	2	66	67	N	
18.	R834-FULL-NAME.	32	68	99	C	
19.	R834-LAST-	17	68	84	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	NAME					
20.	R834-FIRST-NAME	14	85	98	C	
21.	R834-MIDDLE-INITIAL	1	99	99	C	
22.	R834-SOCIAL-SECURITY-NUMBER	9	100	108	N	MASK:999999999
23.	R834-COMMUNICATION-NO.	10	109	118	C	
24.	R834-AREA-CODE	3	109	111	N	
25.	R834-TELEPHONE-NO	7	112	118	N	
26.	R834-RA-ADDR-CARE-OF	25	119	143	C	
27.	R834-RA-ADDR-LINE-2	25	144	168	C	
28.	R834-RA-ADDR-CITY	16	169	184	C	
29.	R834-RA-ADDR-STATE	2	185	186	C	
30.	R834-RA-ZIP-CODE	9	187	195	N	
31.	R834-ADDR-CARE-OF	25	196	220	C	
32.	R834-ADDR-LINE-2	25	221	245	C	
33.	R834-ADDR-CITY	23	246	268	C	
34.	R834-ADDR-STATE	2	269	270	C	
35.	R834-ZIP-CODE	9	271	279	N	
36.	R834-COUNTY-WHERE-ELIGIBLE	2	280	281	C	
37.	R834-DATE-OF-BIRTH-8.	8	282	289	C	
38.	R834-BIRTH-CENTURY	2	282	283	N	VALUE ‘18’ = BORN IN 1800’s VALUE ‘19’ = BORN IN 1900’s VALUE ‘20’ = BORN IN 2000’s
39.	R834-BIRTH-YR	2	284	285	C	VALUE SPACES = No birth date entered
40.	R834-BIRTH-MO	2	286	287	C	VALUE SPACES = No birth date entered
41.	R834-RANGE-YR1 redefines R834-BIRTH-MO		286	287	C	VALUE SPACES = No birth date entered
42.	R834-BIRTH-DA	2	288	289	C	VALUE SPACES = No

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
						birth date entered
43.	R834-RANGE-YR2 redefines R834-BIRTH-DA		288	289	C	VALUE SPACES = No birth date entered
44.	R834-SEX	1	290	290	C	
45.	R834-RACE	2	291	292	C	
46.	R834-LANGUAGE-QUALIFIER	2	293	294	C	
47.	R834-LANGUAGE-CODE	3	295	297	C	
48.	R834-DATE-OF-DEATH-8.	8	298	305	N	
49.	R834-D-CN	2	298	299	N	
50.	R834-D-YR	2	300	301	N	
51.	R834-D-MO	2	302	303	N	
52.	R834-D-DA	2	304	305	N	
53.	R834-REF-FIELDS-1.	28	306	333	C	
54.	R834-PAYMENT-CATEGORY	3	306	308	C	
55.	R834-PGM-TYPE	1	309	309	C	VALUE 'M' = R834-MCO-ONLY VALUE 'P' = R834-MHN-ONLY VALUE 'S' = R834-SCHIP-MCO-ONLY VALUE 'B' = R834-MCO-OR-MHN VALUE 'X' = R834-NOT-MGC-ELIG
56.	R834-MEDICARE-TYPE	1	310	310	C	VALUE 'R' = R834-RAILROAD-ID VALUE 'R' or 'M' = R834-MCARE-ID
57.	R834-MEDICARE-ID	12	311	322	C	
58.	R834-ETHNICITY-CD	2	323	324	C	
59.	R834-PREG-IND	1	325	325	C	
60.	R834-PREG-DUE-DATE	8	326	333	C	
61.	R834-REF-FIELDS-2.	30	334	363	C	
62.	R834-HOUSEHOLD-NO	9	334	342	N	
63.	R834-HOUSEHOLD-HEAD-ID	10	343	352	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
64.	R834-REC-TYPE-CODE	2	353	354	C	
65.	R834-ENROLL-IND	1	355	355	C	
66.	R834-LOCKIN-BEGIN-CN	2	356	357	N	
67.	R834-LOCKIN-BEGIN-YR	2	358	359	N	
68.	R834-LOCKIN-BEGIN-MO	2	360	361	N	
69.	R834-LOCKING-BEGIN-DA	2	362	363	N	
70.	R834-REF-FIELDS-3.	19	364	382	N	
71.	R834-ALT-RECIP-ID	10	364	373	C	
72.	R834-ALT-RECIP-SSN	9	374	382	C	
73.	R834-PREF-PROVIDER-LAST-ORG	25	383	407	C	
74.	R834-PREF-PROVIDER-FIRST	10	408	417	C	
75.	R834-PREF-PROVIDER-MIDDLE	1	418	418	C	
76.	R834-PREF-PROVIDER-ENTITY-CODE	1	419	419	C	
77.	R834-PREF-PROVIDER-RELATION	2	420	421	C	
78.	R834-TPL-INFO. occurs 5 times	116	422	1001	C	
79.	R834-POLICY-NUMBER	25	422	446	N	
80.	R834-GROUP-TPL-NO	20	447	466	N	
81.	R834-CARRIER-CODE	5	467	471	C	
82.	R834-CARRIER-NAME-34	34	472	505	C	
83.	R834-COVERAGE-IND occurs 21 times	10	506	526	C	
84.	R834-DATE-TIME-QUAL	3	527	529	C	
85.	R834-TPL-EFF-DATE	8	530	537	C	
86.	R834-RSP-ELIG-	8	1002	1009	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
	DATE-8.					
87.	R834-RSP-ELG-CN	2	1002	1003	N	
88.	R834-RSP-ELG-YR	2	1004	1005	N	
89.	R834-RSP-ELG-MO	2	1006	1007	N	
90.	R834-RSP-ELG-DA	2	1008	1009	N	
91.	R834-RSP-INELIG-DATE-8.	8	1010	1017	C	
92.	R834-RSP-INL-CN	2	1010	1011	N	
93.	R834-RSP-INL-YR	2	1012	1013	N	
94.	R834-RSP-INL-MO	2	1014	1015	N	
95.	R834-RSP-INL-DA	2	1016	1017	N	
96.	R834-HH-HEAD-LAST-NAME	17	1018	1034	C	
97.	R834-HH-HEAD-FIRST-NAME	14	1035	1048	C	
98.	R834-HH-HEAD-MIDDLE-INITIAL	1	1049	1049	C	
99.	R834-HH-HEAD-SUFFIX	3	1050	1052	C	
100.	R834-REF-FIELD-4.	37	1053	1089	C	
101.	R834-PLAN-PROV-NO	6	1053	1058	N	
102.	R834-PCP-PROV-NO	6	1059	1064	N	
103.	R834-PCP-NPI-NO	10	1065	1074	N	
104.	R834-BENEFIT-CCYYMM	6	1075	1080	N	
105.	R834-CHOICE-REASON-CD	3	1081	1083	C	
106.	R834-DISENROLL-REASON-CD	3	1084	1086	C	
107.	R834-ERROR-CODE	3	1087	1089	C	
108.	R834-CHAIN-PROV-NUMBER	9	1090	1098	C	
109.	R834-ZAP-IND	1	1099	1099	C	VALUE 'Y' = ZAP TRANSACTION
110.	R834-CHG-INFO-IND	1	1100	1100	C	VALUE 'Y' = DEMO-INFO-CHANGED

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/C	Description/Mask
111.	R834-MEDS-ENROLL-IND	1	1101	1101	C	VALUE 'N' or 'R' MEDS AUTO ASSIGN VALUE 'N' = MEDS-NEW VALUE 'R' = MEDS-REVIEW VALUE 'Y' = MEDS-MGC-ELIG VALUE 'X' = MEDS-NOT-MGC-ELIG
112.	R834-REGION	1	1102	1102	C	
113.	R834-MMIS-ENROLL-IND	1	1103	1103	C	VALUE 'Y' = MMIS-MGC-ELIG VALUE 'N' = MMIS-NOT-MGC-ELIG
114.	R834-SORT-BYTE	1	1104	1104	C	
115.	R834-RECIPS-MOTHER-ID	10	1105	1114	C	
116.	R834-MOTHER-ID-CHG-IND	1	1115	1115	C	VALUE 'Y' = MOTHER-ID-CHANGED
117.	FILLER	30	1116	1145		

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 0044297. 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 a special file created specifically for the MCO's to relay information about newborns to each of the plans on a daily basis. The file corresponds to all confirmed newborn placements by the Enrollment Broker. This file will be created each night that the 834 interface executes with the Enrollment Broker.

MCO/MHN/MAXIMUS Sync File Layout

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

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

FORMS

SAMPLE WIC REFERRAL FORM

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

Name of Person Being Referred: _____

Address: _____

Telephone Number: _____

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

___ Pregnant woman

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

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

___ Infant (age 0-1)

___ Child under age 5

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

Provider's Name _____

Provider's Phone _____

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

_____

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

Send completed form to:

WIC Program Contact
Address
Phone Number

HYSTERECTOMY ACKNOWLEDGMENT FORM
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

□ ALWAYS COMPLETE THIS SECTION □

Recipient Name _____ Medicaid ID No. _____

Physician's Name _____ Date of Hysterectomy _____

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

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

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

PATIENT'S SIGNATURE DATE

WITNESS' SIGNATURE DATE

INTERPRETER'S SIGNATURE (if necessary) DATE

PHYSICIAN STATEMENT

IT HAS BEEN EXPLAINED TO THE ABOVE PATIENT AND/OR HER REPRESENTATIVE BY ME PRIOR TO SURGERY BOTH ORALLY AND IN WRITING THAT THE HYSTERECTOMY TO BE PERFORMED IS MEDICALLY NECESSARY AND NOT FOR THE SOLE PURPOSE OF RENDERING HER INCAPABLE OF BEARING CHILDREN (REPRODUCING) NOR IS THE HYSTERECTOMY FOR MEDICAL PURPOSES WHICH BY THEMSELVES DO NOT MANDATE A HYSTERECTOMY.

PHYSICIAN'S SIGNATURE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW ARE APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient listed above:
(Check one)

1 □ I informed her that this operation would make her permanently incapable of reproducing (This certification for retroactively eligible recipient only - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made).

2 □ She was already sterile due to

_____.
CAUSE OF STERILITY

3 □ She had a hysterectomy performed because of a life-threatening situation due to

_____.
DESCRIBE EMERGENCY SITUATION

and the information concerning sterility could not be given prior to the hysterectomy.

For the above reason(s), I am requesting an exception to the acknowledgment requirement for the hysterectomy.

PHYSICIAN'S SIGNATURE

This form may be reproduced locally

INSTRUCTIONS FOR COMPLETING HYSTERECTOMY ACKNOWLEDGMENT FORM

Always complete this section

1. Member Name: Member's Name can be typed or handwritten. Must be completed.

2. Medicaid ID No: Member's Identification Number can be typed or handwritten. Must be completed.

3. Physician's Name: Physician's Name can be typed or handwritten. Must be completed.

4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete this section for enrollee who acknowledges receipt prior to hysterectomy

5. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery. (if the patient cannot sign her name she can mark an "X" in patient's signature blank if there is a witness)

6. Witness Signature/Date: The witness must sign and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting.

7. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in is/her own handwriting.

If Section A is completed, **STOP HERE.**

Section B: Complete this section when any of the exceptions listed below are applicable

8. Retroactive Eligible Member Only: This box is checked only if the enrollee was approved retroactively. A copy of the Medicaid card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.

9. This box is checked if the patient was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.

10. This box is checked if the patient had a hysterectomy performed because if a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.

11. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

DEPT. OF HEALTH & HUMAN SERVICES
P.O. Box 8206
Columbia, S.C. 29202-8206

INDIVIDUALS INFORMED CONSENT TO NON - THERAPEUTIC STERILIZATION FOR MEDICAID RECIPIENTS

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

PART I CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for the
(Doctor or clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____.
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature Month Day Year

MEDICAID ID NUMBER

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check):

( ) American Indian or Alaska Native
( ) Black (not of Hispanic origin)
( ) Hispanic
( ) Asian or Pacific Islander
( ) White (not of Hispanic origin)

PART II INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

_____ _____
Interpreter Date

FORM
DHHS 1723
3 - 97

PART III STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of individual)
Consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary, I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at ant time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent Date

_____
Facility

_____
Address

PART IV PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon
_____ on _____
(Name: Individual to be sterilized) (Date sterilized)
I explained to him/her the nature of the sterilization operation

_____
(Specify type of operation)
the fact that it is intended to be a final and irreversible procedure and the discomfort, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (CROSS OUT THE PARAGRAPH WHICH IS NOT USED.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstance (check applicable box and fill in information requested):

( ) Premature delivery
Individual expected date of delivery: _____
( ) Emergency abdominal surgery (describe circumstance):

_____ Date _____
Physician

License No: _____ Group No: _____

INSTRUCTIONS FOR COMPLETING STERILIZATION CONSENT FORM

All sections of the "Sterilization for Medicaid Recipients" consent form (SCDHHS form 1723, Jan. 1989 edition) must be completed. If the consent form is correctly completed and meets the Federal Regulations, the service may be rendered. Please see the Correctable/Non-Correctable Error Chart for a listing of errors that can and cannot be changed on a Consent form. Listed below are instructions on completing the form followed by the Error Chart.

Part I

1. Name of physician or group scheduled to do sterilization procedure. If the physician or group is unknown, put the phrase "OB on call".

2. Name of the sterilization procedure (i.e., bilateral tubal ligation [BTL]).

3. Birth date of the member. The member must be 21 years old when he/she signs the consent form.

4. Member's name.

5. Name of the physician or group scheduled to do the sterilization or the phrase "OB on call".

6. Name of the sterilization procedure.

7. Member's signature and date. If the member signs with an "X", an explanation must accompany the consent form.

8. Member's Medicaid number.

Part II

9. If the member had an interpreter translate the consent form information in a foreign language (i.e., Spanish, French, etc.), the interpreter must complete this section. **If an interpreter was not necessary, put N/A in these blanks.**

Part III

10. Member's name.

11. Name of sterilization procedure.

12. Signature and date of the person who counseled the member on the sterilization procedure. This date should match the date of the member's signature date. Also complete the facility address. An address stamp is acceptable if legible.

Part IV (This part is completed after the sterilization procedure is performed).

13. Member's name.

14. Date of the sterilization procedure. (Be sure this date matches the date on the claim.)

15. Name of the sterilization procedure.

16. EDC date is required if sterilized within the 30 day waiting period and the member was pregnant.

17. An explanation must be attached if an emergency abdominal surgery was performed within the 30 day waiting period. At least 72 hours is required to pass before the sterilization and the sterilization procedure may not be the reason for the emergency surgery.

Please note: If the member is pregnant, premature delivery is the only exception to the 30 day waiting period.

18. Physician signature and date. A physician's stamp is acceptable. The rendering or attending physician must sign the consent form. The physician's date must be dated the same as the sterilization date or after.

Correctable/Non-Correctable Error Chart for Sterilization Consent Form	
A. Doctor or Group Name	Correctable Error
B. Name of Procedure	Correctable Error
C. Patient Date of Birth	Correctable Error. Date of Birth on the CMS 1500 form, and consent form should all match. Patient **MUST** be 21 years old to sign form.
D. Patient Name	Correctable Error. Name should match name on the CMS 1500 form.
E. Doctor or Group Name	Correctable Error
F. Name of Procedure	Correctable Error
G. Patient Signature	NOT A CORRECTABLE ERROR. The signature must be the patient's signature. If the patient is unable to sign or signs with an "X", an explanation must accompany the consent form.
G. Date	NOT A CORRECTABLE ERROR without detailed medical records documentation.
H. Medicaid ID Number	Correctable Error
Part II – Interpreter's Statement	
A. Foreign Language Used	Correctable Error
A. Interpreter Signature	Correctable Error
A. Date	Correctable Error
Part III – Statement of Person Obtaining Consent	
A. Patient Name	Correctable Error
B. Procedure	Correctable Error. This procedure must match B and F.
C. Signature of Person Obtaining Consent	NOT A CORRECTABLE ERROR
C. Date	NOT A CORRECTABLE ERROR without detailed medical records documentation. This date must match PARTI-G. *
C. Facility Address	Correctable Error. An address stamp is acceptable if legible.
Part IV – Physician's Statement	
A. Patient's Name	Correctable Error
B. Date of Procedure	Correctable Error. This date must match the date of service on the claim form.
C. Procedure	Correctable Error. This procedure must match PART I B and F, and procedure code on claim.
D. Expected Date of Delivery	Correctable Error
D. Emergency Abdominal Surgery	Correctable Error. An explanation must be attached to the claim.
F. Physician Signature	Correctable Error. A physician's stamp is acceptable.
F. Date	NOT A CORRECTABLE ERROR if the date is prior to the sterilization without detailed medical records documentation. * CORRECTABLE ERROR if field is blank.
F. License Number (Medicaid Individual Provider Number)	Correctable Error. The provider number is the same as on the CMS claim form.
F. Group Number (Medicaid Group Provider Number)	Correctable Error. The group provider number is the same as on the CMS claim form.

* Most commonly occurring errors.

ABORTION STATEMENT

This certification meets FFP requirements and must include all of the aforementioned criteria.

Patient's Name: _____

Patient's Medicaid ID#:_____

Patient's Address:_____

_____

Physician Certification Statement

I, _____, certify that it was necessary to terminate the pregnancy of _____ for the following reason:

( ) A. Physical disorder, injury, or illness (including a life-endangering condition caused or arising from pregnancy) placed the patient in danger of death unless abortion was performed. Name of condition: _____

( ) B. The patient has certified to me the pregnancy was a result of rape or incest and the police report is attached.

( ) C. The patient has certified to me the pregnancy was a result of rape or incest and the patient is unable for physiological or psychological reasons to comply with the reporting requirements.

_____ _____

Physician's Signature Date

The patient's certification statement is only required in cases of rape or incest.

Patient's Certification Statement

I, _____, certify that my pregnancy was the result of an act of rape of incest.

_____ _____

Patient's Signature Date

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

INSTRUCTIONS FOR COMPLETING ABORTION STATEMENT FORM

1. Patient's Name: The name of the patient can be typed or handwritten.

2. Patient's Medicaid ID #: The patient's Medicaid identification number can be typed or handwritten.

3. Patient Address: Patient's complete address. This can be typed or handwritten.

4. Name of Physician: The physician who performed the abortion procedure. This can be typed or handwritten.

5. Patient's Name: This can be typed or handwritten.

6. Reason: Check the box that indicates the necessity to terminate the pregnancy.

7. Name of Condition: The diagnosis or name of medical condition which makes abortion necessary.

8. Physician Signature: The physician must sign his/her name and date in his/her own handwriting.

9. Patient's Certification Statement: Complete this section only in cases of rape or incest.

10. Patient's Name: This can be typed or handwritten.

11. Patient's Signature: Patient must sign his/her name and date in his/her own handwriting.

South Carolina Department of Health and Human Services
REQUEST FOR MEDICAID ID NUMBER

FROM (Provider name and address):	TO: (DHHS Medicaid Eligibility)

IDENTIFYING INFORMATION FURNISHED BY MEDICAID PROVIDER

A. MOTHER:

Name:_____ _____

Address:_____ _____

Social Security Number:_____ Date of Birth:_____ _____

Did the mother have a permanent sterilization procedure? __Yes ___ No

Medicaid ID Number:_____ County:_____

Medicaid Eligibility Worker Name (if known):_____

B. CHILD:

Name:_____ _____

Date of Birth:_____ Race:_____ Sex:_____

Has application been made for a SSN for the child? ___Yes ___No

Is the child a member of the mother's household? ___Yes ___No

Provider representative furnishing information:_____

Telephone number:_____ Date:_____

MEDICAID ELIGIBILITY INFORMATION FURNISHED BY DHHS
(within 5 working days)

Child's Medicaid ID Number:_____

Effective date of eligibility:_____

Medicaid Eligibility Worker:_____ Date:_____

Location:_____ Telephone number: _____

DHHS Form 1716 ME (November 2003)

Plan Initiated Disenrollment Request

P.O. Box 8691, Columbia, SC 29202-9255

This member is to be disenrolled from the following plan _____ for the reason listed below. Please check the box that applies. Documentation must be submitted for any reason marked with an asterisk (*). Lack of sufficient documentation may result in denial.

☐ Member becomes age 65 or older;

☐* MCO determines the member has Medicare coverage;

☐ Member elects Hospice;

☐ Member elects Home and Community Based Waiver Program;

☐* Member is in a long-term care facility/nursing home more than thirty (30) calendar days;

☐* Member is placed out of home (i.e. Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF));

☐* Member becomes an inmate of a Public Institution;

☐* Member moves out of the State or MCO service area and plan does not operate in the new service area;

☐* Member has died;

☐* Member fails to follow rules of the managed care plan;

☐* Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MCO's ability to furnish services to the member or other enrolled members;

☐* Other_____

Print the Name of Member to be Disenrolled (Last, First, Middle Initial)	Birth Date	Medicaid ID Number	Requested Disenrollment Date

Address **c/o** _____ **Street** _____ **City/State/Zip** _____	**Phone Number** (_____) _____ **County** _____

Signature: _____ Date: _____

The South Carolina Department of Health and Human Services will determine if the Health Plan has shown good cause to disenroll the Medicaid member. All decisions will be reflected on the monthly 834 file. Medicaid members have the right to appeal enrollment and disenrollment decisions with the South Carolina Department of Health and Human Services.

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

Fax one completed form, and documentation, per member to: **1-877-552-4672**

Do Not include a cover sheet

Print Form

SC Managed Care General Drug Request Form

Instructions to Physicians*

I. Provider Information (Please Print)		II. Member Information	
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:	
III. Drug Information (ONE DRUG REQUEST PER FORM)		Health Plan/Fax Number for Form Submission: Click Arrow to Choose from a Plan Below	
Drug Name and Strength:			
Specific Diagnosis for this Medication:	Dosage Form:	Dosage Interval:	Qty per Day:
Expected Length of Therapy:			
IV. Medication History for this Diagnosis		Number of Refills:	

A.

☐ Yes ☐ 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

☐ Yes ☐ No Patient has previously taken the requested product for _____ (give length of time)
If yes, please indicate trial below

☐ Yes ☐ No Patient has a documented drug interaction **[PROVIDE FURTHER DETAIL IN SECTION V]**

☐ Yes ☐ No Patient has documented adverse drug experiences (side effects, adverse drug reaction) **[PROVIDE FURTHER DETAIL IN SECTION V]**

Product 1: _____ Dates Tried: _____

Product 2: _____ Dates Tried: _____

B. Is this request for continuation of a previous approval: YES ☐ NO ☐

C. Has strength, dosage or quantity required per day increased or decreased?
YES ☐ [Indicate rationale for continuation in section V and submit form] NO ☐

V. Rationale for Request/Pertinent Clinical Information (ATTACH ADDITIONAL SHEET IF MORE SPACE IS REQUIRED)

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.

Provider Signature*: _____ Date: ☐☐☐

MCO USE ONLY

☐ Approved Comments:

☐ Denied Date: ____/____/____ Signature _____

DISCLAIMER: This review does not constitute approval of payment for services. The member must be eligible for services at the time services are rendered.

*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 – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

ACIP – Centers for Disease Control Advisory Committee on Immunization Practices.

Administrative Days – Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient stay.

Actuarially sound capitation rates - Capitation rates that--(1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the contract; and (3) have been certified, as meeting the requirements of this paragraph, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Adjustments to smooth data – Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

AFDC/Family Independence - Aid to Families with Dependent Children.

Applicant - An individual seeking Medicaid eligibility through written application.

Beneficiary - An individual who is Medicaid eligible and meets the criteria to enroll in the Managed Care Organization or Medical Homes Network programs.

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 - Current Procedural Terminology, most current edition.

Capitation Payment - The monthly payment which is paid by SCDHHS to a MCO for each enrolled Medicaid MCO Program member for the provision of benefits during the payment period.

Care Coordination - The manner or practice of planning, directing and coordinating health care needs and services of Medicaid MCO Program members.

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

Case - A household consisting of one or more Medicaid eligibles.

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

Certificate of Coverage - The term describing services and supplies provided to Medicaid MCO Program members, 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 Medicaid MCO Program member is responsible for in accordance with 42 CFR , § 447.50.

Comprehensive Risk Contract – A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: (1) Outpatient hospital services; (2) Rural health clinic services; (3) FQHC services; (4) Other laboratory and X-ray services; (5) Nursing facility (NF) services; (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) Family planning services; (8) physician services; and (9) Home health services.

Contract Dispute - A circumstance whereby the 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 the Medicaid MCO Contract coverage.

Core Benefits - A schedule of health care benefits provided to Medicaid MCO Program 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 Plan for Medical Assistance.

MCO - The domestic licensed MCO that has executed a formal agreement with SCDHHS to enroll and serve Medicaid MCO Program members under the terms of the Contract. The term MCO shall include all employees, sub MCOs, 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 Medicaid applicants/eligibles in person, through direct mail advertising or telemarketing by an employee or agent of the MCO for the purpose of influencing an individual to enroll with the MCO plan.

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

Disenrollment - Action taken by SCDHHS or its designee to remove a Medicaid MCO Program member from the 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 or Medicaid or the Medicaid MCO Program.

Dual-eligibles - Applicants that receive Medicaid and Medicare benefits.

Dually Diagnosis/Dual Disorders - An individual who has both a diagnosed mental health problem and a problem with either alcohol and/or drug use.

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 SC State Plan for Medical Assistance under Title XIX.

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 and/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 the MCO contract.

Enrollment - The process in which a Medicaid eligible selects or is assigned to an MCO and goes through a managed care educational process as provided by SCDHHS or its agent.

Enrollment (Voluntary) - The process in which an applicant/recipient selects a Contractor and goes through an educational process to become a Medicaid MCO Program member of the Contractor.

External Quality Review (EQR) – The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services than an MCO or its contractors furnish to Medicaid recipients.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR§438.354, and performs external quality review, other EQR-related activities set forth in 42 CFR§438.358, or both.

Evidence of Coverage - The term which describes services and supplies provided to Medicaid MCO Program members, which includes specific information on benefits, coverage limitations and services not covered. The term "evidence of coverage" is interchangeable with the term "certificate of coverage".

Expanded Services - A covered service provided by the MCO which is currently a non-covered service(s) by the SC State Plan for Medical Assistance or is an additional Medicaid covered service furnished by the MCO to Medicaid MCO Program 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 certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a Medically under served Area.

Family Planning Services - Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Fee-for-Service Medicaid Rate - A method of making payment for health care services based on the current Medicaid fee schedule.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself of some other person. This 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 set by the NCQA.

HHS - United States Department of Health and Human Services.

Home and Community Based Services - In-home or community-based support services that assist persons with long term care needs to remain at home.

Hospital Swing Beds – Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as "swing bed" hospitals. A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting Federal and State requirements of participation for swing bed hospitals.

ICD-9 - International Classification of Disease, Clinical Modification, 9th Edition, Clinical Modification.

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 who is housed in or confined to a correctional facility (e.g. prison, prison facility, jail etc) 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 Part 489; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) Meets the solvency standards of 42CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or contractors.

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

Marketing – Any communication approved by SCDHHS, from an MCO to a Medicaid recipient who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to disenroll from, another MCO Medicaid product.

Marketing Materials – Materials that (1) are produced in any means, by or on behalf of an MCO and (2) can be reasonably interpreted as intended to market to potential members.

Mass Media - A method of public advertising that can create plan name recognition among a large number of Medicaid recipients and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Material Change – As applicable to contracts, a material change is one that is relevant and/or significant to the terms of the agreement as determined by one or both parties or SCDHHS.

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

to Medicaid recipients and is paid amounts pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medical Networks-is an integrated delivery system of healthcare services, there can multiple medical networks in a county.

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 - Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid MCO Program member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid MCO Program member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Member or Medicaid MCO Program member - An eligible person(s) who voluntarily enrolls with a SCDHHS approved Medicaid MCO.
NCQA – The National Committee for Quality Assurance is a private, 501(c)(3) non-for-profit organization founded in 1990,dedicated to improve dhealth care quality..

NDC - National Drug Code.

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

Newborn - A live child born to a member during her membership or otherwise eligible for voluntary enrollment under the Contract.

Non-Contract Provider - Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have not contracted with or are not employed by the MCO to provide health care services.

Non-Covered Services - Services not covered under the SC State Plan for Medical Assistance.

Non-Emergency - An encounter with a health care provider by a Medicaid MCO Program member who has presentation of medical signs and symptoms, that do not require 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.

Out-of-Plan Services - Medicaid services not included in the MCO's Core Benefits and reimbursed fee-for-service by the State.

Ownership Interest - The possession of equity in the capital, the stock or the profits of the entity. For further definition see 42 CFR 455.101 (2009 as amended).

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

Protected Health Information (PHI) - means the same as the term protected health information in 45 CFR §160.103.

Policies - The general principles by which SCDHHS is guided in its management of the Title XIX program, as further defined by SCDHHS promulgations and state and 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 providing

primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining continuity of care.

Prior Authorization - The act of authorizing specific approved services by the MCO before they are rendered.

Program - The method of provision of Title XIX services to South Carolina recipients as provided for in the SC State Plan for Medical Assistance and SCDHHS regulations.

Provider – Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Managed Care Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Quality – As related to external quality review, the degree to which an MCO increases the likelihood of desire health outcomes of its enrollees through structural and operational characteristics and through the provision of health services consistent with current professional knowledge.

Quality Assessment - Measurement and evaluation of success of care and services offered to individuals, groups or populations

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 to receive services as provided for in the SC State Plan for Medical Assistance.

Referral Services - Health care services provided to Medicaid MCO Program 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 under the Medicaid program and reimbursed at the Fee-For-Service Medicaid Rate.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another.

RHC - A South Carolina licensed rural health clinic is certified by the CMS and receiving Public Health Services grants. A RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A RHC provides a wide range of primary care and enhanced services in a medically under served area.

Risk - A chance of loss assumed by the MCO which arises if the cost of providing core benefits and covered services to Medicaid MCO Program members exceeds the capitation payment made 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 - 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 Medicaid MCO Program 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 and S.C. Code Ann. §§1-23-310 et seq. (1976, as amended).

SSA - Social Security Administration.

SSI - Supplemental Security Income.

Screen or Screening - Assessment of a member's physical or mental condition to determine evidence or indications of problems and the need for further evaluation or services.

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

Social Services - Medical assistance, rehabilitation, and other services defined by Title XIX and SCDHHS regulations.

South Carolina State Plan for Medical Assistance - A plan, approved by the Secretary of SCDHHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to recipients pursuant to Title XIX.

Subcontract - A written agreement between the MCO and a third party to perform a 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.

Targeted Case Management - Services which assist individuals in gaining access to needed medical, social, educational, and other services. Services include a systematic referral process to providers.

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

Third Party Resources - Any entity or funding source other than the Medicaid MCO Program member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care provided to a Medicaid MCO Program member.

Third Party Liability (TPL) - Collection from other parties who may be liable for all or part of the cost of items or health care services provided to a Medicaid MCO Program member.

Title XIX - Title 42, United States Code, Chapter 7, subchapter XIX, as amended. (42 U.S.C.A. § 1396 et seq.)

UB-04 - A uniform bill for inpatient and outpatient hospital billing. The required form is the UB-04 HCFA 1500.

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/EPSDT - A routine medical visit for one of the following: EPSDT visit, family planning, follow-up to a previously treated condition or illness, adult and/or any other 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.Children deemed nutritionally deficient and have a low income are covered up to age five .

APPENDIX 1

Members' and Potential Members' Bill of Rights

Each Member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information—enrollment notices, informational materials, instructional materials, available treatment options and alternatives, etc.—in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and the 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.
    - Any cost sharing requirements.
    - Service area.
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals.
    - Any restrictions on member's freedom of choice among network providers.

  - Providers not accepting new patients.
  - Benefits not offered by the 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 Medicaid 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

Transportation Broker Listing and Contact Information

Broker: Medical Transportation Management (MTM) If you live in one of these counties call: **1-866-831-4130** **Region 1** Abbeville Anderson Greenville Greenwood Laurens Oconee Pickens	**Broker: Medical Transportation Management (MTM)** If you live in one of these counties call: **1-866-831-4130** **Region 2** Cherokee Chester Lancaster Spartanburg Union York	Broker: LogistiCare If you live in one of these counties call: **1-866-431-9635** Region 3 McCormick Edgefield Saluda Newberry Lexington Fairfield Richland
Broker: LogistiCare If you live in one of these counties call: **1-866-445-6860** **Region 4** Aiken Allendale Barnwell Bamberg Orangeburg Calhoun Clarendon Kershaw Lee Sumter	Broker: LogistiCare If you live in one of these counties call: **1-866-445-8915** **Region 5** Georgetown Horry Marion Marlboro Williamsburg Chesterfield Darlington Dillon Florence	Broker: LogistiCare If you live in one of these counties call: **1-866-445-9954** Region 6 Berkeley Beaufort Charleston Colleton Dorchester Jasper Hampton

APPENDIX 4

March, 3 2010

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

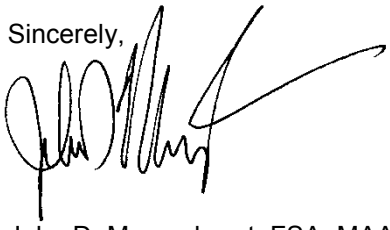
Re: April 2010 – March 2011 MCO Rate Calculation and Certification

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 April 2010 – March 2011 capitation rates for the South Carolina Medicaid Managed Care program.

Please call me if you have questions.

Sincerely,



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

JDM/vrr

Attachment

Milliman

State of South Carolina
Department of Health and Human Services
April 2010 – March 2011
Capitation Rate Development for
Medicaid Managed Care Program

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

Prepared by:
Milliman, Inc.

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Actuary

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This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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F5: Standard Supplemental Teaching Payment Pass-through Payment Calculation – SFY 0809
F6: Standard April 2010 – March 2011 Supplemental Teaching Payment Pass-through Payment

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Actuarial Certification:

Q: Actuarial Certification of April 2010 – March 2011 South Carolina Medicaid Managed Care Capitation Rates

Attachments:

Attachment 1: Data Adjustment Specifications - Standard Managed Care - In-Rate Criteria
Attachment 2: Listing and Definitions of Class C Diagnostic Codes

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

I. EXECUTIVE SUMMARY

This report documents the development of April 2010 – March 2011 managed care organization (MCO) capitation rates for South Carolina's Medicaid Managed Care program.

The South Carolina Department of Health and 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 April 2010 – March 2011 capitation rates produced by the rating methodology are actuarially sound to comply with CMS regulations.

Appendices A – I document the development of the April 2010 – March 2011 capitation rates for medical benefits. Appendices J – M document the development of the April 2010 – March 2011 capitation rates for prescription drug benefits. Appendices N and O show the breakdown of the April 2010 – March 2011 capitation rates by major service category. Appendix P calculates the fiscal impact of the April 2010 - March 2011 capitation rates. Appendix Q contains our actuarial certification.

Section II of the report provides a short background regarding South Carolina's Medicaid managed care program. Sections III – V document the South Carolina Medicaid Managed Care 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.

APRIL 2010 – MARCH 2011 CAPITATION RATES AND ACTUARIAL CERTIFICATION

Table 1 shows the statewide rate change from the October 2009 – March 2010 MCO capitation rates to the April 2010 – March 2011 capitation rates. Table 1 shows the rate changes including and excluding the supplemental teaching payments since the payments are a pass-through to providers.

Table 1
South Carolina Department of Health and Human Services
April 2010 – March 2011 Capitation Rate Change
Based on September 2009 Enrollment by Rate Cell
Includes Infants

	October 2009 – March 2010 Rate	April 2010 – March 2011 Rate	Percentage Change
Including Supplemental Teaching Payments			
Ethically Limited Services	$271.75	$278.55	2.5%
Standard Services	336.50	347.36	3.2%
Total	**$301.23**	**$309.88**	**2.9%**
Excluding Supplemental Teaching Payments			
Ethically Limited Services	$261.65	$267.78	2.3%
Standard Services	324.89	334.87	3.1%
Total	**$290.44**	**$298.33**	**2.7%**

Note the MCOs covering ethically limited services and the MCOs covering standard services have materially different enrollment distributions by rate cell.

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Table 2 compares the rate cell specific changes including supplemental teaching payments.

Table 2 South Carolina Department of Health and Human Services April 2010 – March 2011 Capitation Rates – Including Supplemental Teaching Payments					
Ethically Limited Services					
Rate Cell	**October 2009 – March 2010 Rate**	**Medical Rate**	**Prescription Drug Rate**	**Total Capitation Rate**	**Percent Change**
TANF: 0 - 2 months old	$850.48	$860.79	$12.15	$872.94	2.6%
TANF: 0 - 2 months old – LBW Withhold	1,042.27	930.37	N/A	930.37	-10.7%
TANF: 3 - 12 months old	264.97	231.36	27.35	258.71	-2.4%
TANF: Age 1 - 6	105.84	85.75	19.76	105.51	-0.3%
TANF: Age 7 - 13	88.57	61.54	32.29	93.83	5.9%
TANF: Age 14 - 18 Male	101.89	77.76	32.74	110.50	8.4%
TANF: Age 14 - 18 Female	134.80	112.17	28.89	141.06	4.6%
TANF: Age 19 - 44 Male	250.67	237.06	57.17	294.23	17.4%
TANF: Age 19 - 44 Female	327.95	288.98	63.20	352.18	7.4%
TANF: Age 45+	539.33	458.10	128.08	586.18	8.7%
SSI	812.04	660.83	184.32	845.15	4.1%
SSI – LBW Withhold	2.04	2.25	N/A	2.25	10.3%
OCWI	408.27	388.79	24.67	413.46	1.3%
Duals	177.23	159.40	23.67	183.07	3.3%
Maternity Kicker Payment	5,867.39	5,993.26	N/A	5,993.26	2.1%
Very Low Birth Weight Kicker Payment	60,266.16	57,964.68	N/A	57,964.68	-3.8%
Low Birth Weight Kicker Payment	11,142.26	9,338.02	N/A	9,338.02	-16.2%
Standard Services					
Rate Cell	**October 2009 – March 2010 Rate**	**Medical Rate**	**Prescription Drug Rate**	**Total Capitation Rate**	**Percent Change**
TANF: 0 - 2 months old	$850.49	860.79	12.15	872.94	2.6%
TANF: 0 - 2 months old – LBW Withhold	1,042.28	930.37	N/A	930.37	-10.7%
TANF: 3 - 12 months old	265.00	231.36	27.35	258.71	-2.4%
TANF: Age 1 – 6	105.85	85.75	19.76	105.51	-0.3%
TANF: Age 7 - 13	88.66	61.59	32.36	93.95	6.0%
TANF: Age 14 - 18 Male	101.90	77.79	32.74	110.53	8.5%
TANF: Age 14 - 18 Female	141.27	115.55	32.38	147.93	4.7%
TANF: Age 19 - 44 Male	250.83	237.30	57.17	294.47	17.4%
TANF: Age 19 - 44 Female	336.76	295.29	66.23	361.52	7.4%
TANF: Age 45+	539.94	458.67	128.31	586.98	8.7%
SSI	813.23	661.71	184.81	846.52	4.1%
SSI – LBW Withhold	2.04	2.25	N/A	2.25	10.3%
OCWI	425.89	406.34	26.54	432.88	1.6%
Duals	177.48	159.63	23.72	183.35	3.3%

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Maternity Kicker Payment	6,203.32	6,323.31	N/A	6,323.31	1.9%
Very Low Birth Weight Kicker Payment	60,266.22	57,964.68	N/A	57,964.68	-3.8%
Low Birth Weight Kicker Payment	11,142.42	9,338.02	N/A	9,338.02	-16.2%

Table 3 compares the rate cell specific changes excluding supplemental teaching payments.

Table 3
South Carolina Department of Health and Human Services
April 2010 – March 2011 Capitation Rates – Excluding Supplemental Teaching Payments

Ethically Limited Services					
Rate Cell	**October 2009 – March 2010 Rate**	**Medical Rate**	**Prescription Drug Rate**	**Total Capitation Rate**	**Percent Change**
TANF: 0 - 2 months old	$758.47	762.36	12.15	774.51	2.1%
TANF: 0 - 2 months old – LBW Withhold	1,042.27	930.37	N/A	930.37	-10.7%
TANF: 3 - 12 months old	244.80	210.57	27.35	237.92	-2.8%
TANF: Age 1 - 6	101.09	81.04	19.76	100.80	-0.3%
TANF: Age 7 - 13	85.61	58.30	32.29	90.59	5.8%
TANF: Age 14 - 18 Male	98.35	74.03	32.74	106.77	8.6%
TANF: Age 14 - 18 Female	129.03	106.67	28.89	135.56	5.1%
TANF: Age 19 - 44 Male	244.42	228.24	57.17	285.41	16.8%
TANF: Age 19 - 44 Female	319.45	279.28	63.20	342.48	7.2%
TANF: Age 45+	528.14	444.18	128.08	572.26	8.4%
SSI	787.54	631.73	184.32	816.05	3.6%
SSI – LBW Withhold	2.04	2.25	N/A	2.25	10.3%
OCWI	369.77	354.25	24.67	378.92	2.5%
Duals	161.47	141.59	23.67	165.26	2.3%
Maternity Kicker Payment	5,867.39	5,993.26	N/A	5,993.26	2.1%
Very Low Birth Weight Kicker Payment	60,266.16	57,964.68	N/A	57,964.68	-3.8%
Low Birth Weight Kicker Payment	11,142.26	9,338.02	N/A	9,338.02	-16.2%
Standard Services					
Rate Cell	**October 2009 – March 2010 Rate**	**Medical Rate**	**Prescription Drug Rate**	**Total Capitation Rate**	**Percent Change**
TANF: 0 - 2 months old	$758.48	762.36	12.15	774.51	2.1%
TANF: 0 - 2 months old – LBW Withhold	1,042.28	930.37	N/A	930.37	-10.7%
TANF: 3 - 12 months old	244.83	210.57	27.35	237.92	-2.8%
TANF: Age 1 – 6	101.11	81.04	19.76	100.80	-0.3%
TANF: Age 7 - 13	85.69	58.35	32.36	90.71	5.9%
TANF: Age 14 - 18 Male	98.36	74.05	32.74	106.79	8.6%
TANF: Age 14 - 18 Female	135.44	109.97	32.38	142.35	5.1%
TANF: Age 19 - 44 Male	244.58	228.48	57.17	285.65	16.8%
TANF: Age 19 - 44 Female	328.07	285.41	66.23	351.64	7.2%
TANF: Age 45+	528.75	444.73	128.31	573.04	8.4%
SSI	788.70	632.57	184.81	817.38	3.6%
SSI – LBW Withhold	2.04	2.25	N/A	2.25	10.3%

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

OCWI	386.29	370.84	26.54	397.38	2.9%
Duals	161.72	141.81	23.72	165.53	2.4%
Maternity Kicker Payment	6,203.32	6,323.31	N/A	6,323.31	1.9%
Very Low Birth Weight Kicker Payment	60,266.22	57,964.68	N/A	57,964.68	-3.8%
Low Birth Weight Kicker Payment	11,142.42	9,338.02	N/A	9,338.02	-16.2%

The actuarial certification of the April 2010 – March 2011 Medicaid Managed Care capitation rates is included as Appendix Q. 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 fee-for-service cost and eligibility data for SFY 0708 and SFY 0809, historical reimbursement information, TPL recoveries, fee schedules, and several provider reimbursement analyses to calculate the South Carolina Medicaid Managed Care 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 April 2010 – March 2011 Medicaid Managed Care 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 dated July 1, 2009 apply to this report and its use.

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

II. BACKGROUND

Medicaid MCOs have been operating in South Carolina since 1996. In August 2007, SC DHHS implemented the South Carolina Healthy Connections Choices program to more effectively enroll members in MCOs. Healthy Connections Choices is a program that helps Medicaid members enroll in MCOs and is part of the SC DHHS overall Medicaid reform plan. When members enroll, they choose an MCO and a doctor (or clinic). Healthy Connections Choices helps members choose a MCO that is best for them.

With the help of MCOs, the medical home network, and enrollment counselors, SC DHHS seeks to increase care coordination and disease prevention methods not found in traditional fee-for-service Medicaid. Those who choose to enroll in an MCO also will establish crucial relationships with a primary care doctor. Under fee-for-service, many Medicaid beneficiaries are left to navigate the health care system on their own, leading many to seek only sporadic care or emergency services.

Under South Carolina Healthy Connections Choices, participants receive the same benefits as those in traditional Medicaid, and also extra services offered through the MCOs. These extra services may include benefits such as unlimited doctor visits, eyeglasses and dental care for adults, smoking cessation classes, and programs tailored for those with specific diseases.

There are two main categories of Medicaid managed care plans in South Carolina: traditional Managed Care Organizations (MCOs) and a Medical Home Network (MHN).

The MHN program is a primary care case management program and is composed of a Care Coordination Services Organization (CSO) and the PCPs enrolled in that network. The CSO supports the physicians and enrolled members by providing care coordination, disease management, and data management. The PCPs manage the health care of their members, which includes authorizing services, provided by other health care providers.

There are currently five MCOs and one MHN participating in the South Carolina Medicaid program.

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III. METHODOLOGY AND RESULTS - GENERAL

This section of the report describes general aspects of the April 2010 – March 2011 South Carolina Medicaid Managed Care capitation rate methodology.

BASE DATA

SC DHHS provided detailed Medicaid fee-for-service claims and eligibility data from SFY 0405 through September 2009. For the purpose of the April 2010 – March 2011 capitation rate calculation, we used fee-for-service data from the two most recent complete state fiscal years available: SFY 0708 and SFY 0809.

CLARIFICATIONS TO IN-RATE CRITERIA

SC DHHS made the following clarifications to the in-rate criteria for the April 2010 – March 2011 rate calculation. These clarifications are included in the detailed Attachment 1 specifications.

- Clarified the definition of BabyNet services (see page 12)
- Added an exclusion for communicable disease services (see page 12)
- Added mental health services provided by nurse practitioners to the mental health exclusion
- Added optometrist provider type to the list of covered services which were historically paid fee-for-service
- Modified the list of MCO excluded services for vision services
  - The list of excluded service is V2500-V2599, 92070, 92310-92313, and 92340
  - Clarified that services provided by optometrists are subject to the exclusion
- Clarified that the mental health exclusion due to a diagnostic code of class C does not apply to emergency room services coded under revenue code 450

SC DHHS also clarified that MCOs are responsible for all ambulance services that are not the responsibility of the non-emergency transportation brokers.

CLARIFICATIONS TO RATE CELL ASSIGNMENT

SC DHHS made the following clarification to the assignment of babies to the TANF under age one rate cells for the April 2010 – March 2011 rate calculation.

Babies are assigned to a rate cell based on their month of birth. For example, a baby born anytime in April 2010 will be assigned to:

- The 0 - 2 month rate cell in April, May, and June 2010
- The 3 - 12 month rate cell in July – December 2010 and January – April 2011
- The 1 – 6 year rate cell starting in May 2011

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Note the TANF 1 – 3 month rate cell in effect for the October 2009 – March 2010 rates has been renamed the TANF 0 – 2 month rate cell. The assignment of babies by month of life has not changed.

The TANF 4 – 12 month rate cell in effect for the October 2009 – March 2010 rates has been renamed the TANF 3 – 12 month rate cell and includes an additional one month of eligibility (i.e., in April 2011 a baby born in April 2010 is now assigned to the TANF 3 – 12 month rate cell rather than the TANF 1 – 6 year rate cell).

RETROACTIVE ELIGIBILITY PERIODS AND ENROLLMENT LAG

Recipient enrollment in the fee-for-service program can and does occur retroactively. When an individual applies and qualifies for Medicaid coverage, SC DHHS reimburses claims which occurred during the retroactive qualification period prior to their application. SC DHHS backdates the eligibility of the individual to accommodate the retroactive coverage.

There is a lag between the first date of eligibility and the date of enrollment in an MCO. Factors which contribute to this lag include the fact that MCO enrollment is voluntary and Medicaid eligibility is always on the first day of the month in which the application was received. Once a Medicaid recipient signs up for an MCO, they will be enrolled on the first day of the subsequent month.

The retroactive enrollment period is not covered by the MCO. Retroactive exposure and claims were included in the data provided to 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 subject to retroactivity so their claims and enrollment are counted from the month of birth.
- Three months of claims and eligibility are removed for SSI and SSI related payment categories.
- 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.

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ELIGIBILITY CATEGORY ASSIGNMENT

The assignment of payment categories to eligibility category was provided by SC DHHS and is summarized in Table 4 below.

Table 4
South Carolina Department of Health and Human Services
Eligibility Category Assignment

Payment Category Code	Eligibility Category
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
Other	SSI

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 5 below shows the ineligible payment categories.

Table 5
South Carolina Department of Health and Human Services
Excluded Payment Category Codes

Payment Category	Description	Payment Category	Description
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

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49	S3 SLMB

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Table 6 shows the only waiver programs eligible for Medicaid Managed Care. All other waiver program enrollees are excluded.

Table 6
South Carolina Department of Health and Human Services
Included Waiver Programs

Waiver Program Code	Description
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
MCPC	Integrated Personal Care Service CRCF Recipients

MCO PROGRAMS WITH ETHICAL LIMITATIONS

The MCOs offering the ethically limited benefit package are bound to abide by the principles set forth in the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops. In accordance with their ethical obligations, certain MCOs shall not provide, support or participate in the delivery of any services, including family planning services, which are inconsistent with such directives. This limitation precludes certain MCOs from performing case management, quality management, utilization review services, and claims processing in relation to family planning services.

Family planning services are defined as all services (including counseling), procedures, devices, and medications for the purpose of infertility treatment or for the purpose of preventing or terminating pregnancy including temporary and permanent sterilization procedures, such as tubal ligation, vasectomy procedures, and abortions. All family planning services are subject to the Ethical Limitations.

Consistent with prior years, capitation rates are calculated separately for the Ethically Limited benefit package and Standard benefit package. The cost associated with these family planning services is not explicitly categorized in the attached appendices, but one could determine family planning costs by service category by comparing the corresponding appendices. The following appendices show the Ethically Limited rate development:

- Appendices A1 and A2
- Appendices B1 and B2
- Appendices C1 and C2
- Appendices D1 and D2
- Appendix E1
- Appendix F1, F2 and F3
- Appendix G1
- Appendix H1 ad H3
- Appendix I1
- Appendices J1 and J3

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- Appendices K1 and K3
- Appendix L1
- Appendix M1

We calculated separate rates for the Ethically Limited benefit package only for those rate cells that are expected to incur family planning and related services that are excluded from services offered by MCOs subject to ethical limitations. The following rate cells have different rates for the standard and ethically limited benefit package:

- TANF: Age 7 – 13
- TANF: Age 14 – 18 Male
- TANF: Age 14 – 18 Female
- TANF: Age 19 – 44 Male
- TANF: Age 19 – 44 Female
- TANF: Age 45+
- SSI
- OCWI
- Duals
- Maternity Kicker Payment

The ethically limited capitation rates for the other rate cells are equal to the rates calculated for the standard benefit package.

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IV. METHODOLOGY AND RESULTS – MEDICAL BENEFITS

This section of our report describes the April 2010 – March 2011 South Carolina Medicaid Managed Care 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 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, MCO selection, managed care impact, and incurred but not reported (IBNR) claims.

3. Calculate estimated April 2010 – March 2011 managed care costs by eligibility category.

4. Adjust for Third Party Liability (TPL) recoveries, administrative days, administrative expenses, and supplemental teaching payments.

5. Adjust SSI rates for MCO specific risk scores.

Each of the above steps is described in detail below.

Step 1: Extract Fee-For-Service Experience Data

In this step the fee-for-service experience for SFY 0708 and SFY 0809 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. The following services are excluded consistent with the Policy and Procedure Guide for Managed Care Organizations. Milliman used Attachment 1 prepared by SC DHHS to determine which services were to be excluded from the capitation rate methodology.

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 MCO 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.

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- $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 MCO capitation rate calculation.

Mental Health and Substance Abuse Services Exclusion:

The mental health and substance abuse services detailed below are excluded from the MCO contract and will continue to be reimbursed by the Medicaid program on a fee-for-service basis.

- Inpatient: DRGs 424 - 437 and 521 – 523,

- Inpatient and outpatient: primary diagnosis has a class code of C (defined in Attachment 2), except in emergency room (revenue code 450 is present on claim),

- Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS),

- Services provided by the Department of Mental Health (DMH), and

- Professional: see specific criteria in Attachment 1.

Dental Exclusion:

All dental services except for fluoride application (HCPCS code D1206) are excluded from the MCO contract and will continue to be reimbursed by the current Medicaid program on a fee-for-service basis.

BabyNet, Communicable Diseases, and Sickle Cell Exclusion:

Claims relating to Baby Net, Communicable Diseases, and Sickle Cell services are removed from the capitation rate calculation because they are not covered under the Medicaid Managed Care program.

Baby Net claims were identified as those claims meeting all of the following criteria:

- Procedure codes T1016, T1017, and T1027

- Provider type of 22 (medical clinics) and provider specialty of 51 (DHEC)

- Provider number of DHEC01 – DHEC 46, DHEC59

Communicable Diseases claims were identified as those claims meeting all of the following criteria:

- Provider type of 22 (medical clinics) and provider specialty of 51 (DHEC)

- Primary diagnosis in the COMDHEC table

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- Provider number of DHEC01- DHEC46, DHEC59

Sickle cell claims were identified as those claims meeting all of the following criteria:

- 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

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Repricing:

Under the fee-for-service Medicaid Program, FQHCs and RHCs are paid on a per-encounter basis for all services provided during a visit. The raw claims experience reflects this payment difference from other providers. The claims data is adjusted so that FQHC and RHC payment levels are on a "per-claim" basis, making them equivalent to payment levels to other providers. Codes S4437 - S4440 and T1015 are repriced to reflect the non-FQHC, non-RHC payment of 99213 plus $10.00 for other ancillary services provided during a visit. The repricing rate for those codes is $60.03 effective October 1, 2009. Codes 99381-99385 and 99391-99394 (EPSDT) were re-priced to non-FQHC, non-RHC fee-for-service levels as well.

Table 7 below shows the non-FQHC, non-RHC unit cost for each code effective October 1, 2009.

Table 7
South Carolina Department of Health and Human Services
FQHC and RHC Repricing Rates

CPT Codes	Unit Cost
99381	$83.59
99382	90.67
99383	89.30
99384	97.23
99385	97.23
99391	67.10
99392	75.03
99393	74.34
99394	81.77

Claims are repriced using the lesser of (1) the non-FQHC, non-RHC fee-for-service fee and (2) the per encounter fee. The "lesser of" logic only materially impacts the dual eligible rate cell because Medicaid typically only pays a portion of the Medicare deductible and coinsurance for these services for dual eligibles.

Long Term Care Benefit Limit:

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Nursing home services are excluded from the MCO contract (defined as nursing facility and rehabilitative services at the skilled, intermediary, or sub-acute level of care).

While nursing home services are excluded from the MCO contract, MCOs are required to cover enrollees for other services during the first 30 days of confinement in a long term care facility and until they can be reasonably disenrolled from the MCO. MCO enrollment will not be terminated in the middle of a month; therefore, MCOs will be required to cover contract services through the end of the month in which the 30 day stay is reached.

To account for this benefit limit, we identified days beyond the 30 day benefit limit and removed the associated dollars and enrollment from the base period experience data as shown in Appendices A1 through A4 and B1 through B4. We removed claims and eligibility starting the first of the month after 30 days in a LTC facility had been reached (e.g., we removed claims and eligibility starting September 1, 2008 for a nursing home stay of at least 30 days that started on July 15, 2008).

Direct and Indirect Graduate Medical Education:

Graduate Medical Education (GME) payments have been removed from inpatient hospital claims in the data. Both direct and indirect GME payments are excluded from the MCO contract.

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

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

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, October 1, 2008 and October 1, 2009. 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, claims between October 1, 2007 and October 1, 2008, and claims after October 1, 2008.

- 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.

- Claims prior to October 1, 2008 were adjusted to account for the October 1, 2008 rate change (the claims after October 1, 2008 already reflect the October 1, 2008 rate change). The October 1, 2008

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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, C3, D1, and D3.

Hospital Outpatient Reimbursement Adjustment:

SC DHHS implemented reimbursement changes for outpatient facilities on October 1, 2007, October 1, 2008, and October 1, 2009. Effective October 1, 2007, SC DHHS increased hospital outpatient reimbursement for all facilities. Effective October 2008 and revised October 1, 2009, 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, claims between October 1, 2007 and September 30, 2008, and claims after October 1, 2008.

- 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.

- Claims prior to October 1, 2008 were adjusted to account for the October 1, 2008 hospital specific multipliers. The composite change factor is an increase of 28.3% 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).

- All hospital outpatient claims were adjusted to account for the October 1, 2009 rate change. The October 1, 2009 composite change factor in an increase of 6.3% 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

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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, C3, D1, and D3.

Physician Reimbursement Adjustment:

Effective October 2009, physician reimbursement is 86% of the 2009 South Carolina Medicare fee schedule. Private rehabilitation therapists are reimbursed at 95% of the 2009 Medicare fee schedule for physical therapy, occupational therapy, and speech therapy services. Pediatric sub-specialists are reimbursed at 120% of the 2009 Medicare fee schedule for CPT codes 99201 – 99477 and at 100% of the 2009 Medicare fee schedule for all other codes.

Effective October 1, 2009, the Medicare fee basis changed to the April 2009 Medicare fee schedule for all services.

To develop the adjustment factors shown in Appendices C1, C3, D1, and D3, 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 April 2010 – March 2011 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 change in the year of the applicable Medicare fee schedule

The fee schedule percentage change reflects the change in the percentage of Medicare fees used to reimburse physicians. For example from September 1, 2006 to September 30, 2007 physicians were reimbursed at 85% of the 2007 Medicare fee schedule and after October 1, 2009 are reimbursed at 86% of the 2009 Medicare fee schedule. The fee schedule percentage change is the ratio of 86% and 85%.

The year of the Medicare fee schedule 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 2008 Medicare fee schedule to the 2009 Medicare fee schedule using the mix of services used between October 1, 2008 and June 30, 2009 to develop the fee schedule RBRVS change factor for the October 1, 2008 through June 30, 2009 period used in our rate setting methodology.

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Table 8 below shows the two components of the physician reimbursement change by time period and provider type.

Table 8 South Carolina Department of Health and Human Services Physician Reimbursement Change Factors			
Provider Type	**Percentage Change**	**Medicare Fee Schedule Change to 2009**	**Overall Factor**
July 2007 – October 2007 Fee Schedule Period			
Physician	1.0118	1.0286	1.0407
Private Providers	0.9500	1.0322	0.9806
Pediatric Sub-Specialists	1.0000	1.0141	1.0141
November 2007 – September 2008			
Physician	1.0000	1.0174	1.0174
Private Providers	0.9500	1.0112	0.9607
Pediatric Sub-Specialists	1.0000	1.0131	1.0131
October 2008 – June 2009			
Physician	1.0238	1.0059	1.0298
Private Providers	1.0000	1.0024	1.0024
Pediatric Sub-Specialists	1.0157	1.0029	1.0187

The adjustment factors range from 0.998 to 1.045 for the various TANF rate cells, from 1.000 to 1.029 for SSI, from 1.000 to 1.039 for OCWI and from 1.000 to 1.034 for Duals.

Durable Medical Equipment Reimbursement Adjustment:

DME services are reimbursed at 100% of the April 1, 2009 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%.

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

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- Supplies

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 April 2010 – March 2011 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 year change

The fee schedule percentage change reflects the change in the percentage of Medicare fees used to reimburse DME products. Effective October 2008, DME services were reimbursed at 97% and 87% of Medicare fees for supplies and equipment respectively. DME reimbursement reverted back to its original level in October 2009.

The fee schedule year change reflects the overall change in the Medicare fee schedule in effect at the time of each claim. Prior to October 2008, SC DHHS applied the 2004 Medicare fee schedule for DME services. Between October 2008 and June 2009, SC DHHS applied the 2008 Medicare fee schedule for DME services. These factors were developed using the 2004 and 2009 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 Medicare DME fee schedule increased 10.6% from 2004 to 2009 for equipment codes and increased 2.3% for supply codes. The Medicare DME fee schedule increased 3.6% from 2008 to 2009 for equipment codes and increased 3.1% for supply codes.

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 0.974 and 1.065.

Maternity & Epidural Reimbursement Adjustment:

Effective October 2008, the reimbursement for labor, delivery, and epidural CPT codes were reduced to the following amounts:

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> $1,000 for the labor and delivery procedure codes 59409, 59514, 59612, and 59620

> $461 for procedure code 01967 and $195 for 01968

In August 2009 the reimbursement was restored to the original levels. We developed a reimbursement change factor in order to adjust claims incurred between October 2008 and August 2009 to their pre-October 2008 reimbursement levels.

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. Milliman conducted a confidential survey of all participating MCOs to gain a better understanding of the contractual arrangements currently in place across the state for the Medicaid Managed Care program. The survey covered most typical reimbursement arrangements and MCOs were asked to provide complete information regarding their current contractual adjustments.

Results of the survey were compiled, analyzed, and Milliman determined that the following adjustments are appropriate:

> Hospital inpatient hospital outpatient: 1.00

> Physician services: 1.02

> Other services: 1.00

We believe the large hospital inpatient and hospital outpatient reimbursement increases on October 2008 and October 2009 (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 Assessment Benefit Limit:

Certain mental health assessment services are limited to two sessions per calendar year. The codes to be limited to two sessions each are CPT codes 90801 and 90802. Dollars and units associated with sessions that exceeded the limit of two were removed in the capitation rate calculation to reflect this limitation.

The cost impact of this reduction in reimbursement varies from 0.971 to 1.000 for the various TANF rate cells, 0.998 to 1.000 for SSI, 1.000 for OCWI, and 0.989 to 1.000 for Duals.

Durable Medical Equipment Benefit Limit:

Effective February 1, 2009, SC DHHS implemented various limits on DME benefits. The adjustment factors reflect the impact of the following benefit changes:

> Increased pre-authorization for cranial bands

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- Nebulizer coverage limit of one per two years from one per year
- Nebulizer kits coverage limit of 15 kits per month from 31 per month
- Rent-to-own manual wheelchair coverage (custom wheel chair purchase allowed)

The cost impact of this reduction in reimbursement varies between 0.667 and 1.000 for the various TANF rate cells, between 0.987 and 1.000 for SSI, between 0.991 and 1.000 for OCWI, and between 0.991 and 1.000 for Duals.

Physician Benefit Limits:

SC DHHS implemented several physician benefit limits:

- Effective July 1, 2009, chiropractic visits are limited to 8 visits per recipient per year, a reduction from a 12 visit limit.
- Elimination of coverage for after-hours physician visits (CPTs 99050 eliminated on July 1, 2008 and 99051 eliminated on January 1, 2009).
- Effective January 1, 2009, elimination of coverage for group physical and occupational therapy services.
- Effective August 1, 2009, frequencies and service limits are implemented for rehabilitative therapy services as described in Table 9 below.

Table 9
South Carolina Department of Health and Human Services
Rehabilitative Therapy Services Limits

Procedure Code	Unit of Service	Frequency / Service Limit	Annual Service Limit
92507	15 minutes	4 units per day	300 units per year
92508	15 minutes	4 units per day	300 units per year
97110	15 minutes	4 units per day	300 units per year
97530	15 minutes	4 units per day	300 units per year

The cost impact of these benefit changes varies from 0.989 to 1.000 for the various TANF rate cells, 1.000 for SSI, between 0.999 and 1.000 for OCWI, and 1.000 for Duals.

Radiology Benefit Limit:

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This adjustment factor reflects a limit of two chest X-Rays (CPT 71010) per day as recommended by the National Correct Coding Initiative (NCCI) and limits on X-Ray readings (elimination of payment for modifier 99). These benefit limits were effective January 1, 2009.

The cost impact of these benefit changes varies from 0.939 to 1.000 for the various TANF rate cells, and from 0.999 to 1.000 for SSI, OCWI and Duals.

Synagis® Benefit Limit:

The Synagis® dosage limit was reduced from 6 to 5 doses effective October 15, 2008. No prior approval is required for 5 doses as long as they are given at least 30 days apart and meet the guidelines of the American Academy of Pediatrics (AAP) for Synagis® administration.

To develop the adjustment factor we summarized Synagis® utilization by individual and determined the dollar impact of applying the reduction in dosage limit. We then summarized our results by service category for each rate cell. Adjustment factors varying from 0.981 to 1.000 were applied to the immunization services for the TANF rate cells and from 0.998 to 1.000 for SSI. As expected, this change in benefit limit only impacted children 6 years old and younger.

Audiology Benefit Limit:

Several audiology services are covered under the MCO contract up to the limits specified in Table 10 below. Any services exceeding these limits have been removed.

Table 10
South Carolina Department of Health and Human Services
Audiology Services Limits

Procedure Code	Modifier	Frequency
92552		6 per year
92557		1 per year
92557	52	6 per year
92567		6 per year
92568		2 per year
92584		1 per implant
92585		No Limit
92585	52	No Limit
92587		No Limit
92588		No Limit
92590		6 per year
92592		6 per year
92592	52	6 per year
92626		10 per year
V5011		6 per year

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V5090		6 per year
V5275	RT	6 per year
V5275	LT	6 per year

For each individual, we summarized the count for each procedure and determined the impact of the limits by service category for each rate cell.

The cost impact of this adjustment varies from 0.999 to 1.000 for the various TANF rate cells and 1.000 for SSI, OCWI, and Duals.

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 January 2010 including claims paid through September 30, 2009. The claims data used in developing the Medicaid Managed Care rates also includes claims paid through September 30, 2009 allowing for three months of run-out for SFY 0809 and fifteen months of run-out for SFY 0708. The IBNR adjustment reflects an estimate of the claims that will be paid after September 30, 2009 for SFY 0809 incurred claims. We expect a limited amount of additional claims to be paid for SFY 0708 for the SSI population only.

The annual completion factors was developed using a composite of the lag 3 through 14 completion factors for SFY 0809.

MCO Selection Adjustment:

The MCO selection adjustment modifies the FFS base data to the morbidity level of the 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 11. Milliman's March letter provides the detailed calculation of the selection adjustments. The MCO selection factor is fully implemented for the April 2010 – March 2011 rate period.

Table 11
South Carolina Department of Health and Human Services
MCO Selection Adjustment

Rate Cell	SFY 0708 Adjustment	SFY 0809 Adjustment
TANF: 0 - 2 months old	1.0330	1.0600
TANF: 0 - 2 months old – LBW Withhold	1.0000	1.0000
TANF: 3 - 12 months old	1.0000	1.0000
TANF: Age 1 – 6	0.9306	0.8681
TANF: Age 7 – 13	0.9306	0.8681
TANF: Age 14 - 18 Male	0.9306	0.8681
TANF: Age 14 - 18 Female	0.9306	0.8681

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TANF: Age 19 - 44 Male	0.9579	0.9442
TANF: Age 19 - 44 Female	0.9579	0.9442
TANF: Age 45+	0.9579	0.9442
SSI	0.9278	0.8889
OCWI	0.9579	0.9442
Duals	1.0000	1.0000
Maternity Kicker Payment	1.0000	1.0000
Very Low Birth Weight Kicker Payment	1.0330	1.0600
Low Birth Weight Kicker Payment	1.0330	1.0600

The selection adjustment for the TANF 0 - 2 month rate cell represents the difference in FFS and MCO enrollment of babies in the first, second, and third months of life. Based on analysis of SFY 0708 and SFY 0809 FFS enrollment and September 2009 MCO enrollment, MCO enrolled a relatively higher proportion of babies in the first month of life compared to recent FFS enrollment. This enrollment pattern began in June 2009 and has remained stable.

Since the PMPM cost in the first month of life is much higher than in the second and third months of life, the MCOs therefore enroll a somewhat more costly mix of babies age 0 - 2 months compared to the FFS data that makes up the basis for the rate calculation.

Table 12 shows the calculation of the selection factor for the TANF 0 - 2 month rate cell.

Table 12
South Carolina Department of Health and Human Services
TANF: 0-2 Months Rate Cell Selection Factor Development

	SFY 0708 FFS Cost PMPM	SFY 0708 FFS Case Months	September 2009 MCO Case Months
Month 0	$2,899.14	35,811	1,864
Month 1	$520.87	35,706	1,675
Month 2	$362.09	33,288	1,646
Total	**$1,283.07**	**104,805**	**5,185**
Composite FFS Cost		$1,283.07	$1,325.45
Selection Factor			1.0330
	SFY 0809 FFS Cost PMPM	**SFY 0809 FFS Case Months**	**September 2009 MCO Case Months**
Month 0	$2,915.82	24,329	1,864
Month 1	$511.70	25,144	1,675
Month 2	$361.08	24,457	1,646
Total	**$1,253.03**	**73,930**	**5,185**
Composite FFS Cost		$1,253.03	$1,328.13
Selection Factor			1.0600

Trend SFY 0708 to SFY 0809:

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

Trend rates from SFY 0708 to SFY 0809 were developed by rate category and type of service for Medicaid Managed Care eligible services and individuals using fee-for-service data from SFY 0708 through SFY 0809. The trends were set adjusting for FFS cost changes caused by enrollment shifts by rate cell and changes in the MCO selection factor. We examined the trended SFY 0708 costs compared to the SFY 0809 costs and made further adjustments to promote general consistency over the entire MCO eligible population.

Table 13 below summarizes the estimated fee-for-service trend rates by major 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 for SFY 0708 to SFY 0809
Medical Benefits

Service Category	TANF Infants	TANF Children	TANF Adults	OCWI	SSI	Duals	Maternity Kick
Hospital Inpatient	0.0%	4.0%	4.0%	4.0%	12.0%	2.0%	4.0%
Hospital Outpatient	12.0%	12.0%	12.0%	12.0%	18.0%	10.0%	0.0%
Physician	2.0%	2.0%	2.0%	4.0%	8.0%	0.0%	0.0%
Other	2.0%	2.0%	2.0%	8.0%	4.0%	-8.0%	0.0%

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 MCO selection factor when setting the managed care savings adjustments. The managed care savings adjustments are shown in Table 14 below.

Table 14
South Carolina Department of Health and Human Services
Medicaid Managed Care Savings Assumptions

Service Category	Savings Percentage
Hospital Inpatient – Medical / Surgical	15%
Hospital Inpatient – Maternity Non-deliveries & Newborn	15%
Hospital Inpatient – Maternity Delivery	0%
Hospital Inpatient – SNF	0%
Hospital Outpatient	15%

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Emergency Room	20%
Professional	15%
Professional – Office Visits for Age <14 TANF and OCWI Rate Cells	0%
Professional – Office Visits for Other Rate Cells	15%
Professional – Injection & Immunization for Age <14 TANF Rate Cells	0%
Professional – Injection & Immunization for Other Rate Cells	15%
Professional – Maternity Delivery	0%
Other	20%

Step 3: Calculate Estimated April 2010 – March 2011 Managed Care Costs

In Step 3, SFY 0708 and SFY 0809 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 0708 fee-for-service data by eligibility category and service category for all covered service categories.

2. Summarize the adjusted SFY 0809 fee-for-service data by eligibility category and service category for all covered service categories.

3. Calculate the composite SFY 0809 PMPM costs by eligibility category. The composite is calculated as a weighted average of projected SFY 0708 and SFY 0809 costs based on each year's eligibility category specific member months.

4. Trend the composite SFY 0809 costs to April 2010 – March 2011 using projected inflation factors.

The inflation factors used to project expenditures from SFY 0809 to April 2010 – March 2011 are based on inflation factors used for South Carolina's most recent Medicaid budget projection and represent "best estimate" utilization trends. Table 15 below shows the annual inflation factors from SFY 0809 to April 2010 – March 2011. The annual rates are applied for the 21 month projection period.

Table 15
South Carolina Department of Health and Human Services
Medicaid Managed Care Annual Utilization Inflation Rates
SFY 0809 to April 2010 – March 2011

Service Category	Annual Inflation Rate
Hospital Inpatient	4.0%
Hospital Outpatient	4.0%

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Professional – TANF Children, OCWI, Duals & Kick	4.0%
Professional – TANF Adults and SSI	8.0%
Other	4.0%

Appendices E1 and E2 present the detailed April 2010 – March 2011 Managed Care cost estimates.

Step 4: Adjust for TPL Recoveries, Administrative Days, Administrative Expenses, and Supplemental Teaching Payments

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 0.995 for SFY 0708 and SFY 0809. This adjustment is shown in Appendices G1 and G2.

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 1.0007 for SFY 0708 and SFY 0809. This adjustment is shown in Appendices G1 and G2.

Administration:

Table 16 shows the administrative allowances for medical and pharmacy services by rate cell as a percentage of capitation revenue (excluding the supplemental teaching pass-through):

Table 16
South Carolina Department of Health and Human Services
Administrative Allowance as a Percent of Revenue

Rate Cell	Medical Services	Pharmacy Services
TANF: 0 - 2 months old	13.0%	9.0%
TANF: 0 - 2 months old – LBW Withhold	13.0%	NA
TANF: 3 - 12 months old	13.0%	9.0%
TANF: Age 1 - 6	13.0%	9.0%
TANF: Age 7 - 13	13.0%	9.0%
TANF: Age 14 - 18 Male	13.0%	9.0%
TANF: Age 14 - 18 Female	15.0%	9.0%
TANF: Age 19 - 44 Male	13.0%	9.0%
TANF: Age 19 - 44 Female	15.0%	9.0%
TANF: Age 45+	13.0%	9.0%

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

SSI	13.0%	9.0%
OCWI	15.0%	9.0%
Duals	Set equal to SSI	Set equal to SSI
Maternity Kicker Payment	7.5%	NA
Very Low Birth Weight Kicker Payment	13.0%	NA
Low Birth Weight Kicker Payment	13.0%	NA

The total administration allowance is 12.0% of the final capitation rates (medical and pharmacy) excluding the supplemental teaching payment pass-through. 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 Appendices G1 and G2.

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Supplemental Teaching Payments:

SC DHHS provided Milliman with lists of teaching physicians eligible for Medicaid Enhanced Payments during SFY 0809. We used these lists to compile all claims consistent with Attachment 1 for each of the providers and calculated the Supplemental Teaching Payments as 35% of billed charges with total payment per claim not to exceed total billed charges. The Supplemental Teaching Payment calculation procedure is summarized below:

1. Summarize the SFY 0708 Supplemental Teaching Payments for the listed providers by eligibility category and adjust for:
   - Utilization trend at the same rates used for the SFY 0708 to SFY 0809 trends in Table 13.
   - Billed charge trend of 5%.
   - IBNR adjustment
   - Average professional managed care adjustment by rate cell
2. Summarize the SFY 0809 Supplemental Teaching Payments for the listed providers by eligibility category and adjust for:
   - IBNR adjustment
   - Average professional managed care adjustment by rate cell
3. Calculate the composite SFY 0809 Supplemental Teaching Payments PMPM by eligibility category. The composite is calculated as a weighted average of projected PMPM cost for SFY 0708 and SFY 0809 based on each year's eligibility category specific member months.
4. Project to April 2010 – March 2011 using the following adjustments:
   - Utilization trend at the same rates used for the SFY 0809 to April 2010 – March 2011 trends in Table 15.
   - Annual billed charge trend of 5%.
   - TPL adjustment of 0.995.
   - The MCO selection adjustments shown in Table 11.

The Supplemental Teaching Payments are calculated in Appendices F1 – F6.

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Step 5: Adjust SSI Rate for MCO Specific Risk Score

The Medicaid Managed Care capitation rate methodology includes a risk adjustment component to account for the difference in morbidity among MCOs for the SSI eligibility category.

Risk adjusted payments are more accurate and appropriate than paying a fee-for-service average by age and gender and eligibility category. With an average payment system, MCOs' financial incentives are to seek the healthy and avoid the sick. With risk adjusted payments, MCOs can expect to be reimbursed based on the level of need of their Medicaid beneficiaries. In such an environment, MCOs can expect that they will be rewarded for designing better services and delivering them more efficiently for people with any kind of condition or level of need, including those with complex conditions and high levels of need. The implementation of a risk adjustment process should minimize the effect of anti-selection.

Milliman recommended the implementation of the Restricted Medicaid Rx model for the determination of risk adjustment. This recommendation is based upon the current limited availability of complete and credible diagnosis information through encounter data.

Medicaid Rx is a pharmacy based diagnosis system developed by the researchers at the University of California, San Diego (UCSD). Medicaid Rx is a standalone pharmacy-based methodology and was not combined with the diagnosis based risk adjustment system. The Restricted Medicaid Rx model excludes prescriptions for GAD (Gastric Acid Disorder), folate and iron deficiency anemias, EENT (Eyes, ears, nose, and throat), insomnia, pain, and low-cost infections. These categories of drugs, as identified by UCSD researchers, may be susceptible to gaming and their inclusion in a risk adjustment model might create an incentive for over prescribing. The risk score calculation also excluded the Depression / Anxiety and Psychotic Illness / Bi-polar disease categories. These disease categories were excluded since mental health services are not covered by the managed care plans.

Medicaid Rx risk adjustments for April 2010 through September 2010 capitation payments will be based on December 2009 SSI enrollment by MCO and SFY 0809 FFS and MCO encounter data pharmacy claims. Medicaid Rx risk adjustments for October 2010 through March 2011 capitation payments will be based on June 2010 SSI enrollment by MCO and CY 2009 FFS and MCO encounter data pharmacy claims. Both fee-for-service and encounter data related to pharmacy claims incurred in Fiscal Year 2009 will be used in the determination of the risk scores. SSI non-dual MCO enrollees with at least six month of exposure in either fee-for-service or managed care Medicaid during the base period will be included in the development of the average risk scores.

An MCO's SSI capitation rate will be determined based on the following formula:

MCO Capitation Rate = Base Capitation Rate x MCO Adjusted Risk Factor

The composite of the MCO Adjusted Risk Factors for all MCOs will be 1.000.

Milliman will provide a separate letter documenting the development of the MCO Adjusted Risk Factors that will be applied to the April 2010 – March 2011 SSI capitation rates.

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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 benefit package only.

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 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. Delivery with sterilization services are only included in the standard benefit package rate.

- 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 5th digit being 1 or 2) and reimbursement type equal to 1

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.

LOW BIRTH WEIGHT KICKER PAYMENT

The Low Birth Weight (LBW) kicker payments includes all non-pharmacy claims associated with low birth weight deliveries for the first three months of life that would otherwise be included in the 0 - 2 month rate cell.

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We assigned a birth weight category to infants for which an actual delivery claim could be found in the available claims data. We used ICD-9 codes 7640X, 7641X, 7642X, 7649X, 7650X, 7651X, V213X to define low birth weight babies if the applicable code could be found in the claims data two days prior or after the date of birth. We used the fifth digit of the code to categorize birth weight as shown in Table 17:

Table 17
South Carolina Department of Health and Human Services
Low Birth Weight Baby Classification

Grouping Number	Code	Description
1	1, 2, 3, 4, 5	Very Low Birth Weight: Less than 1,500 grams
2	6, 7, 8	Low Birth Weight: 1,500 – 2,500 grams
3	0, 9	Normal Birth Weight: Over 2,500 grams

If an infant had multiple birth weight codes in the claims data, we used the lowest birth weight code. Note that if diagnosis coding is inaccurate or incomplete, our assignment will also be inaccurate or incomplete. About 10% of FFS births have low birth weight diagnosis indicators.

The Low Birth Weight kicker payment is developed consistent with the methodology outlined in Steps 1 through 5 in Section IV of this report.

The LBW funding pool is established using historical LBW incidence rates reported by the MCOs for SFY 0809. The MCOs reported that 2.2% of births are very low birth weight (less than 1,500 grams) and 11.4% of births are low birth weight (1,500 – 2,500 grams). SC DHHS believes the higher reported incidence rates in the MCO population reflect more accurate birth weight coding under managed care than under FFS and do not reflect a higher incidence of LBW cases under managed care.

Appendices H1 – H4 show the calculation of the final LBW kicker payment amounts and the LBW withhold to fund the LBW kicker payment funding pool. The LBW withhold is a reduction to the monthly capitation rate for the TANF 1 – 3 month and SSI rate cells.

- The LBW kicker payment was set at 80% of the expected cost of a LBW birth. The remainder of the expected cost of the LBW birth was included in the age 1 – 3 month monthly capitation rate. By setting the kicker payment lower than the expected cost of the LBW case, SC DHHS provides a clear incentive for the MCOs to manage the incidence of LBW births.

- The LBW kicker payment pool is distributed to the MCOs throughout the year as they report LBW births. The reporting process follows the same manual process used for the maternity delivery kicker payment administration. Birth weight is reported as a data field on the maternity delivery kicker payment data submission.

- SC DHHS always pays out the entire LBW funding pool to the MCOs in a rate year no matter how many LBW babies are born. If there are fewer than expected LBW births in a year, the remainder of the LBW funding pool will be distributed to the MCOs in proportion to the number of LBW babies born

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into each MCO (i.e., the effective LBW kicker payment amount is increased). If there are more than expected LBW births in a year, the plans will settle with SC DHHS at the end of the year and split the LBW funding pool based on the number of LBW babies born into each MCO (i.e., the effective LBW kicker payment is reduced).

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V. METHODOLOGY AND RESULTS – PRESCRIPTION DRUG BENEFITS

This section of our report describes the April 2010 – March 2011 South Carolina Medicaid Managed Care 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 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 April 2010 – March 2011 managed care costs by eligibility category.

4. Adjust for Third Party Liability (TPL) recoveries, MCO selection, and administrative expenses.

5. Adjust SSI rates for MCO specific risk scores.

Each of the above steps is described in detail below.

Pending federal health care reform legislation would amend title XIX of the Social Security Act to reduce the costs of prescription drugs for enrollees of Medicaid managed care organizations by extending the rebates offered under fee-for-service Medicaid to such organizations. If or when a bill including this language passes, modifications to the assumptions detailed below are required to reflect the availability of increased prescription drug rebates to managed care organizations. These adjustments could vary depending how the bill is implemented.

Step 1: Extract Fee-For-Service Experience Data

In this step the fee-for-service experience for SFY 0708 and SFY 0809 is summarized by eligibility category and script tier for populations eligible to enroll in the Medicaid Managed Care program. Milliman used Attachment 1 prepared by SC DHHS to determine populations eligible to enroll in the Managed Care program.

Appendices J1 – J4 show Step 1.

Cost Sharing

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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 MCO capitation rate calculation.

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 Medicaid Managed Care program. Each adjustment factor is explained in detail below.

Appendices K1 – K4 show the impact of the Step 2 adjustments.

MCO Contractual Adjustment:

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 0.930 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 has two components. First, the number of overrides for the 4 prescriptions per month limit is reduced from an unlimited amount to a maximum of 6 overrides, effectively limiting the maximum number of scripts per member per month to 10 for adults 21 years of age or older. Secondly, the 34 day supply per prescription is reduced to a 31 day supply.

To develop the adjustment factors, we summarized monthly script count and day supplies by individual and applied the limits mentioned above and calculated 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 also reflect the elimination of coverage for expectorants and cough / cold medicines that is effective February 1, 2009.

The adjustment factors vary from 0.831 to 0.999 for the various TANF rate cells, from 0.938 to 0.983 for SSI, from 0.992 to 0.999 for OCWI, and from 0.965 to 0.999 for Duals.

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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.

MCO Selection:

We assumed the same MCO selection factors shown in Table 14.

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 SFY 0708 is 1.000 and slightly above 1.000 for SFY 0809 for certain rate cells.

Trend SFY 0708 to SFY 0809:

Trend rates from SFY 0708 to SFY 0809 were developed by rate category and type of service for Medicaid Managed Care eligible services and individuals using fee-for-service prescription drug data from SFY 0708 through SFY 0809. The trends were set adjusting for FFS cost changes caused by enrollment shifts by rate cell and changes in the MCO selection factor. We examined the trended SFY 0708 costs compared to the SFY 0809 costs and made further adjustments to promote general consistency over the entire MCO eligible population.

Table 18 below summarizes the estimated fee-for-service trend rates by service category for the Medicaid Managed Care program eligible populations.

Table 18
South Carolina Department of Health and Human Services
Medicaid Fee-For-Service Historical Trends
Prescription Drug Benefits

Service Category	TANF	OCWI	SSI	Duals
Generic	8.0%	0.0%	16.0%	-20.0%
Multi-Source Brand	8.0%	0.0%	16.0%	-20.0%
Single-Source Brand	12.0%	0.0%	16.0%	-20.0%
Over-The-Counter	8.0%	0.0%	16.0%	-20.0%
Unidentified	8.0%	0.0%	16.0%	-20.0%

Managed Care Savings Adjustment:

The managed care savings adjustment was developed based on a target generic dispensing rate of 75% of prescriptions and a reduction in the prescription utilization rates. Fee-for-service Medicaid achieves a generic

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dispensing rate of approximately 65%. Based on Milliman's Prescription Drug Rating model, moving from a 65% to a 75% generic dispensing rate would result in savings of 15%. 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 April 2010 – March 2011 Managed Care Costs

In Step 3, SFY 0708 and SFY 0809 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 0708 fee-for-service data by eligibility category and prescription drug tier.

2. Summarize the adjusted SFY 0809 fee-for-service data by eligibility category and prescription drug tier.

3. Calculate the composite SFY 0809 PMPM costs by eligibility category. The composite is calculated as a weighted average of projected SFY 0708 and SFY 0809 costs based on each year's eligibility category specific member months.

4. Trend the composite SFY 0809 costs to April 2010 – March 2011 using projected inflation factors.

The inflation factors used to project expenditures from SFY 0809 to April 2010 – March 2011 are based on inflation factors used for South Carolina's most recent Medicaid budget projection and represent "best estimate" PMPM cost trends. Table 19 below shows the annual inflation factors from SFY 0809 to April 2010 – March 2011. The annual rates are applied for the 21 month projection period.

Table 19
South Carolina Department of Health and Human Services
Medicaid Fee-For-Service Annual PMPM Cost Inflation Factors –
SFY 0809 to April 2010 – March 2011
Prescription Drug Benefits

Service Category	TANF	OCWI	SSI	Duals
Generic	6.0%	3.0%	7.5%	6.0%
Multi-Source Brand	8.5%	4.5%	10.5%	9.0%
Single-Source Brand	8.5%	4.5%	10.5%	9.0%
Over-The-Counter	4.0%	2.0%	4.5%	4.0%
Unidentified	7.0%	3.5%	8.5%	7.0%

Appendices L1 and L2 present the detailed April 2010 – March 2011 Managed Care cost estimates.

Step 4: Adjust for TPL Recoveries and Administrative Expenses

Third Party Liability Recoveries:

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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 0.995 for SFY 0708 and SFY 0809. This adjustment is shown in Appendices M1 and M2.

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

Administration:

We used the administrative allowances shown in Table 16.

The prescription drug administrative allowance is 9% of the prescription drug capitation rates. The total administration allowance is 12.0% of the final capitation rates (medical and pharmacy) excluding the supplemental teaching payment pass-through. 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 Appendices M1 and M2.

Step 5: Adjust SSI Rate for MCO Specific Risk Score

An MCO's SSI capitation rate will be determined based on the following formula:

MCO Capitation Rate = Base Capitation Rate x MCO Adjusted Risk Factor

The composite of the MCO Adjusted Risk Factors for all MCOs will be 1.000.

Milliman will provide a separate letter documenting the development of the MCO Adjusted Risk Factors that will be applied to the April 2010 – March 2011 SSI capitation rates.

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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 South Carolina Medicaid Managed Care 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 – M.

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 contractor 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 20
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,

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	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 21
South Carolina Department of Health & Human Services
Hospital Outpatient Service Groupings by Revenue Code

Service Category	Revenue Code
Emergency Room	'0450'-'0459','0681'-'0689','0981'
Surgery	'0360'-'0369','0490'-'0499','0790'-'0799','0975'
Radiology	'0255','0320'-'0329','0330','0331'-'0332','0333','0335','0339','0340','0341','0342', '0343','0344','0349','0350'-'0352','0359','0371','0400'-'0403','0404','0405'-'0409', '0610'-'0612','0613','0614'-'0616','0617','0618'-'0619','0621','0972','0973','0974'
Pathology	'0300'-'0309','0310'-'0319','0923','0925','0971'
Pharmacy & Blood	'0250'-'0253','0256'-'0257','0259','0380'-'0389','0390'-'0399','0630'-'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'-'0269', '0270'-'0279','0280'-'0289','0370','0372','0374','0379','0410'-'0419','0460'-'0469', '0470'-'0479','0500'-'0509','0510','0511'-'0518','0519','0520'-'0521','0522'-'0529', '0530'-'0539','0540'-'0549','0560'-'0569','0622'-'0629','0634'-'0635','0670'-'0679', '0700'-'0709','0710'-'0719','0720'-'0729','0740'-'0749','0750'-'0759','0760'-'0769', '0770'-'0789','0800'-'0809','0810'-'0819','0820'-'0889','0890'-'0899','0900'-'0919', '0920','0922','0924','0929','0940'-'0942','0944'-'0945','0946'-'0949','0951'-'0960', '0961','0962','0963'-'0964','0969','0976','0980','0982','0983','0984','0986','0987'-'0988','0990'-'9999'

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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.

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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

The MCO capitation rates are developed using South Carolina fee-for-service Medicaid data for a comparable population to that enrolled in MCOs. SC DHHS calculates State-set rates by rate category on a statewide basis. Please refer to Sections III – V of this report for more details.

AA.1.1 – Actuarial Certification

Please refer to Appendix Q for our actuarial certification of the April 2010 – March 2011 capitation rates. The April 2010 – March 2011 South Carolina Medicaid Managed Care 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 P includes a projection of total expenditures and Federal-only expenditures based on actual September 2009 MCO enrollment, October 2009 – March 2010 capitation rates and April 2010 – March 2011 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

The South Carolina Medicaid Managed Care program 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

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

The April 2010 – March 2011 rates documented in this report are the initial capitation rates for the April 2010 – March 2011 Medicaid Managed Care contracts.

AA.2.0 – Base Year Utilization and Cost Data

The base year utilization and cost data is SFY 0708 and SFY 0809 fee-for-service data for the population that is eligible to enroll in an MCO.

Only State Plan services that are covered under the South Carolina Medicaid Managed Care 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

The rate structure includes a rate cell that only applies to individuals who receive retroactive Medicare eligibility while enrolled in an MCO. The Dual Eligible rate cell includes all Medicaid services and Medicare crossover claims payments that are the responsibility of the MCOs for a dually eligible individual.

AA.2.3 – Spend Down

The spend down population is excluded from the Medicaid managed care program and the capitation rate development.

AA.2.4 – State Plan Services Only

The base utilization and cost data is SFY 0708 and SFY 0809 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 April 2010 – March 2011 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

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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 0.995 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 South Carolina Medicaid managed care 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 were removed from the base data in the capitation rate calculation.

AA.3.9 – FQHC and RHC Reimbursement

The rate development methodology includes an actuarially equivalent rate for services rendered by FQHCs and RHCs. The claims data is adjusted so that FQHC and RHC payment levels are on a "per-claim" basis, making them equivalent to payment levels to other providers. Please refer to the Federally Qualified Health

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Center (FQHC) and Rural Health Clinic (RHC) Repricing portion of Section III of this report for a detailed explanation on the method used to convert the FQHC and RHC encounter rate to a fee-for-service equivalent.

AA.3.10 – Medical Cost Trend Inflation

Trend rates from SFY 0708 to SFY 0809 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 0809. The trends were set adjusting for FFS cost changes caused by enrollment shifts by rate cell and changes in the MCO selection factor.

The inflation factors used to project expenditures from SFY 0809 to April 2010 – March 2011 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 0708 and April 2010 – March 2011.

AA.3.11 – Utilization Adjustments

Utilization trend is included in AA.3.10.

AA.3.12 – Utilization and Cost Assumptions

The April 2010 – March 2011 capitation rates for the SSI population will use the Medicaid Rx risk adjuster to adjust the rates for each participating MCO. Medicaid Rx uses recipients' prescription drug usage information to develop a risk score for each individual. Section IV, Step 5 explains how the risk scores are calculated and applied to the participating MCOs' rate for the SSI population.

The April 2010 – March 2011 capitation rates for the TANF and OCWI populations are risk adjusted using age and gender only. SC DHHS will continue to monitor the MCO population through MCO encounter data submission to assess the relative risk of the MCO and fee-for-service populations.

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.

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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

The April 2010 – March 2011 capitation rates for the SSI population will use the Medicaid Rx risk adjuster to adjust the rates for each participating MCO. Medicaid Rx uses recipients' prescription drug usage information to develop a risk score for each individual. Section III, Step 5 explains how the risk scores are calculated and applied to the participating MCOs' rate for the SSI population.

Milliman will provide a separate letter documenting the development of the MCO Adjusted Risk Factors that will be applied to the April 2010 – March 2011 SSI capitation rates.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

None

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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

SC DHHS has implemented a withhold and incentive arrangement for the contract period of April 2010 through March 2011. The terms of the withhold and incentive arrangement are outlined in the contract with the MCOs. The incentive will not exceed 105% of the capitation rates. The withhold and incentive are based on an actuarially sound methodology and will be based on the provisions of the contract. The capitation rates shown in this report do not reflect the withhold provision. Withhold payments will be available to both private and public contractors, and will not be conditioned upon intergovernmental transfer agreements. Withhold payments will be reviewed on an annual basis, and will not be renewed automatically.

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March 3, 2010

South Carolina Department of Health & Human Services
Capitated Contracts Ratesetting
Actuarial Certification
April 2010 – March 2011 Medicaid Managed Care 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 Medicaid Managed Care capitation rates for April 2010 – March 2011 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 April 2010 – March 2011. To the best of my information, knowledge and belief, for the period from April 2010 to March 2011, 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.

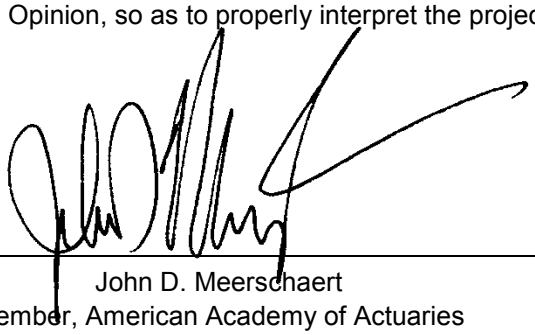
In making my opinion, I relied upon the accuracy of the underlying claims and eligibility data records and other information. A copy of the reliance letter received from SC DHHS is attached and constitutes part of this opinion. I did not audit the data and calculations, but did review them for reasonableness 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.

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2010 – March 2011 capitation rates for this program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

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.



John D. Meerschaert
Member, American Academy of Actuaries

March 3, 2010

Milliman

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

Eligibility Criteria

Eligibility File Type	Criteria	Notes	Notes
Recipient	Exclude Recipient Payment Categories:10,14,15,33,41,42,43,48,49,50,52,54,55,56,70,90,92		Recipient Detail Flag
Recipient	Exclude if age >= 65 on date of service		Over 65 Flag
Recipient	Exclude Dual eligible members		Dual Flag
Recipient	Retroactive Eligibility	See Methodology and Results - General	Retro Elig Flag
Recipient	Long Term Care Exclusion	See Methodology and Results - Medical Benefits	LTC Flag
RSP	Exclude where RSP Program in: 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		RSP Flag

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	01	Any	Exclude if Prior Authorization (PA) starts with “TR”	
Z	01	Any	Exclude if Provider Number = TR0001	
Z	All	Any	Exclude if DRG = 103, 302, 480, 481, 495, 512, 513	
Z	01	Any	Exclude if Provider Category of Service = 01 ***AND*** DRG in (424-437 OR 521-523)	
Z	02	Any	Exclude if Provider Control Facility in (010, 011)	
Z	02	Any	Exclude if Prior Authorization (PA) starts with “TR”	
Z	02	Any	Exclude if Provider Number = TR0002	
Z	01 and 02	Any	Exclude if Principal Diagnostic Class Code is "C" (except in Revenue Code - emergency room)	Principal Diagnostic Class Code located in the State's Diagnostic reference table.
Z	02	Any	Exclude if Principle Surgical Procedures in (96.54, 23.01-24.99)	
Z	02	Any	Exclude if Reimbursement Type = 1 ***AND*** 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	All	Any	Exculde if Procedure Codes in (H0002, H0031)	
A or B	All	Any	Exclude all Procedure Codes that begin with "D" except D1206	
A	19	Only specialties: 04, 06, 25, 86, 99	Exclude if Procedure Code = 99420 ***AND*** Modifier in (TG, 0TG)	
A	19	Only specialties: 04, 06, 25, 86, 99	Exclude if Procedure Code = S3260	
A	19	04	Audiology Services exclusion subject to service limits by procedure code	See Methodology and Results - Medical Benefits
A	20 or 21	31	Exclude if Procedure Code in (V2500-V2599,92070, 92310-92313,92340)	
A	33 or 34	34	Exclude if Procedure Code in (V2500-V2599,92070, 92310-92313,92340)	
A	20 or 21	Any	Exclude if Provider Control Facility in (010, 011)	
A	20 or 21	Any	Exclude if Procedure Code in (90804–90829, 90847, 90853, 90862, 90870, 90882, 90887, 90899) ***AND*** Modifier = 000	
A	19	86	Exclude if Provider Control Facility is (010,011)	
A	19	86	Exclude if Procedure Code in (90804–90829, 90847, 90853, 90862, 90882) ***AND*** Modifier = 000	
A	19	86	Mental Health limits to 2 each per year Procedure Codes 90801 and 90802	
A	20 or 21	Any	Exclude if Procedure Code = 96101 ***AND*** Modifier in (HP, 0HP, 000)	
A	20 or 21	Any	Exclude if Procedure Code in (90804, 90806, 90847, 90853) ***AND*** Modifier in (0HN, HN, 0HO, HO, 0HP, HP)	
A	20 or 21	Any	Mental Health limits to 2 each per year of Procedure Codes 90801 and 90802	
A	21	Any	Exclude if Prior Authorization (PA) starts with "TR"	
A	21	Any	Exclude if Provider Number = TR0003	
A	22	Only specialties: 95, 96, 51, 21, 50, 58, 93, 94, 97, 98	Exclude if Procedure Code in (X2040, X2041, S3260, T1002, T1003)	
A	22	Only specialties: 95, 96, 51, 21, 50, 58, 93, 94, 97, 98	Exclude if Procedure Code = T1015 ***AND*** Modifier in (0HE, HE)	
A	22	Only specialty: 95	Exclude claims where the last 2 bytes of Billing 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 ***AND*** Procedure Code in (S0700-S0703)	
A	22	Only specialty: 96	Exclude if Provider Number = MC0015 ***AND*** Procedure Code in (99241-99245) ***AND*** Modifier in (TF, 0TF)	
A	22	Only specialty: 96	Exclude if Provider Number in (MC0008, MC0009, MC0010, MC0011, MC0021, MC0040) ***AND*** Procedure Code in (T1016, T1017, S0315, S0316, S9445, 99204, 99213, 99214, 99215)	Sickle cell services

A	22	Only specialty: 51	Exclude if Procedure Code in (T1016, T1017, T1027) ***AND*** Provider Number in (DHEC01-DHEC46, DHEC59)	BabyNet services
A	22	Only specialty: 51	Exclude if Primary Diagnosis in COMDHEC table ***AND*** Provider Number in (DHEC01-DHEC46, DHEC59)	Commiunicable Diseases
A	35, 36, 37, 38, 60, 76	Any	Include all claims	
A	80	Any	Exclude if Provider Control Facility = 017 ***AND*** Primary Diagnosis in COMDHEC table	
A	81	Any	Include all claims	
A	82	Any	Include all claims	
A	19 or 21	01, 84, 85, 87	Include All claims	

Note only provider types (19,20,21,22,33,34,35,36,37,38,60,76,80,81,82) are included in rate setting for A claim types.

Pharmacy Claims

Claim Type	Provider Type	Provider Specialty	Criteria	Notes
D	70	Any	Include All Claims	

Note only provider type 70 is included in rate setting for D claim types.

Family Planning Claim Identification for Ethically Limited Rates

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 ***AND*** Fund Code = CA	

Note these additional exclusions are only used in rating Ethically limited plans.

APPENDIX 5

Select Health of South Carolina, Inc.
Ethical Limitations

AmeriHealth Mercy Health Plans (AMPH) Ethical Limitations

AMHP is bound to abide by the principles set forth in the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops in all of its activities. In accordance with its ethical obligations, AMHP shall not provide, support or participate in the delivery of any services, including family planning services, which are inconsistent with such directives. This limitation shall preclude AMHP from performing case management, quality management, utilization review services and claims processing in relation to family planning services.

Family planning services are defined as all services (including counseling), procedures, devices and medications for the purpose of infertility treatment or for the purpose of preventing or terminating pregnancy including temporary and permanent sterilization procedures, such as tubal ligation and vasectomy procedures, and abortions. All family planning services are subject to AMHP's Ethical Limitations.

Note: Codes and descriptions are current as of May 1, 2009

Diagnosis Codes

635.00 through 635.92	Legally induced abortions
636.00 through 636.92	Illegally induced abortion
637.00 through 637.92	Unspecified abortion
779.6	Termination of pregnancy
V15.71	Personal history of contraception
V25.0 through V25.09	Encounters for contraceptive management
V25.1	Insertion of IUD
V25.2	Sterilization
V25.3	Menstrual extraction
V25.40	Contraception surveillance, NOS
V25.41	Contraception pill surveillance
V25.42	IUD Surveillance
V25.43	Implantable Subdermal Contraception
V25.49	Contraception Surveillance, Necessary
V25.5	Family Planning Device
V25.8	Contraceptive Management, Necessary
V25.9	Contraceptive Management, NOS
V26.31	Genetic counseling on procreative management
V26.41	Procreative management counseling

1 South Carolina Department of Health and Human Services (SCDHHS) considers these to be family planning diagnoses. AmeriHealth Mercy considers them to be either family planning or medical diagnoses. AmeriHealth Mercy will not pay for these diagnoses for South Carolina Medicaid members.

V26.34	Testing of male for genetic disease carrier status
V26.49	Other procreative management, counseling and advice
V26.51	Tubal Ligation status
V26.52	Vasectomy status
V26.81	Encounter for assisted reproductive fertility procedure cycle
V26.89	Other specified procreative management
V45.5 through V45.59	Follow-up, post insertion of contraceptive device
DRG 3742	Routine vaginal delivery with bilateral tubal ligation

Procedure Codes

Below are listed procedure codes that carry a Family Planning, Abortion, or Sterilization indicator. As a general rule, these codes are considered outside the MCO's core benefits. In some rare cases it may be appropriate for a code to be utilized for a medical (Non-Family Planning, Non-Abortion, or Non-Sterilization) procedure. In such cases, the service will be considered a covered service.

Family Planning services - rendered but utilizing a procedure code that is not indicated on the list below - are non-covered services under the ethical limitation plan. These services should be billed to regular Medicaid Fee-for-Service. The plan is encouraged to check the monthly Fee Schedule to insure that they have the most current listing.

Family Planning Procedure Codes

11975	INSERT, IMPLANTABLE CONTRACEPT
11976	REMOVAL IMPLANTABLE CONTRACE
11977	REMOV W/REINS IMPLANT CONTRAC
11981	INSERT NON-BIODEGRADE DRUG DELIV IMPLANT with OFP modifier
11982	REMOVE NON-BIODEGRADE DRUG DELIV IMPLANT with OFP modifier
11983	RMOVE/REINSRT NON-BIO DRUG DELIV IMPLANT with OFP modifier
54900	EPIDIDYMOVASOSTOMY ANASTOM E
54901	EPIDIDYMOVASOSTOMY ANASTO EPI
55200	VASOTOMY CANNULI W/WO INCIS VA
55300	VASOTOMY VASOGRAM SEMINAL VE
57170	DIAPHRAGM FITTING W INSTRUCTION
58300	INSERTION OF INTRAUTERINE DEVICE
58301	REMOVAL OF INTRAUTERINE DEVICE
58340	CATH&INTRO SALINE OR CONTR MAT
58350	CHROMOTUBATION OF OVIDUCT INC
58750	TUBAL REANASTOMOSIS
58760	FIMBRIOPLASTY

2 Because a tubal ligation is sometimes performed with this DRG, DRG 374, when a bilateral tubal ligation is included, will be considered to be family planning, i.e., carved out of the captation paid by South Carolina to AmeriHealth Mercy. AmeriHealth Mercy will not pay for DRG 374 when a bilateral tubal ligation is included for South Carolina members.

58825 TRANSPOSITION OVARY(S)
58920 WEDGE RESECTION UNIL BILAT
74740 PERCUTANEOUS HYSTEROGRAM
89300 SEMEN ANALYSIS W/HUHNER
89310 SEMEN ANALYSIS MOTILITY & COUNT
89320 SEMEN ANALYSIS COMPLETE
89322 SEMEN ANALYSIS; VOLUME, COUNT, MOTILITY, AND DIFFERENTIAL USING STRICT MORPHOLOGIC CRITERIA
89331 SPERM EVALUATION, FOR RETROGRADE EJACULATION, URINE (SPERM CONCENTRATION, MOTILITY, AND MORPHOLOGY, AS INDICATED)
99401 E/M PREVENT MED COUNSELING, IND with OFP modifier
A4261 CERVICAL CAP FOR CONTRACEPTIVE USE
A4266 DIAPHRAGM FOR CONTRACEPTIVE U
A4267 CONTRACEPTIVE SUPPLY, CONDOM,
A4268 CONTRACEPTIVE SUPPLY, CONDOM,
A4269 SPERMICIDE
A4269 CONTRACEPTIVE SUPPLY, SPERMICID
G0027 SEMEN ANALY; PRESENCE/MOTIL SPE
H1010 NON-MEDICAL FAM PLAN ED, PER SE
H1011 FAMILY ASSESSMENT BY LIC BEHAV
H2000 COMPREHENSIVE MULTIDISCIPLINAR
H2001 REHABILITATION PROGRAM, PER 1/2
J1055 INJ MEDROXYPROGESTERONE AETAT
J1051 INJECTION, MEDROXYPROGESTERONE ACETATE
J1056 IN,MEDROXYPROGEST ACET/ESTR CY
J7300 INTRAUTERINE COPPER CONTRACEPT
J7303 CONTRACEPTIVE, HORMONE W/VAGI
J7302 LEVONGESTREL – RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM
J7304 CONTRACEPTIVE SUPPLY, HORMONE PATCH,EACH
J7306 LEVONGESTREL IMPLANT SYSTEM,INCL SUPPLIE
J7307 ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES
S0181 ONDANSETRON HYDROCHLORIDE, ORAL, 4MG
S4981 INSRT LEVONORGESTREL-RELEAS INTRAUTERINE
S4989 CONTRACEPTIVE INTRAUTERINE DEV
S4993 CONTRACEPTIVE PILLS FOR BIRTH CO
S9445 PATIENT EDUCATION, NOT OTHERWIS with OFP modifier
S9446 PATIENT EDUCATION, NOT OTHERWIS with OFP modifier
T1023 SCREENING TO DETERMINE THE APPR with OFP modifier

Sterilization Procedure Codes

55250 VASECTOMY UNI/BIL (SEP PRO)INC P
55450 LIGATION(PERCUTAN)VAS DEFERNS U
58565 HYSTEROSCOP,SURG;W/BILAT FALLOP TUBE CAN
58600 TRANSECT FALLOPIAN TUBE UNIL & B
58605 TRANSECT FALLOPIAN TUBE POSTPA
58611 LIGATION TRANSEC FALLOP TUBE W/
58615 OCCLUSION FALLOP TUBE(S)BY DEVI
58670 LAP SURG FULGURATION OVIDCT W/
58671 LAP SURG OCCL OVIDUCTS DEV EG B
58672 LAPAROSCOPY SURGICAL W/ FIMBRI

Abortion Procedure Codes

59100 HYSTEROTOMY, ABDOMINAL (e.g. HYDATIDIFORM MOLE, ABORTION)
59840 INDUCED ABORTION PER D&C
59841 INDUCE ABORT, DILATION & EVAC
59850 INDUCE ABORT,BY INJECT INCLD HOS
59851 INDUCE ABORT,D&C &/OR EVACUATI
59852 INDUCED AB BY AMNIO INJ W HYSTE
59855 INDUCE ABORT BY VAG SUPPOSIT INC
59856 INDUCE ABORT VAG SUPPOS HOSP AD
59857 INDUCE ABORT VAG SUPPOS HOSP AD
59866 MULTIFETAL PREGNANCY REDUCTIO
59870 UTERINE EVAC&CURETTAGE FOR HY
S0191 MISOPROSTOL,ORAL,MCG
S0199 MEDICALLY INDUCED ABORTION BY
X0191 MISOPROSTOL,ORAL,MCG
X0199 MEDICALLY INDUCED ABORTION BY

Surgical Procedure Codes

FAMILY PLANNING

surg_proc_	surg_proc_name
63.82	RECONSTRUCT SURGI DEVID VAS DEF
65.22	OVARIAN WEDGE RESECTION
66.79	FALLOP TUBE REPAIR NEC
66.8	FALLOPIAN TUBE INSUFFLAT
66.21	BILATERAL ENDOSCOPIC LIGATION
66.22	BILATERAL ENDOSCOPIC LIGATION
66.29	OTHER BILATERAL ENDOSCOPIC
66.31	OTHER BILATERAL LIGATION
66.32	OTHER BILATERAL LIGATION
66.39	OTHER BILATERAL DESTRUCTION
66.91	FALLOPIAN TUBE ASPIRAT
66.93	IMPL FALLOP TUBE PROSTH
66.94	REMOV FALLOP TUBE PROSTH
66.95	BLOW THERAPEUT INTO TUBE
66.96	FALLOPIAN TUBE DILATION
66.99	FALLOPIAN TUBE OP NEC
69.7	INSERTION OF IUD
69.91	INSERT UTERINE DEVICE
69.92	ARTIFICIAL INSEMENATION
87.82	GAS HYSTEROSALPINGOGRAM
87.83	DYE HYSTEROSALPINGOGRAM
87.91	CONTR SEMIN VESICULOGRAM
96.17	VAG DIAPHRAGM INSERTION
97.24	REPLACE VAG DIAPHRAGM
97.71	REMOVAL IUD
97.73	REMOV VAGINAL DIAPHRAGM
99.96	SPERM COLLECTION